



**State of Florida
Correctional Medical Authority**

**2012-2013
Annual Report
and
Report on Aging Inmates**

December 2013

State of Florida Correctional Medical Authority

Section 945.602, Florida Statutes creates the Correctional Medical Authority (CMA).

The governing board of the CMA is composed of seven people appointed by the
Governor and subject to Senate confirmation.

Peter C. Debelius-Enemark, MD, Chair
Representative
Physician

Katherine E. Langston, MD
Representative
Florida Medical Association

Ryan D. Beaty
Representative
Florida Hospital Association

Joyce A. Phelps, ARNP
Representative
Nursing

Lee B. Chaykin
Representative
Healthcare Administration

Harvey R. Novack, DDS
Representative
Dentistry

Leigh-Ann Cuddy, MS
Representative
Mental Health

December 31, 2013

The Honorable Rick Scott
Governor of Florida

The Honorable Don Gaetz, President
The Florida Senate

The Honorable Will Weatherford, Speaker
Florida House of Representatives

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

It is my pleasure to provide you with a copy of the Correctional Medical Authority's 2012-13 Annual Report on the status of health care delivery system in the Florida Department of Corrections including the required annual report on the status and treatment of elderly offenders. This report summarizes our activities during Fiscal Year 2012-13 which included rebuilding the CMA and two on-site physical and mental health surveys of major correctional institutions. The report describes the work of the Authority's governing board and staff, as well as plans to reinstitute the CMA's quality management committee and budget workgroup to fulfill our statutory responsibility to assure that adequate standards of physical and mental health care are maintained in correctional institutions.

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

Sincerely,

Jane Holmes-Cain, LCSW

Jane Holmes-Cain, LCSW
Executive Director

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INTRODUCTION

Purpose of the Report

Per F.S. 945.6031, the CMA is required to report annually to the Governor and Legislature on the status of the Department of Corrections' (DOC/Department) health care delivery system. This report contains information regarding the history of the CMA, legal updates, the privatization of health care within the DOC and CMA staff activities. The second section, required by F.S. 944.8041, contains a report on the status and treatment of elderly offenders

History of the CMA

The CMA was created in July 1986, while the state's prison healthcare system was under the jurisdiction of the federal court as a result of litigation that began in 1972. *Costello v. Wainwright* (430 U.S. 57 (1977)) was a class action suit brought by inmates alleging that their constitutional rights had been violated by inadequate medical care, insufficient staffing, overcrowding, and poor sanitation. The CMA was created as part of the settlement of that case and continues to serve as an independent monitoring body providing oversight of the systems in place to provide health care to inmates in the Department of Corrections (Department/DOC). In the final order closing the *Costello* case, Judge Susan Black noted that the creation of the CMA made it possible for the Federal Court to relinquish the prison monitoring and oversight function it had performed for the prior twenty years. In light of "Florida's affirmation of its continued commitment to the CMA's independence" and the support from the Defendant and the State of Florida, the court found that the CMA was capable of "performing an oversight and monitoring function over the Department in order to assure continued compliance with the orders entered in this case."

More recently, in December 2001, DOC entered into a settlement agreement in a lawsuit (*Osterback v. Crosby*, 16 Fla. Weekly Fed. D 513 (N.D. Fla. 2003)) involving mentally ill inmates housed in close management (CM). The purpose of close management is to confine inmates separate from the general inmate population for reasons of security and for the order and effective management of the prison system. The *Osterback* agreement included a stipulation that the CMA monitor provisions of the agreement including clinical, administrative, and security components of the program designed to ensure effective treatment of mental illness in

the CM population. The CMA completed its special monitoring responsibilities pending the outcome of the federal court's hearing of the case. The Department completed and complied with each component of the CM corrective action plan process. The court entered a final judgment ruling in favor of the Department and the case was closed on March 28, 2008. Facilities with CM are now monitored as part of the regular CMA survey process.

In the 2011 legislative session, the CMA lost its funding. Governor Rick Scott vetoed a conforming bill which would have eliminated the CMA from statute. In the 2012 legislative session, the Governor requested funding be restored. The Legislature concurred and funding was provided effective July 1, 2012. Osterback, along with the multitude of lawsuits related to the provision of correctional health care, serve as reminders of the CMA's important role in ensuring proper health and mental health care is provided to incarcerated members of society.

Update on Legal/Fiscal Issues

The right of inmates to access adequate health care has been constitutionally guaranteed and upheld by the courts (Estelle v. Gamble, 429 U.S. 97 (1976)). It is important to remember the CMA and all functions set forth by the Legislature resulted from federal court findings that Florida's correctional system provided inadequate health care and an oversight agency with board review powers was needed.

It is well documented that inmates are disproportionately more likely to suffer from a variety of chronic communicable diseases, mental health problems, and substance abuse issues than persons in the community. More than 18 percent of hepatitis C virus carriers in the country and one-third of those with active tuberculosis pass through the jail or prison system.¹ Inmates are affected by HIV/AIDS in greater numbers.² Inmates are also disproportionately affected by

1. National commission on correctional health care (2004). *The health status of soon-to-be released inmates: A report to congress, Volume 1*. September 2001. (No. 189735). Chicago, IL: Author.

2. Department of Justice (2010, September) *Office of Justice Programs, Bureau of Justice Statistics Bulletin*, Washington, D.C. U.S. Retrieved November 11, 2013 from <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4452>.

other chronic health conditions, including diseases of the cardiovascular and respiratory systems, as well as certain types of cancers.³

Many inmates come into prison with poor health status due to lack of preventive medical and dental care, untreated chronic disease, mental illness, years of substance dependence (e.g., alcohol, tobacco, illicit drugs), and the effects of previous incarcerations. The generally poorer health status of inmates and the aging population combined with the increasing cost of health care has resulted in medical care being a primary contributor to steadily increasing state budgets.⁴

Legal Update

Several states have recently been faced with legal challenges involving prison health care. The Mississippi Department of Corrections (*Dockery v. Epps*, No. 13-0032 (S.D. Miss. 2013). has been accused of, among other concerns, not adequately protecting the health and well being of inmates housed at the East Mississippi Correctional Facility. It was alleged that inmates were not provided with adequate medical and nutritional care and were not protected from physical abuses and violence. In 2013, plaintiffs filed suit against the correctional facility with the assistance of the American Civil Liberties Union and the Southern Poverty Law Center.⁵

The state of Wisconsin settled a lawsuit in 2010 involving health care at its women's prison. The suit was filed on behalf of 700 inmates alleging that the consequences of inadequate physical and mental health care led to an extensive outbreak of staphylococcus aureus infection, needless long-term health problems, and suicides. The settlement required the construction of a new facility for female inmates, the addition of full time medical staff, and additional mental health staff.

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

3. Binswanger, IA., Krueger, P.M., Steiner, J.F. (2009) *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population*. Journal of Epidemiology and Community Health, 63: 912-919.

4. Aging Inmate Committee, American Correctional Association, *Aging Inmates: Correctional Issues and Initiatives*, Corrections Today, August/September 2012, 84-87.

5. American Civil Liberties Union. <https://www.aclu.org/prisoners-rights/dockery-v-epps> accessed November 4, 2013.

and Rehabilitation alleging that the medical care provided in its institutions was so inadequate that it violated the Eighth Amendment and was, thus, considered to be cruel and unusual punishment. The state agreed to remedy the conditions in a settlement in 2002. However, in 2006, after years of insufficient progress towards a constitutionally adequate system, the federal court removed control of the prison health care system from the state and appointed a federal receiver to take over the system. To date, the receivership remains active.⁶

The above are only a few examples of the multitude of pending lawsuits stages. By ensuring that the quality of health care does not fall below constitutionally mandated standards, the CMA performs a risk management function for the State of Florida's correctional health care system.

Legislative Issues: Privatization of Health Care Services

On December 21, 2012, DOC entered into a contract with Wexford Health Sources, Inc., a private, for-profit company, to provide comprehensive health care services for Florida inmates located at nine correctional institutions (CI) in South Florida: Hardee CI, DeSoto CI, Charlotte CI, Okeechobee CI, Martin CI, Everglades CI, Dade CI, Homestead CI, and South Florida Reception Center. The contract will be in place for five years and may be renewed at its conclusion for another five years.

On October 15, 2012, DOC entered into a contract with Corizon, Inc., a private, for-profit company, to provide comprehensive health care services for Florida inmates located in Regions I and II, as well as the following institutions in Region III: Avon Park CI, Hernando CI, Lake CI, Polk CI, Sumter CI, Zephyrhills CI, and Central Florida Reception Center. Although, there were several delays secondary to legal challenges, Corizon, Inc. was eventually awarded the contract. The contract will be in place for five years and may be renewed at its conclusion for another five years.

The provision of health care services remains governed by the expectations and standards set forth by the Department.

6. California Prison Health Care Services: www.cphcs.ca.gov/docs/resources/factsheet.pdf accessed November 4, 2013.

Current Functions

The CMA is comprised of a seven member volunteer board of appointed by the Governor and confirmed by the Florida Senate. The CMA Board is comprised of health care professionals from various administrative and clinical disciplines, including nurses, hospital administrators, dentists, and mental and physical health care experts. The CMA has a staff of six full time employees and utilizes independent third parties for certain functions. Although the CMA is currently housed within the administrative structure of the Executive Office of the Governor, the CMA is an independent state agency charged with the responsibility of overseeing the health care delivery system of Florida's DOC. As an independent agency, pursuant to its expressed statutory provisions, the CMA's purpose is to assist the delivery of health care services for inmates in the Department by advising the Secretary of Corrections of the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care. The CMA fulfills this purpose by advising the Governor and the Legislature of the status of the Department's health care delivery system and by assuring the adequate standards of physical and mental health care for inmates are maintained at all DOC institutions.

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

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

Strategies employed by the CMA to meet its objectives include:

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

This annual report describes the activities of the CMA during the Fiscal Year (FY) 2012-13, including the findings of two on-site institutional surveys.

CMA STAFF ACTIVITIES

Rebuilding the CMA

During the 2012 legislative session, funding for CMA was authorized and the CMA functions were placed within the Executive Office of the Governor. In October 2012, an Interim Executive Director was appointed. A Staff Assistant and an OPS Senior Government Analyst were hired to re-establish the CMA. Archived materials and computer documents (e.g., survey tools, previous reports, Board materials) were retrieved in order to launch the new CMA. By March 2013, a full staff had been hired, including four analysts and an administrative professional.

CMA Board Activities

During the start-up phase, the Interim Executive Director recruited CMA Board members according to statutory requirements. By February 28, 2013, the Board was in place and the orientation meeting was held April 18, 2013. Board members were provided with the CMA background information, an overview of the survey process and other functions, a description of board member duties, and other information related to orientation. A representative from the Attorney General's Office gave a presentation on Florida's open government laws, including the Sunshine Law and Public Records Act, and representatives from OHS gave a report on the status of the health care delivery system. A Chair was elected and an Executive Director appointed. By the end of the fiscal year, six of the seven seats had

been filled. Board members have been involved in CMA activities and have provided valuable input into improving CMA operations.

Survey Process

Significant effort was made this fiscal year to recruit and train new clinical surveyors. For FY 2012-13, the CMA maintained ongoing agreements with 11 physicians, 14 dentists, 10 clinical associates, and 9 registered nurses to provide physical health care audits. There were 6 psychiatrists, 10 psychologists, 17 mental health professionals, 7 clinical associates, and 7 registered nurses available to assist as mental health surveyors. New CMA surveyors participated in a teleconference orientation on June 13, 2013.

The majority of CMA staff was hired in March 2013 and underwent rigorous training to prepare to lead survey teams, support surveyors, analyze data, and participate in the writing of professional reports. CMA analysts who are independently licensed mental health professionals were also trained to participate as surveyors. Mock surveys and institutional tours were conducted at two correctional facilities to provide additional training opportunities for new CMA staffers.

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

Policy Review

During FY 2012-13, the CMA reviewed all policies, procedures, and Health Service Bulletins (HSBs) which govern the provision of health care and are the primary way consistency in practice among health care staff is assured. According to F.S. 945.6034 the CMA is required to review OHS policies pertinent to health care and provide qualified professional advice regarding that care. In addition, CMA staff updated medical, nursing, mental health, and administrative survey tools as indicated, to maintain consistency with DOC policies and procedures, as well as community standards of care.

Inmate Correspondence

As part of its mission to ensure adequate standards of physical and mental health care are

maintained at all institutions, CMA staff respond to inmate correspondence. During FY 2012-13, two letters were received, reviewed, and responses provided to inmates. CMA anticipates an increase in inmate correspondence for FY 2013-14 as inmates and their families are made aware of the CMA's return.

Inmates who write to the CMA are referred first to the DOC grievance process in an attempt to resolve their problems if they have not already filed a grievance on the issue. In some cases, grievances are denied and inmates write requesting the CMA's help in addressing their concerns. Because the CMA is not authorized to direct staff in DOC institutions or to require that specific actions be taken by the Department, inmate letters relating to health care issues are sent to OHS for investigation and response. The CMA responds directly to inmates and copies of responses to inmates from DOC are also provided to the CMA upon request. Health care issues identified in inmate letters are subsequently reviewed during on-site surveys. Monitoring inmate correspondence is a valuable risk management function in which the CMA and OHS collaborate to prevent systemic deficiencies in health care from occurring.

2012-13 SURVEY ACTIVITIES

Introduction

CMA was fully functional by April 2013, however since FY 2012-13 ended June 30, only two on-site institutional surveys were conducted to evaluate the provision of both physical and mental health services. One institution was selected from Region II and one was selected from Region III. Generally, institutions were selected based on the date of the most recent survey. Effort is made by CMA staff during the scheduling process to ensure a fair representation is selected from each of the three regions in the state.

The CMA utilizes a variety of licensed community and public health care practitioners, including physicians, psychiatrists, dentists, nurses, psychologists, and other mental health professionals to conduct surveys. The survey process includes a clinical review of the physical, dental, and mental health care provided at each institution. Cases selected for review are representative of inmates who were receiving mental and/or physical health services, or who were eligible to receive such services. In order to appear in the final report, there must be a finding of non-compliance with the standard in at least twenty percent of records reviewed in

the selected sample to which the standard applies. Administrative issues such as the existence and application of written policies and procedures, staff training, and confinement practices are also reviewed. CMA surveyors also conduct a physical inspection of the facilities to confirm that medical, dormitory, and confinement areas meet acceptable standards of sanitation and that all needed supplies are adequately maintained.

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

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

Survey Findings

Two surveys were conducted during the FY 2012-13. Zephyrhills CI (ZEPCI) and Union CI (UCI) were inspected May 8–9, 2013, and June 19–20, 2013, respectively. The above institutions were chosen because of the length of time that had passed prior to the last survey and because of their unique missions.

ZEPCI and UCI share some similarities. Each houses relatively large populations of male inmates who are medically and psychiatrically complex. Physical and mental health care is provided on both an outpatient and inpatient basis.

Physical/Dental Health Findings

For the purposes of this annual report, findings resulting in corrective action will be differentiated between those that are related to deficiencies in documentation and deficiencies

regarding the provision of clinical services.

There were several significant trends identified regarding the documentation of physical health care services at the two institutions surveyed. Both ZEPCI and UCI were cited for several similar issues. Frequently, historical information regarding inmate's health status and baseline diagnostic information was lacking in the medical record. Problem lists were frequently inaccurate or out of date. Lastly, medication orders were not always signed, dated, and timed.

Several trends regarding the provision of physical health services were noted at the two institutions. Most notably, many inmates were not vaccinated according to the Department standards outlined in the immunization requirement and infectious disease protocols. The most common concern was that inmates were missing pneumococcal vaccines. It was also noted that inmates immunocompromised by HIV/AIDS were not appropriately offered hepatitis vaccinations.

Mental Health Findings

In both institutions surveyed in FY 2012-13, issues regarding documentation were noted. Medication orders were not consistently signed, dated, and/or timed. Mental health records were often disorganized, with records not filed according to the standard Departmental format. Vital signs and weights were not consistently documented for inmates in the inpatient units.

Surveyors expressed concern regarding the provision of services in the inpatient units at UCI. In over half of the records reviewed, the documentation indicated inmates did not receive the required number of therapeutic services. These services are especially important in working towards targeted problems in an attempt to progress the inmate to a lower level of care. Additionally, evaluations, risk assessments, and other clinical contacts were not consistently completed as required.

Recommendations for FY 2012-13

Based on the survey findings the CMA makes the following recommendations:

Physical Health

- Ensure medication orders are signed, dated, and timed by the ordering clinician;
- Determine a method to guarantee that problem lists are current and complete to provide an ongoing guide for reviewing the health status of patients and planning appropriate care;
- Review the policy regarding the documentation of baseline health information (e.g., physical examination, laboratory results, and assessment information) with institutional staff so they are aware of necessary recording requirements.

Mental Health

- Ensure medication orders are signed, dated, and timed by the ordering clinician;
- Ensure medical records are organized according to Department standards;
- Ensure timely and specific documentation of inmate's participation in group activities in inpatient units;
- Ensure timely evaluations and assessments are performed for inmates in inpatient units.

Corrective Action Plan (CAP) Process

Each time an institution is surveyed by the CMA, a written report is published which outlines the findings noted and suggests corrective actions to be taken at the institutional level. Within 30 days of the publication of the report, the Department submits a CAP to the CMA. The CAP addresses the concerns noted in the survey report by describing the corrective actions the institutions are proposing to remedy the deficiencies.

Usually four to five months after the CAP is implemented (but no less than three months), CMA staff evaluates the CAP to measure the effectiveness of the corrective actions. These actions most often take the form of in-service training to applicable staff and record monitoring efforts to ensure staff are complying with the recommended changes.

CAP Update

Because only two surveys were conducted in FY 2012-13, no CAP assessments have been completed within the time frame covered by this annual report. At the time of this report, OHS and CMA have approved the CAPs provided by the two institutions cited above. Both ZEPCI and UCI are in the process of monitoring and complying with the requirements set forth in their individual CAPs. These results will be addressed in the annual report for FY 2013-14.

CMA Committees

Quality Management's Committee (QMC)

The mission of the CMA QMC is to provide feedback to the Department regarding its quality management process and to assure that corrective actions and policy changes identified through the process are effective. The Department's quality management process is designed to detect statewide trends in health care treatment and track any problems that require corrective action. Through its QMC, the CMA operates as an oversight body of the Department's quality management program, reviewing the self-evaluation of quality of care. This includes the mortality review process, utilization management, and credentialing/re-credentialing. Since the priority for the CMA in FY 2012-13 was rebuilding, no QMC meetings were held. The QMC will be re-established in FY 2013-14.

Budget and Personnel Workgroup

In order to carry out the CMA's responsibilities to advise the DOC Secretary on cost containment measures and make recommendations on the OHS budget, the CMA will convene a budget and personnel workgroup. The workgroup's primary activities are reviewing the OHS legislative budget request, providing recommendations regarding funding the request to the Governor and Legislature, and reviewing the Department's health care expenditures and cost management processes. The workgroup will be re-established in FY 2013-14.

Aging and Older Inmates in the Florida Department of Corrections

2012-2013

The Correctional Medical Authority is required to report annually on the status of elderly inmates in Florida.⁷ The requirement for an annual report is the result of a 1999 Florida Corrections Commission and House of Representatives Committee on Corrections study of elderly and aging inmates. The legislation that required the annual report also included language directing the Department of Corrections to develop and implement preventive fitness and diet modifications that might lead to decreased long-term medical costs for elderly inmates. The Department was directed to reexamine and alter then existing policies and procedures to allow for adoption of a healthier lifestyle by the elder population. The legislation required staff training programs on effective supervision of elderly inmates and information on detecting physical or mental changes that affect behavior and warrant medical attention.⁸ This report describes the population of inmates age 50 and over admitted to Florida's prisons during 2010-2013 and those housed in the system at the close of the last fiscal year. It also provides an overview of the health care services used by older inmates and the cost of purchasing care that could not be provided within the system. The OHS provided the data on Florida inmates used in this report.

Characteristics of Older and Aging Inmates

The age at which an inmate is considered "older" or "elderly" varies across state and federal jurisdictions. Florida classifies inmates age 50 and older as "aging or elderly."⁹ Although age 50 is not generally considered "elderly," many experts in prison health care use this age because inmates' life experiences prior to and while in prison contribute to a lower life expectancy. Older inmates generally have poorer health status due to lack of health care prior to incarceration, personal habits such as smoking, alcohol, and drug abuse, and in some cases the impact of stress and isolation from previous incarceration.¹⁰

7. s. 944.8041, Fla. Sta., (2013).

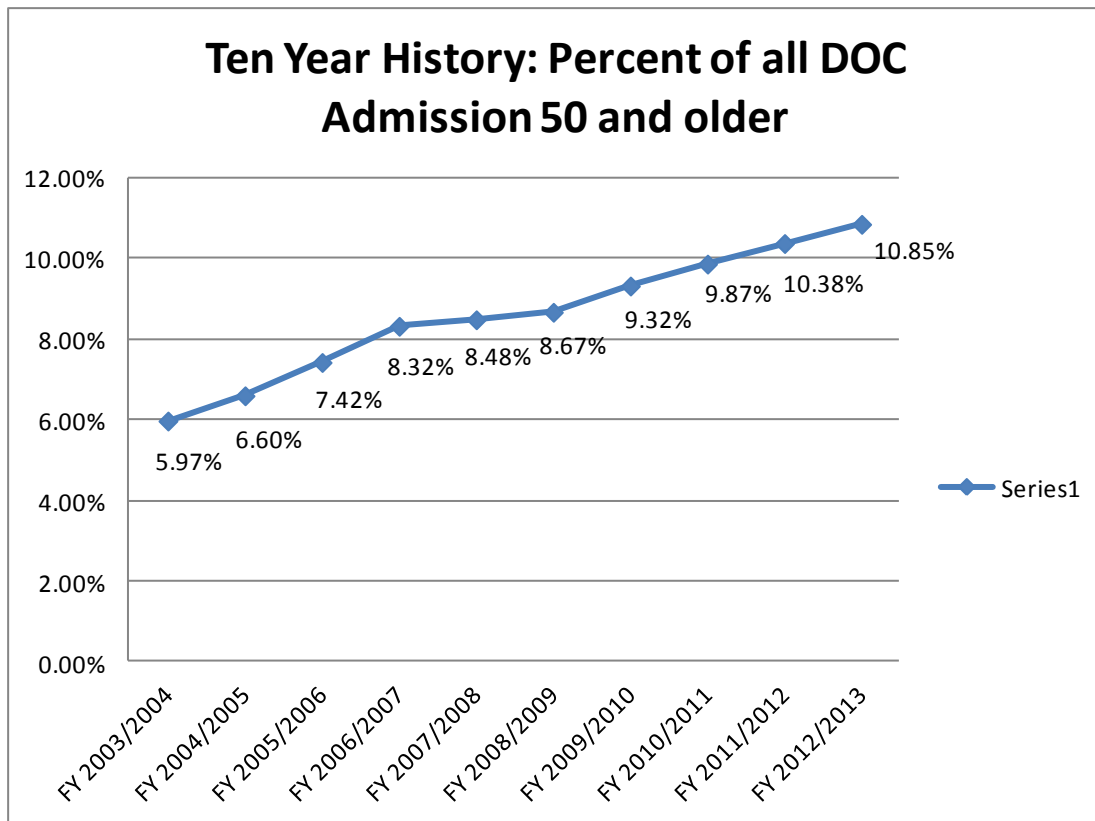
8. Ibid.

9. Fla. Admin. Code R.33-601-217. (2010), Elderly Offender Housing

10. Aging Inmate Committee, American Correctional Association, *Aging Inmates: Correctional Issues and Initiatives*, Corrections Today, August/September 2012, 84-87.

Population and Demographic Trends: Admissions 2012-13

During FY 2012-13, the number of admissions of older inmates to DOC continued to increase as a percentage of total admissions. In FY 2011-12 the age ≥ 50 admissions accounted for 10.38 percent (3,349) of all admissions. This year they accounted for 10.85 percent (3,613) of the 33,295 admissions. It is estimated that the percentage of elderly admissions will continue to follow national trends and increase over the foreseeable future.



In FY 2012-13, 86 percent of older inmates admitted were between the age of 50-60. Only 70 admissions, or 1.9 percent, were 71 years of age or older. The average age at admission for inmates age 50 and older was 55.8 for males and 55.2 for females. Older inmate admissions were slightly more likely to be white (57.4 percent) than the general population as a whole (53.20 percent) and slightly more likely to be male (90.7 percent) than the general population as a whole (88.40 percent).

Population and Demographic Trends : 2012-13 Population Age 50 and Older

At the close of FY 2012-13 (June 30), the resident population of the prison system was 100,884 individuals. Inmates age 50 and older comprised 19.4 percent of the population, or 19,600 inmates. This represents a 6.7 percent increase in the older inmate cohort of the prison population on June 30, 2012, when there were 18,368 inmates age 50 and over, representing 18.3 percent of the total prison population. The majority of elderly inmates (62.4 percent) in prison at the end of the fiscal year were serving time for violent crimes.

| Typical Inmate Age 50 and Older | |
|---|--------------|
| Male | 94.6% |
| White | 54.7% |
| History of Prior DOC Commitments | 53.3% |
| Mean Age | 55.7 |
| Mean Sentence | 8.28 |
| Offenses (Primary) | |
| Sexual/Lewd Behavior | 21.2% |
| Murder/Manslaughter | 20.8% |
| Drug | 13.5% |

Male inmates over age 50 accounted for 19.7 percent of all men in the prison population, 94.6 percent of inmates age 50 and older, and 18.4 percent of the entire prison population on June 30, 2013. Female inmates over age 50 accounted for 14.9 percent of all women in the prison population, 5.4 percent of inmates age 50 and older, and 1.1 percent of the entire prison population on June 30, 2013.

Of the 100,884 inmates in prison on June 30, 2013, 13,585 (13.5 percent) are expected to die during the course of their imprisonment. As could be expected, inmates age 50 and over are far more likely than younger inmates to die to prison. Although older inmates were 19.4 percent of the June 30, 2013 population, they represent 43.7 percent of all inmates expected to die in prison. Within the age cohort of all inmates over age 50 (19,600), at least one fourth (5,935) are expected to die in prison.

Housing Assignments

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

In the majority of DOC facilities, the age 50 and older population is less than 25 percent of the total facility population. At the time of this report, two facilities had no inmates age 50 and older (Lake City Correctional Facility (privately operated) and Lancaster CI). Seven facilities had older inmate populations that exceeded 25 percent of the total population; they are listed in the chart below.

| Institution | Total Population | Population age 50 and older | Percent total population |
|----------------|------------------|-----------------------------|--------------------------|
| Union CI | 1932 | 1431 | 74.07% |
| Lake CI | 1158 | 296 | 25.56% |
| Everglades CI | 1568 | 512 | 32.65% |
| SFRC | 1821 | 618 | 33.94% |
| Dade CI | 1612 | 531 | 32.94% |
| Hardee CI | 1866 | 525 | 28.14% |
| Zephyrhills CI | 1023 | 373 | 36.46% |

The Department does not classify inmates for housing assignments solely based on age. Elderly inmates are housed in most of the Department's major institutions consistent with their custody level and medical status. Several of the facilities with significant populations of elderly inmates house specialized programs to assist elderly inmates that require intensive medical care or skilled nursing services. The Reception and Medical Center (RMC) has a licensed hospital that enables DOC to provide hospital services to inmates of any age with chronic and/or acute medical issues. RMC also provides advanced respiratory services, including to those inmates that may be ventilator dependent. Skilled nursing services for medically complex patients are provided at the South Unit of the Central Florida Reception Center (CFRC), Zephyrhills CI, and Lowell CI. Two facilities (CFRC and South Florida Reception Center (SFRC)), currently

provide palliative care services. Skilled nursing services for less medically complex inmates can be usually be provided at any DOC institution that provides infirmary care.

Health Status of Older Inmates

In FY 2012-13, the Department provided health services to 134,441 inmates, which was the total population of inmates housed in DOC for that fiscal year. Every inmate is assigned a health classification at the time of his/her admission to the system. This classification includes a medical grade (M1-M5, M9), mental health grade (S1-S6), impairment grade (P, H, E, S), and work classification (W1-W5). The number assigned to an inmate is based on the severity or acuity of the medical or mental health condition with one indicating the lowest level of need. Medical grade nine is assigned to pregnant women and mental health grades four through six are assigned to inmates needing various levels of residential treatment or inpatient hospitalization. Impairment grades are assigned based on physical limitations, hearing impairment, visual impairment, or developmental disability. Of the 1,092 inmates with an assigned impairment grade at the end of FY 2012-13, approximately half (50 percent) were inmates age 50 or older.

| Impairment | All Inmates with Impairment | Inmates \geq Age 50 |
|---------------|-----------------------------|-----------------------|
| Visual | 128 | 46% (59) |
| Hearing | 147 | 49% (72) |
| Physical | 710 | 54% (383) |
| Developmental | 107 | 33% (35) |
| TOTAL | 1092 | 50% (549) |

Inmates who need special assistance or require adaptive devices such as hearing aids, wheelchairs, low bunks, or inmate assistants are provided with these accommodations and issued a special pass. The largest number of passes issued for lower bunks (26,154). Thirty-seven percent of inmates requiring a special pass are over the age of 50. Inmates over 50 also are the highest number of inmates requiring wheelchair assistance (62.8 percent).

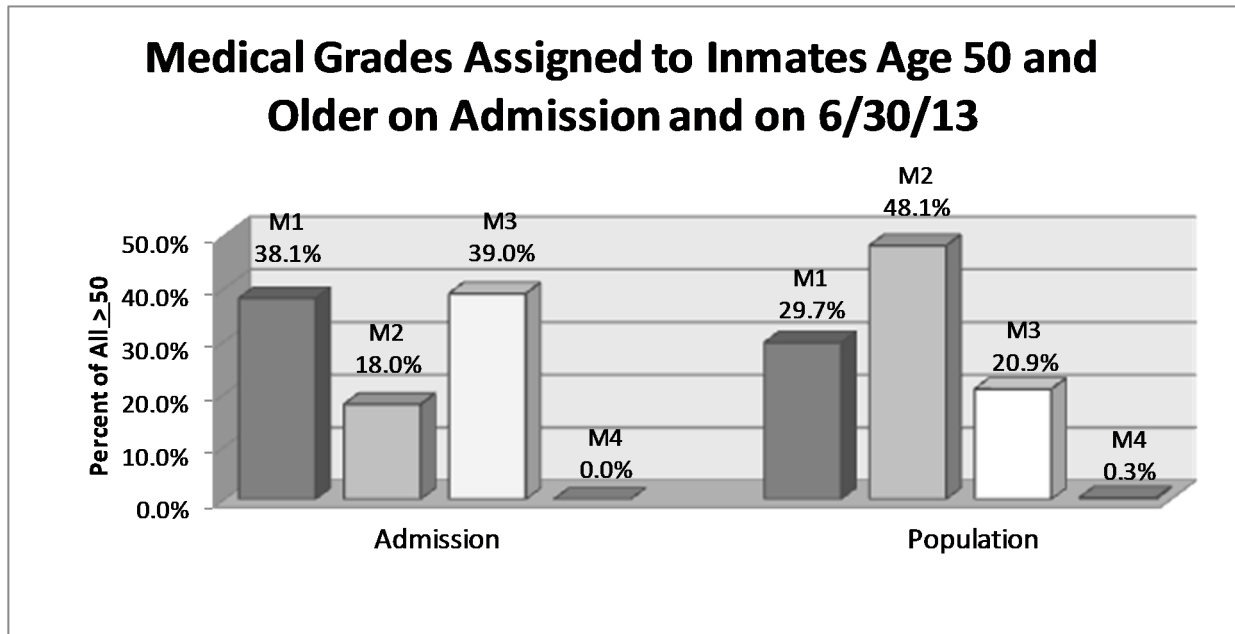
Health Services

In FY 2012-13, 68 percent of all DOC admissions were classified as M1. Older inmates were more likely to be assessed as being in poorer health at admission than were inmates under age 50; 71.7 percent of inmates under 50 were M1 at admission compared to only 38 percent of inmates age 50 and older. Only 12 percent of younger inmates were M3 at admission compared to 39 percent of older inmates.

Although there were fewer older females admitted than younger females (335 versus 3,522), older women were significantly more likely to be M3 at admission in comparison to younger women. Twenty percent of all women age 50 and older were M3 at admission compared to 8 percent of women under 50.

There was more similarity between inmate age cohorts in regard to psychiatric grade (S grade) upon admission; 79 percent of inmates under age 50 were admitted as S1 compared to 71 percent of older inmates. Although there was little difference between the inmates assigned S2 classification, a larger difference was found in S3 classification. There was a six point percentage difference between the older and younger cohorts assigned a psychological grade of S3 at admission, with older inmates more likely to have the higher acuity grade (17 percent versus 11 percent) .

The under age 50 population on June 30, 2013, was significantly more likely to be classified M1 (90.8 percent) than was the age 50 and over status population (9.2 percent). The older inmate population was also less as likely to be M2 (35.8 percent) or M3 (39.4 percent) than the under 50 population (64 percent M2, 60 percent M3).



The shift of older inmates to M2 from both M1 and M3 after initial assessment may be due to the identification of conditions during intake that were unidentified or untreated prior to incarceration. In addition, it is likely that the improvement in inmates' condition is in response to care provided for chronic illnesses.

Inmates request health care services through sick call, which involves submitting a written request. Inmates are then placed on a call out list and report to the designated areas at the appointed time. During FY 2012-13, there were 1,413,703 sick call encounters generated for the 100,884 inmates housed in the Florida correctional system. Older inmates accounted for 30 percent of all sick call encounters.

Inmates with chronic illnesses are enrolled in various specialty clinics. These clinics provide ongoing monitoring and treatment of chronic diseases or conditions to ensure compliance with medication regimens and to detect any changes in an inmate's health status that may impact his/her condition. Inmates with several chronic conditions may be assigned to more than one clinic. There are 52,010 inmates assigned to at least one chronic illness clinic and approximately 41% (21,352) of those assigned are age 50 or older. Although inmates 50 years of age or older make up 19 percent of the prison population, they account for close to half of those enrolled in chronic illness clinics.

| Clinic Contacts for Inmates age \geq 50 | | | |
|---|-----------------------------|-------------------|--------------------------|
| | Contact – Inmates \geq 50 | | |
| CLINICS | Total | Contacts All Ages | Percent of All \geq 50 |
| Cardiovascular | 9,882 | 21,445 | 46% |
| Endocrine | 2,886 | 5,895 | 49% |
| Gastrointestinal | 3,273 | 6,753 | 48% |
| Immunity | 866 | 2,772 | 31% |
| Renal | 48 | 103 | 47% |
| Miscellaneous | 984 | 2,119 | 46% |
| Neurology | 549 | 2,521 | 22% |
| Oncology | 361 | 563 | 64% |
| Respiratory | 1,928 | 6,542 | 29% |
| Tuberculosis | 595 | 3,292 | 18% |
| TOTAL | 21,352 | 52,010 | 41% |

Community Purchased Health Services

The Department contracts with community providers and hospitals to provide medical care and specialty services to inmates in most areas of the state. Some of these services are provided on site at the institution when there is sufficient space, equipment, and personnel to support the provider. In other cases, inmates are transported to community facilities for emergency or highly complex procedures. In FY 2012-13, the Department paid \$114,014,902 for community health care services to inmates, which included 14,705 days of scheduled and emergency hospitalizations; 2,831 ambulatory surgeries; 2,213 emergency room visits; 55,861 examinations by specialty providers; and 28,614 ancillary services (e.g., laboratory tests, x-rays, EKGs, physical therapy). Of the 456 individuals who had multiple admissions to community hospitals, 52 percent were older inmates. Inmates over the age of 50 accounted for 49 percent of all episodes of care and 52 percent of all hospital days, although they represent only 19 percent of the total prison population. The average length of stay for older inmates for an emergency hospitalization averaged 1.5 days longer than for inmates under age 50 and 2.1 days longer for scheduled hospitalizations.

Conclusions and Recommendations

The CMA has been reporting on Florida's aging inmates since 2001 and over the years a substantial volume of information regarding the status of older inmates in Florida and nationwide has been presented. The demands of caring for aging and elderly inmates will continue to have an impact on prison health care expenditures. It is estimated that the average yearly cost for an older inmate is approximately \$70,000 - around two or three times that of younger inmates.¹¹ A significant portion of that difference in cost may be attributed to increased health care costs. In addition to the costs for basic health care, states are facing rising expenses for dental and mental health services. This serves to emphasize the importance of preventive care, early intervention through the careful monitoring of chronic illnesses, and planning for the health care needs of an older population.

It is evident from the data presented here and in the professional literature, that older inmates have more health problems and generally consume more health care services than younger inmates. Older inmates may also place a greater fiscal strain on correctional systems as they may require additional housing and management needs in a prison setting, secondary to their generalized vulnerability and medical conditions. Many of them will never leave prison because of the length of their sentences. Older prisoners will continue to increase in numbers and in the overall percentage of prisoners, and thus, will continue to consume a disproportionate share of an already limited number of resources available for health care and programmatic enhancements within the correctional setting.

Previous reports have made a number of recommendations, including specialized training programs, designating specific institutions for elderly inmates, instituting preventive health measures focused on older inmates, regular assessments, special security reviews, and citizen volunteer programs. Within the resources available, the Department has taken steps to develop some programs that address the needs of older inmates such as consolidation of older inmates at certain institutions and the creation of palliative care programs.

11. Aging Inmate Committee, American Correctional Association, *Aging Inmates: Correctional Issues and Initiatives*, Corrections Today, August/September 2012, 84-87.

There has also been an enhanced focus on preventive care for all inmates which will benefit older inmates. For example, all inmates in the DOC system will receive periodic screenings every five years, with the exclusion of older inmates who will be screened every year. DOC may need to implement program modifications or develop other specialized facilities specifically to meet the needs of older inmates. It is recommended that DOC continue to develop facilities such as the palliative care units and the J Dorm at Zephyrhills CI as these programs can meet the needs of both aging inmates and other inmates with serious and terminal diseases.