State of Florida

Correctional Medical Authority

2013-2014

Annual Report

And

Report on Elderly Offenders

State of Florida Correctional Medical Authority

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

The CMA's governing board is composed of the following seven people appointed by the Governor and subject to confirmation by the Senate:

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, 2014

The Honorable Rick Scott
Governor of Florida

The Honorable Andy Gardiner, President
The Florida Senate

The Honorable Steve Crisafulli, Speaker
Florida House of Representatives

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

In accordance with section 945.6031, Florida Statutes, I am pleased to submit the Correctional Medical Authority's (CMA) 2013-2014 Annual Report on the Florida Department of Corrections' health care delivery system.

This report summarizes our activities during Fiscal Year 2013-2014, which includes on-site physical and mental health surveys of 13 major correctional institutions, including two reception centers and four institutions with annexes or separate units. Additionally, 15 corrective action plan assessments were conducted based on findings from this and the previous year's surveys. It should be noted that the Fiscal Year 2012-2013 report assessed two facilities versus the 13 assessed this year due to the reestablishment of the CMA.

This report details the work of the CMA's governing board, staff, quality management committee, and budget and personnel workgroup towards the fulfillment of our statutory responsibility to assure that adequate standards of physical and mental health care are maintained in Florida's correctional institutions.

During Fiscal Year 2013-2014 the provision of health care services was transitioned from the Department of Corrections to a private contractor in the majority of the institutions in the state. Due to this transition, no definitive trends can be drawn from these survey results. Additionally, there have been changes to CMA methodology which create difficulty in comparing this report to CMA reports from previous fiscal years. The CMA strengthened its methodology of the survey process to include specific criteria to provide a comprehensive assessment of the provision of health care and to include updates from the Department's Health Services policies and procedures. These enhancements are reflected in this year's reporting.

Thank you for recognizing the important public health mission at the core of correctional health care and your continued support of the CMA. Please contact me if you have any questions or would like additional information about our work.

Sincerely,

Jane Holmes-Cain, LCSW
Executive Director

Intentionally left blank

Table of Contents

BACKGROUND

CMA History

The Correctional Medical Authority (CMA) was created in July 1986, while the state's prison health care system was under the jurisdiction of the federal court from 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 the Department of Corrections (DOC) inmates.

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 CM 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 certain clinical, administrative, and security components of the program designed to ensure effective treatment of mental illness in the CM population. Facilities with CM are monitored as part of the regular CMA survey process.

The CMA carried out its mission to monitor and promote delivery of cost-effective health care that meets accepted community standards for Florida's inmates until losing its funding in the 2011 legislative session. However, the Governor vetoed a conforming bill which would have eliminated the CMA from statute and requested that funding be restored. The Legislature restored funding effective July 1, 2012.

Since that time, DOC has contracted with two private companies to provide comprehensive health care services for DOC inmates pursuant to DOC's expectations and standards. Specifically, in December 2012, Wexford Health Sources, Inc. (Wexford) began providing 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. In October 2013, Corizon, Inc. (Corizon) began providing 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. Due to the transition of the provision of health care from DOC to the private corporations, no definitive trends can be drawn from these survey results.

The CMA Board elected its Chair and appointed the Executive Director in April 2013. As of May 2013, the CMA resumed its statutory mandate to assure adequate standards of physical and mental health care for inmates are maintained at correctional institutions and to advise the Governor and Legislature on the status of DOC's health care delivery system now provided by the private contractors.

CMA Structure and Functions

The CMA is composed of a seven-member, volunteer board appointed by the Governor and confirmed by the Florida Senate for a term of four years. The board is comprised of health care professionals from various administrative and clinical disciplines who direct the activities of the CMA's staff. The CMA has a staff of six full-time employees and utilizes independent contractors to complete triennial health care surveys at each institution. Survey reports are followed by monitoring of corrective action plans until such time as the institutions are in compliance with accepted community standards of care. The CMA is an independent reporting agency administratively housed within the Executive Office of the Governor and is charged with the responsibility of overseeing DOC's health care delivery system. The CMA's statutory purpose is to assist the delivery of health care services for inmates 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.

By ensuring that the quality of inmate care remains in compliance with accepted standards, the CMA provides an important risk management function for the State of Florida's correctional health care system, as 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 % 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 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]

The CMA's specific duties and authority are detailed in sections 945.601–945.6035, Florida Statutes, and include:

- Reviewing and advising the Secretary of Corrections on DOC's health services plan, including standards of care, quality management programs, cost containment measures, continuing education of health care personnel, budget and contract recommendations, and projected medical needs of inmates.
- Reporting to the Governor and Legislature on the status of DOC's health care delivery system, including cost containment measures and performance and financial audits.

[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.

[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.

- Conducting surveys of the physical and mental health services at each correctional institution every three years and reporting findings to the Secretary of Corrections.
- Reporting serious or life-threatening deficiencies to the Secretary of Corrections for immediate action.
- Monitoring corrective actions taken to address survey findings.
- Providing oversight for DOC's quality management program to ensure coordination with the CMA.
- Reviewing amendments to the health care delivery system submitted by DOC prior to implementation.

As part of its reporting duties, each year the CMA submits two reports to the Governor and Legislature. The first is the Annual Report, which summarizes the CMA's activities for the fiscal year and reports on the status of DOC's health care delivery system. The second is the Report on Elderly Offenders, which reports on the status and treatment of elderly offenders in the state-administered and private state correctional systems and DOC's geriatric facilities and dorms. The next section of this document contains the Annual Report for Fiscal Year 2013-14 (FY 2013-14), and the final section of this document contains the 2013-14 Report on Elderly Offenders.

2013-14 ANNUAL REPORT

This Annual Report describes the activities of the CMA during FY 2013-14. Specifically, it addresses Board and staff activities, the findings of 13 on-site institutional surveys, the results of 15 corrective action plan assessments, and the CMA's medical review, quality management, and budget review committee activities.

Board Activities

The CMA Board held six public meetings during FY 2013-14 and provided valuable support and guidance to staff. The Board recommended that survey reports include enhanced discussions on the physical, mental, and dental health findings as well as data on the staffing patterns and vacancies at each institution.

The Board supported the Executive Director's cost-saving measures, including reducing travel costs by conducting entrance and exit interviews via conference call when feasible and more efficient scheduling of corrective action plan (CAP) assessments to coordinate with survey travel.

In October 2013, the final board seat for mental health representation was filled and a contract for legal services was executed. The Board approved the FY 2012-13 Annual Report and FY 2014-15 Budget Letter for submission to the Governor and Legislature in December and January, respectively. In June 2014, the Board chose to transition to a monthly meeting schedule in FY 2014-15 to ensure the members remain informed of survey results and ongoing corrective action plan updates in a timely manner.

Staff Activities

This year, in addition to conducting surveys and monitoring corrective action plans, staff furthered the CMA's purpose of assisting in the delivery of health care services for inmates by participating in continuing education and training, conducting policy review, directing inmate correspondence, and publishing a website on which the CMA's reports are easily accessible to the public.

Education and Training

CMA licensed staff participated in continuing education activities to ensure compliance with licensure requirements. Additionally, staff attended a conference focusing on awareness and education about trauma-informed care practices within agencies, including corrections. Staff also attended the Corrections Infections Workgroup where members share information and provide program education to improve infectious disease screening for inmates throughout Florida. In January 2014, the CMA Executive Director conducted a training seminar for Wexford and Corizon leadership. This training was designed to assist in the creation and implementation of successful corrective action plans within the institutions.

Policy Review

Pursuant to section 945.6034, Florida Statutes, DOC submits all health care standards to the CMA for review prior to adoption. All revisions to the health care delivery system's health services bulletins (HSB), policies, procedures, and forms are reviewed by CMA analysts. In FY 2013-14, CMA analysts reviewed 28 physical health and 7 mental health HSBs and provided recommendations as needed to ensure DOC's health service plan continues to meet acceptable standards of community care for inmates. These reviews resulted in a critical update to the guidelines for administering pneumococcal vaccines and facilitation of proper documentation of all baseline and ongoing health information in health records.

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 concerns received via written correspondence and telephone contact. During FY 2013-14, the CMA responded to 24 communications concerning 16 inmates at 11 different correctional institutions. The CMA is not authorized to direct staff in DOC institutions or require specific actions be taken and therefore forwards inmate concerns to the Office of Health Services (OHS) for investigation and response. At the close of this fiscal year, 14 of these inmates had received responses to their concerns. Health care issues identified in inmate's letters are subsequently reviewed during on-site surveys. The CMA collaborates with OHS to prevent systemic deficiencies in health care from occurring. Monitoring inmate correspondence is another important risk management function of the CMA.

CMA Website

In FY 2013-14, the CMA published its website at http://www.flgov.com/correctional-medical-authority-cma, which includes a summary of the services provided, a complete listing of published reports, and contact information. There has been a steady increase in communications from inmates and their families since the site was published and it is expected this trend will continue as the public is made aware of the role the CMA performs for the State of Florida's correctional health care system.

Surveys

The CMA recruits and trains licensed health care practitioners, including physicians, psychiatrists, psychologists, mental health professionals, dentists, physician assistants, nurse practitioners, and registered nurses to survey health care services in prison facilities. In FY 2013-14, the CMA utilized 62 licensed health care professionals as independent contractors throughout Florida.

Staff schedule surveys at institutions from all three regions in the state to ensure each institution will be surveyed every three years as statutorily mandated and to provide the most cost-effective allocation of CMA resources.

In FY 2013-14, the CMA completed 13 surveys, which included two reception centers and four institutions with an annex or separate unit and two private institutions managed by the Department of Management Services. The following table shows the correctional institutions (CI) and facilities (CF) surveyed by region.

Region I	Region II	Region III
Jefferson (JEFCI) Santa Rosa (SARCI) Santa Rosa Annex (SARCI-ANNEX) Taylor (TAYCI) Taylor Annex (TAYCI-ANNEX) Gadsden (GADCF)	Cross City (CROCI) Suwannee (SUWCI) Suwannee Annex (SUWCI-ANNEX) Florida State Prison (FSP) Florida State Prison – West (FSP-WEST)	South Florida Reception (SFRC) South Florida Reception – South (SFRC-SOUTH) Homestead (HOMCI) Martin (MATCI) Central Florida Reception (CFRC) Central Florida Reception – East (CFRC-EAST) Hernando (HERCI) South Bay (SBCF)

The survey process begins with a pre-survey questionnaire completed by institutional staff prior to the survey for CMA to prepare team schedules and record selections. CMA analysts utilize the pre-survey questionnaire along with requested logs and Offender Based Information System (OBIS) reports to identify inmates eligible to receive or currently receiving specific physical and/or mental health services at the institution. From this information, cases are randomly selected and the inmate's medical record requested for on-site review. Record reviews consist of a clinical analysis of the physical, dental, and mental health care provided based on DOC's and community established standards of care published in collaboration with the CMA's oversight.

CMA employs a selection process based on the size of the clinic with an 80 % confidence level. There must be a finding of deficiency with the standard in at least 20 % of records reviewed in the selected sample to constitute a finding in the survey report. 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 equipment and supplies are adequately maintained and available.

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

- Physical evidence – direct observation (tours and observation of evaluation/treatment encounters);
- Testimonial evidence – obtained from 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, and training records;
- Analytical evidence – developed by comparative and deductive analysis from several pieces of gathered evidence.

Surveyors use uniform tools based on DOC's HSBs, policies, procedures, and manuals, which dictate the requirements for the provision of adequate health care for inmates, to complete record reviews. In FY 2013-14, CMA staff and surveyors examined over 4,500 inmate physical and mental health records, finding a total of 835 health care deficiencies as reported to the Secretary of Corrections. Of the 13 institutions surveyed it should be noted that reception services are provided at 2 sites and inpatient mental health care at 3 sites. All findings represent a potential for error in patient care and a failure to meet adequate standards of care. The following pages contain a comprehensive breakdown of the survey findings in FY 2013-14. Complete survey reports for each institution may be obtained from the CMA website at: http://www.flgov.com/correctional-medical-authority-cma/.

Physical Health Findings

Chronic Illness Clinics
The diagnoses were not documented on the problem list. **(JEFCI, CROCI, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, SBCF)**
The baseline history, physical exam, and/or laboratory work were incomplete or missing. **(JEFCI, CROCI, SUWCI-ANNEX, SARCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI, FSP, FSP-WEST, GADCF, SBCF)**
There was no initial and/or ongoing education information documented. **(JEFCI, CROCI, SARCI-ANNEX, SFRC, CFRC-EAST, GADCF)**
The physical examinations were not sufficient to assess the patient's condition. **(CROCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, GADCF)**
There was no evaluation of the control of the disease and/or patient status. **(JEFCI, CROCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI**)
The documentation was not legible, dated, timed, signed, and/or stamped. **(JEFCI, SARCI-ANNEX, SFRC-SOUTH, TAYCI, GADCF)**
Cardiovascular Clinic
Completed labs were not available to the clinician prior to the clinic visit and/or abnormalities were not addressed in a timely manner. **(GADCF)**
Inmates with atherosclerotic cardiovascular disease were not prescribed low dose aspirin. **(FSP)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, CFRC-EAST, FSP, FSP-WEST)**
Endocrine Clinic
The annual laboratory work was incomplete or missing. **(FSP-WEST, GADCF)**
There were no annual fundoscopic exams. **(SUWCI-ANNEX, MATCI, TAYCI, TAYCI-ANNEX, HERCI, FSP, FSP-WEST)**
Inmates with vascular disease were not prescribed aspirin. **(SFRC, HERCI)**
There were no evidence of ACE or ARB therapies. **(HOMCI, MATCI, HERCI)**
Inmates were not seen at the required intervals. **(SUWCI-ANNEX)**
Inmates with HgbA1c levels over 8.0 were not seen every 4 months. **(JEFCI, SARCI-ANNEX)**
There was no evidence of efforts to reduce HgbA1c levels over 7.0. **(JEFCI)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SUWCI-ANNEX, HOMCI, TAYCI, TAYCI-ANNEX, SFRC, HERCI, FSP, FSP-WEST, GADCF, SBFC)**

Gastrointestinal Clinic
The annual laboratory work was incomplete and/or missing. **(CFRC-EAST, GADCF)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, MARTCI, TAYCI, TAYCI-ANNEX)**
Inmates with hepatitis C and no history of A&B infection were not given hepatitis A&B vaccines. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, FSP-WEST, GADCF, SBCF)**
There was no referral to a specialist when indicated. **(GADCF)**
Immunity Clinic
Inmates were not seen at the required intervals. **(SFRC)**
There was no evidence of hepatitis B vaccines or refusals. **(JEFCI, SUWCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, MATCI, TAYCI, TAYCI-ANNEX, CFRC, HERCI, GADCF)**
Serological testing for hepatitis B was incomplete or missing. **(SFRC)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, TAYCI, TAYCI-ANNEX, FSP-WEST, GADCF)**
HIV medications were out of stock. **(TAYCI)**
Miscellaneous Clinic
Laboratory studies were not completed prior to the clinic visit. **(TAYCI-ANNEX)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SUWCI, TAYCI, TAYCI-ANNEX, CFRC, HERCI, FSP-WEST)**
There were no referrals to a specialist when indicated. **(MATCI, TAYCI-ANNEX)**
Neurology Clinic
The annual laboratory work was incomplete or missing. **(GADCF)**
Seizures were not classified or were classified incorrectly. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, SFRC-SOUTH, TAYCI-ANNEX, CFRC, HERCI, FSP-WEST)**
There were no discussions of medication tapering after two years without seizures. **(JEFCI, TAYCI-ANNEX)**
There were no pneumococcal and/or influenza vaccines or refusals. **(SARCI-ANNEX, SFRC, TAYCI, HERCI, GADCF)**
There were no referrals to a specialist when indicated. **(MATCI, HERCI)**
Oncology Clinic
The baseline marker studies were not completed. **(TAYCI, CFRC-EAST)**
There was no evidence labs were reviewed and addressed timely. **(SFRC)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SFRC, SFRC-SOUTH, HOMCI, TAYCI-ANNEX, HERCI, FSP, FSP-WEST)**
There was no referral to a specialist when indicated. **(SFRC-SOUTH)**

Respiratory Clinic
The severity of reactive airway diseases were not documented. **(JEFCI, TAYCI-ANNEX, CFRC-EAST, FSP-WEST)**
Patients with moderate to severe reactive airway disease were not started on anti-inflammatory medication. **(SFRC)**
Rescue inhaler use greater than twice weekly was not addressed. **(JEFCI)**
Appropriate medications were not prescribed and/or reevaluated at each clinic visit. **(JEFCI)**
Inmates were not seen at the required intervals. **(SFRC)**
There was no evidence of peak flow readings at each clinic visit. **(TAYCI, FSP-WEST)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, SFRC, HOMCI, MATCI, TAYCI, TAYCI-ANNEX, CFRC-EAST, HERCI, FSP, FSP-WEST)**
Tuberculosis Clinic
There were no evidence of monthly nursing follow-ups. **(JEFCI, MATCI)**
Tuberculosis medications were not discontinued for elevated AST/ALT and/or adverse reactions. **(MATCI, SBCF)**
The correct number of INH doses were not given. **(JEFCI)**
There were no referrals for the final clinician visit. **(JEFCI, MATCI)**
The laboratory work was not available or reviewed/addressed timely. **(MATCI)**
There were no pneumococcal and/or influenza vaccines or refusals. **(JEFCI, SARCI-ANNEX, SFRC, MATCI, CFRC-EAST, FSP, FSP-WEST)**
Emergency Care
Applicable education was not provided. **(JEFCI)**
Complete vital signs were not documented. **(MATCI, HERCI)**
Follow-up visits were not initiated and/or completed timely. **(JEFCI, TAYCI-ANNEX)**
The follow-up assessment did not adequately address the presenting complaint. **(CFRC)**
Sick Call
The nursing assessment was incomplete. **(MATCI)**
Applicable education was not provided. **(JEFCI, SUWCI-ANNEX, SARCI, TAYCI)**
Complete vital signs were not documented. **(TAYCI)**
Follow-up visits were not initiated and/or completed timely. **(TAYCI, TAYCI-ANNEX)**
The follow-up assessment did not adequately address the presenting complaint. **(JEFCI)**
There was no evidence the clinician's orders from the follow-up visit were completed. **(TAYCI)**
The follow-up documentation was not completed, legible, or timely. **(TAYCI)**

Consultations
The diagnoses were not documented on the problem lists. **(JEFCI,CROCI, SARCI-ANNEX, SFRC, SFRC-SOUTH, HOMCI, MATCI, CFRC, HERCI, FSP, FSP-WEST, GADCF)**
There was no evidence the consultation requests were approved with the signatures of the Chief Health Officer or designee. **(HOMCI, TAYCI)**
The clinical information was insufficient to obtain the consultation services. **(TAYCI-ANNEX)**
Consultations or follow-ups were not initiated and/or completed timely. **(TAYCI, TAYCI-ANNEX)**
The consult reports were not signed, stamped, and/or dated. **(SFRC, SFRC-SOUTH)**
The consultant's recommendations were not incorporated into the treatment plan. **(SUWCI-ANNEX, SFRC, HERCI)**
The consultation logs were incomplete or inaccurate. **(JEFCI, HOMCI, MATCI, TAYCI-ANNEX)**
The clinicians did not document a new plan of care following denial by Utilization Management. **(JEFCI, SFRC-SOUTH, MATCI, TAYCI-ANNEX, HERCI, GADCF)**
Infirmary
The admission orders were incomplete or missing. **(JEFCI, SFRC, GADCF)**
The nursing assessments were not completed within two hours of admission. **(JEFCI, CFRC)**
There was no evidence medications were administered according to orders. **(TAYCI)**
Evidence of daily rounds for acute patients or weekly rounds for chronic patients were missing. **(JEFCI, SFRC)**
Identified nursing problems were not addressed. **(JEFCI, SFRC)**
There were no separate and complete inpatient files. **(JEFCI, SFRC, MATCI, TAYCI, GADCF)**
Documentation for discharges were incomplete or missing. **(JEFCI, SFRC, TAYCI, CFRC, FSP-WEST, GADCF)**
Dental Care
The dark room did not have a safe light for developing X-rays. **(JEFCI)**
Guidelines were not properly followed when taking radiographs. **(HERCI)**
Prosthetic devices were not appropriately disinfected between patients. **(CFRC)**
Dental licenses were not posted. **(HERCI)**
The dental stock medications log was not found in the dental clinic. **(HERCI)**
Preventive dentistry/oral hygiene posters and/or American Heart Association prophylactic regimens were not posted in the dental unit. **(CFRC, HERCI)**
Adequate supplies of personal protective equipment were not available for staff. **(CFRC-EAST)**
Operatories were not in proper working order. **(CFRC-EAST)**
Emergency eyewash station were improperly located. **(HERCI)**

Dental Care
Dental clinic faucets were not touch operated. **(HERCI)**
Dental health questionnaires were not reviewed. **(SARCI-ANNEX)**
The allergy boxes were not completed on the dental record. **(FSP)**
There was no evidence of accurate diagnoses or treatment plans. **(SFRC-SOUTH)**
Intra-System Transfers
Complete vital signs were not documented. **(CFRC)**
The clinician did not review the health record within seven days. **(CROCI, CFRC, HERCI, FSP)**
Arrival/Transfer summaries were incomplete. **(TAYCI, CROCI, CFRC, HERCI, SBCF)**
Pending consultations were not added to the consultation log. **(SFRC)**
Clinic appointments did not take place as scheduled. **(SFRC)**
Medication Administration
Medication orders were not signed, dated, and/or timed. **(SUWCI, SARCI-ANNEX, MATCI, GADCF)**
There was no documentation of the administration route or strength of medication. **(CROCI, SARCI, HERCI, FSP)**
There was no evidence that counseling was provided after medication refusals. **(MATCI)**
Medication orders were not transcribed within the necessary time frame. **(CROCI, CFRC)**
The Medication Administration Records (MARs) did not accurately reflect allergies. **(HOMCI)**
The MARs were not completed, signed and/or initialed. **(MATCI, TAYCI)**
The MAR reviews indicated lapses in medication administration. **(MATCI)**
Periodic Screening
The periodic screening encounter were not documented. **(SARCI-ANNEX)**
Periodic screening encounters were not conducted within one month of the due date. **(SFRC, TAYCI, CFRC)**
There was no evidence all required diagnostic tests were completed timely. **(SUWCI, SFRC, TAYCI, CFRC, GADCF)**
There was no evidence the screenings included all necessary components. **(SUWCI-ANNEX, SFRC, SFRC-SOUTH, MATCI, TAYCI, CFRC, GADCF)**
There was no evidence the inmates were provided with lab results at the screenings. **(SUWCI-ANNEX, TAYCI)**
There was no evidence health education was provided or included all required components. **(SUWCI-ANNEX, TAYCI)**
There was no evidence of referral to the clinician when indicated. **(MATCI)**
The mammography study was not found in the chart. **(HERCI – 2 applicable sites)**

Pill Line
Administering personnel did not wash hands or put on gloves. **(SUWCI, SUWCI-ANNEX, HERCI)**
Oral cavity checks were not conducted by health care personnel. **(SUWCI-ANNEX, MATCI, FSP-WEST)**
Staff did not verify the medication label matched the MAR. **(HERCI)**
The pill room was in disrepair. **(SFRC)**
Pharmacy Services
Controlled substances inventory and invoices were not available. **(SARCI-ANNEX)**
There was no evidence the consulting pharmacist provided annual in-service training for medical staff. **(SARCI, SARCI-ANNEX)**
The consulting pharmacist did not conduct required monthly reviews of MARs. **(CFRC)**
Blood glucose test strips were not dated for expiration and/or were outdated. **(SUWCI, SUWCI-ANNEX)**
There was inadequate space and storage for medications in the pharmacy areas and/or discarded stock medications were not witnessed properly. **(HOMCI, TAYCI, FSP)**
Reception Process (2 Applicable Facilities)
The required tests were not completed within seven days. **(CFRC)**
Laboratory results were not conveyed to the inmate and/or appropriately addressed. **(CFRC)**
There were no problem lists in the medical records. **(CFRC)**
There was no evidence of referral to the clinician when indicated. **(CFRC)**
Institutional Tour
All infirmary beds were not within site or sound of the nurse's station. **(SUWCI, MATCI)**
Medical areas were unorganized, medications improperly stored, and no sharps/biohazard containers available. **(MATCI)**
Personal protective equipment for universal precautions was not available in all required areas. **(JEFCI, MATCI)**
Negative air pressure in medical isolation rooms was inadequate and/or not checked daily when in use. **(SFRC, MATCI, SARCI-ANNEX, TAYCI)**
The blood glucose meters were not in the emergency kit, calibrated, logged, and/or tested timely. **(SARCI-ANNEX, CFRC-EAST, TAYCI-ANNEX)**
There were no hand or eye washing stations and/or products in the appropriate areas. **(SFRC, MATCI, SARCI, SARCI-ANNEX)**
Over-the-counter medications were not current or available in all areas. **(SFRC-SOUTH, TAYCI-ANNEX, FSP)**
Medical equipment was not in proper working condition. **(FSP, FSP-WEST)**
The specimen refrigerator in lab room did not have a biohazard label. **(SARCI-ANNEX)**
There were unclean living conditions and inoperative fixtures noted in dormitory areas. **(SARCI, MATCI, CFRC)**
There was no documentation that first aid kits were inspected monthly. **(SFRC-SOUTH)**

Mental Health Findings

Self-harm Observation Status (SHOS)
Admission orders were not signed/countersigned and/or dated/timed. **(JEFCI, CROCI, MATCI, CFRC, FSP, GADCF)**
Emergency evaluations were not completed prior to SHOS admissions. **(SUWCI, SARCI-ANNEX, TAYCI, CROCI)**
Admission forms were not completed within 2 hours. **(SUWCI, CFRC)**
Inmates were not evaluated on the 4th day to determine if transfer to a Crisis Stabilization Unit (CSU) was needed. **(MATCI, SARCI, TAYCI)**
Clinician's orders did not specify observations every 15 minutes. **(SARCI-ANNEX, CFRC)**
There was no documentation inmates were observed at the frequency ordered by the clinician. **(JEFCI, SUWCI, SARCI-ANNEX, MATCI, FSP)**
Daily nursing evaluations were not completed once per shift. **(JEFCI, MATCI)**
Daily rounds by the clinician were not documented. **(JEFCI, CROCI, SUWCI, SARCI, TAYCI)**
There was no evidence of face-to-face evaluations by the clinician prior to discharge. **(SUWCI, SARCI, TAYCI, GADCF)**
There was no evidence of daily counseling by mental health staff. **(SARCI)**
There was no evidence inmates were seen by mental health staff for post-discharge follow-ups. **(SUWCI, TAYCI, GADCF)**
Entries were not dated, timed, signed, and/or stamped. **(CROCI)**
Mental Health Restraints
Precipitating behavioral signs indicating the need for psychiatric restraints were not documented. **(SFRC)**
Less restrictive means of behavioral control were not documented. **(SARCI-ANNEX, SFRC)**
Telephone orders for restraints were not signed by the clinician. **(MATCI)**
Physician orders did not contain the maximum duration of restraint. **(SFRC)**
There was no documentation inmates were offered fluids or bedpans/urinals every 2 hours. **(SARCI-ANNEX, SFRC, MATCI)**
There was no documentation of inmates' behavior every 15 minutes. **(MATCI)**
There was no documentation inmates' respiration or circulation were checked every 15 minutes. **(SARCI-ANNEX, MATCI)**
There was no documentation inmates' vital signs were taken when released. **(SARCI-ANNEX)**
There was no documentation inmates' limbs were exercised every 2 hours. **(SARCI-ANNEX)**
Restraints were not removed after 30 minutes of calm behavior. **(SFRC)**

Use of Force
Written referrals to mental health were not completed or present in the record. **(JEFCI, MATCI, CFRC, GADCF)**
There was no indication inmates were interviewed by the next working day to determine the level of mental health care needed. **(JEFCI, SUWCI, SARCI-ANNEX, CFRC, GADCF)**
Post use of force physical exams were not completed. **(GADCF)**
Psychological Emergency
Entries were not dated and/or timed. **(SUWCI-ANNEX)**
Responses to mental health emergencies were not documented. **(TAYCI)**
Emergencies were not responded to within 1 hour. **(HOMCI, TAYCI, GADCF)**
Dispositions were not appropriate based on documentation. **(TAYCI-ANNEX)**
There was no appropriate follow-up in response to emergencies. **(TAYCI-ANNEX)**
Inmate Request
Copies of inmate requests were not found in the records. **(JEFCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST)**
Entries were not signed, dated, and/or stamped. **(SUWCI-ANNEX)**
Inmate requests were not responded to within 10 days. **(CFRC)**
Interviews/referrals indicated in requests did not occur as indicated. **(SBCF)**
Special Housing
Mental status exams (MSEs) were not completed within the required timeframe. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX)**
Follow-up MSEs were not completed within the required timeframe. **(JEFCI, SUWCI-ANNEX, SARCI-ANNEX, TAYCI, TAYCI-ANNEX)**
Special housing health appraisals were incomplete or missing. **(MATCI, TAYCI, CFRC)**
Outpatient treatment was not continued as indicated on Individualized Service Plans (ISPs). **(JEFCI)**
There was no documentation that problems with adjustment were responded to appropriately by mental health staff. **(SUWCI-ANNEX)**
Psychotropic medications were not continued. **(CFRC, GADCF)**
Inpatient Psychotropic Medications (3 Applicable Sites)
Psychiatric evaluations did not address all issues. **(SUWCI)**
Initial lab tests were not completed as required. **(SUWCI, SFRC)**
Clinicians' admission notes were not completed within 24 hours. **(SARCI-ANNEX)**
Clinicians' orders were not dated and/or timed. **(SUWCI, SARCI-ANNEX)**
Medications prescribed were not appropriate for symptoms and diagnosis. **(SFRC)**
Signed informed consents for each class of medication were not present. **(SUWCI, SFRC)**
Follow-up lab tests were not completed as required. **(SUWCI, SARCI-ANNEX, SFRC)**
Rationale for Emergency Treatment Orders (ETOs) were not documented. **(SUWCI)**
ETOs were not countersigned, dated, and/or timed. **(SUWCI)**

Inpatient Mental Health Services (3 Applicable Sites)
There was no documentation that inmates were oriented to the unit within 4 hours of admission. **(SUWCI)**
Vital signs were not documented daily for the first 5 days for new admissions. **(SFRC)**
Inmates were not offered the required hours of planned structured therapeutic services. **(SUWCI, SARCI-ANNEX, SFRC)**
Vital signs were not documented at required intervals. **(SFRC)**
Weekly weights were not documented. **(SFRC)**
Outpatient Psychotropic Medication
There was no evidence of appropriate initial laboratory work. **(JEFCI, SUWCI-ANNEX, SARCI, CFRC)**
Psychiatric evaluations were not completed prior to prescribing psychotropic medications. **(MATCI, CFRC, HERCI, FSP)**
Abnormal lab tests were not followed up as required. **(SUWCI, SUWCI-ANNEX, SFRC, CFRC, HERCI, FSP, GADCF)**
Clinicians' orders were not dated, timed, and/or signed. **(JEFCI, MATCI)**
Approved drug exception requests were not present when medications were prescribed for non-approved use. **(SFRC)**
Inmates did not receive medications as prescribed nor were refusals found in medical records. **(JEFCI, SUWCI-ANNEX, SFRC, CFRC)**
Informed consents were not present or did not reflect relevant information to the prescribed medications. **(SUWCI-ANNEX, SFRC, MATCI, CFRC, HERCI)**
Signed refusals were not present in the records after three consecutive or five in one month medication refusals. **(JEFCI)**
There was no evidence nursing staff met with inmates refusing medication for two consecutive days. **(SARCI)**
Follow-up laboratory tests were not completed as required. **(JEFCI, SUWCI, SUWCI-ANNEX, SFRC, HERCI, GADCF)**
Abnormal Involuntary Movement Scales (AIMS) were not administered when required. **(SUWCI-ANNEX, SARCI, CFRC, HERCI, FSP)**
Follow-up sessions were not conducted at appropriate intervals. **(JEFCI, CFRC, HERCI)**
Outpatient Mental Health Services
There was no indication instructions for accessing mental health care were provided. **(CROCI, SUWCI-ANNEX, SFRC)**
Arrival/Transfer Summaries lacked required information or were not completed timely. **(HOMCI, FSP, CFRC-EAST, SFRC)**
Consents for treatment were not signed prior to initiation or renewed annually. **(TAYCI, TAYCI-ANNEX)**

Outpatient Mental Health Services
Case managers were not assigned within three working days. **(JEFCI, SUWCI-ANNEX, HERCI, SBCF)**
Current medications prescribed from sending institutions were not continued prior to the initial appointment with psychiatry. **(JEFCI, SUWCI, HERCI, SBCF)**
Inmates were not seen by psychiatry prior to the expiration of current medication. **(JEFCI)**
Inmate interviews and/or mental health screening evaluations were not completed within 14 days of arrival. **(JEFCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, HERCI)**
Sex offender screenings were not present in records. **(SARCI-ANNEX, CFRC-EAST)**
Consents and/or refusals to sex offender treatment were not present in records. **(JEFCI)**
Biopsychosocial assessments (BPSAs) were not approved by multidisciplinary treatment teams (MDST) within 30 days. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, GADCF)**
ISPs were not completed within 14 days. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST, HERCI)**
ISPs were not signed by the MDST and/or inmates or there were no documented refusals. **(JEFCI, SUWCI-ANNEX, TAYCI, TAYCI-ANNEX, CFRC, FSP-WEST)**
ISPs lacked pertinent information and were not individualized. **(TAYCI, TAYCI-ANNEX, GADCF)**
ISPs were not reviewed or revised at 180 days. **(JEFCI, SUWCI-ANNEX, SARCI, TAYCI, TAYCI-ANNEX, CFRC, CFRC-EAST)**
Mental health problems were not documented on problem lists. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF, CFRC, CFRC-EAST)**
There was no documentation inmates received services listed on ISPs. **(JEFCI, SARCI)**
Counseling was not provided every 30 days for inmates diagnosed with psychotic disorders. **(JEFCI, GADCF)**
Counseling was not provided every 90 days for inmates without psychotic disorders. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF)**
Case management was not conducted every 90 days. **(JEFCI, TAYCI, TAYCI-ANNEX, GADCF)**
There were insufficient details in progress notes to follow the course of treatment. **(TAYCI, TAYCI-ANNEX)**
Frequency of clinical contacts were not sufficient. **(JEFCI, TAYCI, TAYCI-ANNEX)**

Aftercare Planning
Aftercare plans were not addressed in ISPs. **(SUWCI-ANNEX, SARCI-ANNEX, HERCI)**
Consent and authorization forms were not signed by inmates. **(SARCI-ANNEX)**
Summaries of care were not completed within 30 days of End of Sentence (EOS). **(SUWCI-ANNEX, SARCI-ANNEX, SFRC, HERCI, GADCF)**
Assistance with Social Security benefits was not provided within 90 days of EOS. **(SARCI-ANNEX, HERCI, SBCF)**
Reception Process (2 Applicable Sites)
Psychotropic medications were not continued from county jail. **(SFRC)**
Psychiatric evaluations were not completed within 10 days as required. **(CFRC)**
There were no signed releases or refusals for treatment records for inmates in reception over 60 days. **(CFRC)**
Administrative Issues
Therapeutic groups were not conducted. **(JEFCI)**
Weekly clinical supervision for psychological specialist were not consistently conducted. **(JEFCI, TAYCI, TAYCI-ANNEX)**
There were safety concerns including paint and mesh peeling from Isolation Management Rooms. **(SFRC, FSP, FSP-WEST, GADCF)**
Inmates on close management were not provided the opportunity to sign a refusal for group activities. **(FSP)**
Inmate request logs were not completed. **(TAYCI, TAYCI-ANNEX)**
Inmates in special housing were not offered opportunities to speak out of cell to mental health staff during therapeutic contacts. **(GADCF)**
Psychological emergency logs were not completed. **(TAYCI, TAYCI-ANNEX)**
MDST meetings were not held regularly. **(TAYCI, TAYCI-ANNEX)**
There were no protective helmets present. **(CFRC)**

Recommendations for FY 2013-14

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

Physical Health

- Review policies regarding the documentation of baseline health information (e.g., physical examinations, laboratory results, and assessment information) with institutional staff to ensure proper documentation requirements are met;
- Determine a method to guarantee hepatitis, pneumococcal, and influenza vaccinations are completed according to policy and in a timely manner;
- 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;
- Consider developing guidelines for physicians and clinical associates that address requirements of appropriate physical examinations, treatment provision, writing medication and treatment orders, and overall clinical management;
- Provide additional training for physicians and clinical associates regarding timely follow-up of consultations and documentation of a new plan of care following denial of consultation by Utilization Management;
- Determine a method to ensure that procedures to access medical, dental, and mental health care services remain posted in dormitory areas.

Mental Health

- Ensure the required hours of planned structured therapeutic services are provided and documented;
- Create and maintain a system to track use of force episodes indicating inmates in need of mental health follow-up are seen as required;

- Provide additional training for clinicians in the area of required psychiatric laboratory tests (i.e., initial, follow-up, and abnormal follow-up);
- Ensure staff document the observation of inmates in SHOS as ordered by the clinician;
- Determine a method to ensure inmate requests are filed in the medical record in a timely manner;
- Provide training to staff to ensure that mental status exams (MSEs) are completed within the required timeframe for inmates on special housing status;
- Determine a method to ensure that inmates in mental health restraints are offered necessary services (e.g., bedpans, fluids, respiration/circulation checks, etc.) and those services are documented as required.

Corrective Action Plans

The CMA publishes a final report listing all survey findings and suggests corrective actions to be taken at the institutional level. The CMA also provides the institutions with a corrective action plan (CAP) tip sheet including guidelines for creating and submitting the CAP within 30 calendar days of the final report.

Institutional staff submits a written CAP that has been reviewed and approved by the OHS. Corrective action plans typically include in-service training, internal records monitoring, and physical plant improvements. Following CMA approval of the CAP, monitoring takes place for a period of no less than three months at which time the CMA will evaluate the effectiveness of corrective actions.

Following the initial monitoring period, the CMA requests the institution provide documentation of the corrective actions taken, including the monitoring tools for review. Based on this review staff will conduct either an on-site or off-site review and report the status of findings.

Based upon multiple institutions submitting inadequate monitoring, the CMA implemented a new procedure to review the initial monitoring by institutional staff after 30 days.

This process has been beneficial in determining if monitoring efforts are sufficient and allows the CMA to provide institutional staff with suggestions for improvement to increase the likelihood that findings will be monitored correctly. This fiscal year the CMA completed a total of 15 CAP assessments; 9 on-site and 6 off-site record reviews. The following is a complete breakdown of the CAP activities of the CMA during FY 2013-14.

FY 2013-14 Corrective Action Plan (CAP) Assessments **(*Occurred in FY 2014-15)**

Institution	Survey Date	Total Findings	1st CAP Assessment	2nd CAP Assessment	3rd CAP Assessment	4th CAP Assessment	Open Findings
Zephyrhills	May 2013	17	November 2013	April 2014	July 2014*	November 2014*	CLOSED*
Union	June 2013	52	January 2014	June 2014	September 2014*		CLOSED*
Jefferson	July 2013	72	February 2014	June 2014	October 2014*		2
Cross City	August 2013	17	February 2014	May 2014	September 2014*		CLOSED*
Suwannee	August 2013	70	March 2014	May 2014	November 2014*		13
Santa Rosa	September 2013	76	June 2014	October 2014*			3
SFRC South Unit	October 2013	94	May 2014 June 2014	September 2014*			13
Martin	November 2013	55	May 2014	September 2014*			40
Homestead	December 2013	22	May 2014	September 2014*			1

Committee Activities

Medical Review Committee

Per section 945.6032, Florida Statutes, the CMA is required to appoint a medical review committee to provide oversight of DOC's inmate health care quality management program. As part of this responsibility, CMA staff review all DOC amendments to the quality management program prior to implementation. Additionally, the CMA staff attended Quality Management meetings with DOC and the private contractors in November 2013 and June 2014. During these meetings DOC, Wexford, and Corizon presented a summary of the findings from their bi-annual quality reviews.

Quality Management Committee (QMC)

The primary focus of the QMC is a quality review of DOC's mortality review process to ensure the effectiveness of the self-evaluation of the quality of care provided during sentinel events. The QMC's mission is to provide feedback to DOC and the contractors about the efficacy of the process they use to identify health care deficiencies and provide for corrective actions.

The QMC is composed of a licensed physician committee chair and three volunteer health care professionals including one representative from the CMA Board. The committee held its first meeting in May 2014 with DOC and Corizon representatives. The QMC submitted suggestions for improved communication, documentation, and data tracking between DOC and the independent contractors and evaluated four mortality reviews.

Future meetings will include representatives from the other health care contractors. Annually, the QMC will hold one meeting to review a sampling of suicide cases occurring in the past year. The QMC will continue to meet on regular basis and analyze the mortality trends throughout Florida's prison system to provide valuable oversight of DOC's quality management program.

Budget and Personnel Workgroup

The CMA is required to advise the Governor and Legislature on cost containment measures and make recommendations on the inmate health services budget. In December 2013, two citizen volunteers chosen for their budgetary expertise met with the CMA to analyze the inmate health services legislative budget request (LBR) from DOC. The workgroup acknowledged the success of DOC's efforts to reduce pharmaceutical costs through the implementation of the 340B Specialty Care Program (HIV/STD) with the Department of Health and utilizing generic brand medications. Seeing no further areas for major cost-saving initiatives, the CMA advised the Governor in January 2014, of its support for a price level increase of $1,331,495 in health services drug costs as part of the FY 2014-15 inmate health services LBR of $356,808,439.

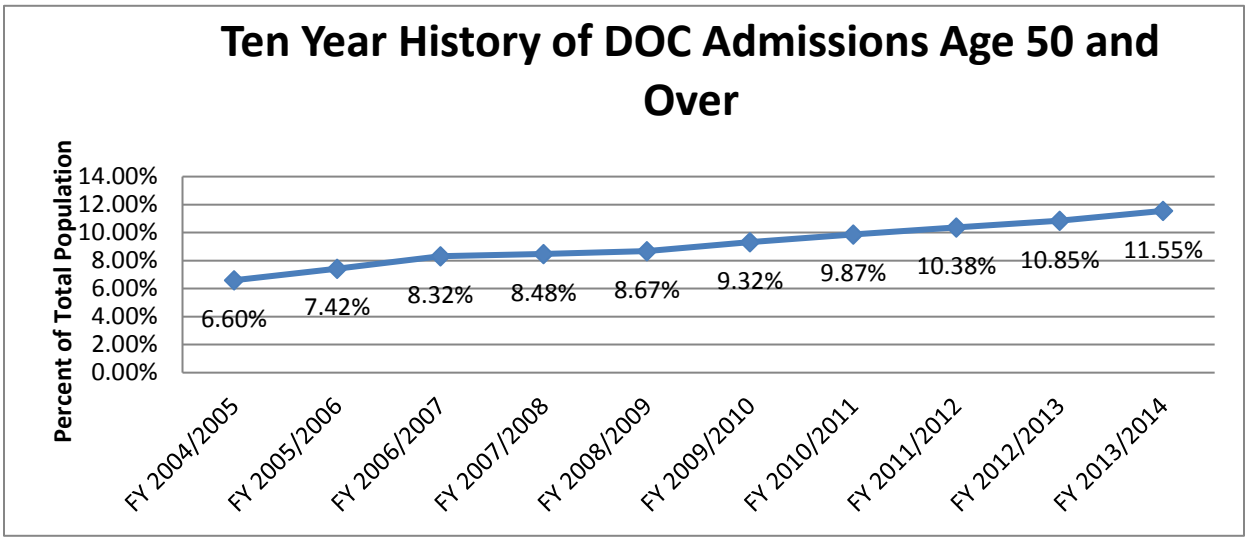
In FY 2013-14, DOC's inmate health services funding totaled $336,209,648 and included 136.5 positions. DOC contracts with Corizon to provide health care services at a single capitation rate of $8.4760 per inmate, per day based on the average monthly number of inmates and a rate of $8.4242 with Wexford.

2013-14 REPORT ON ELDERLY OFFENDERS

In 1999, the Florida Corrections Commission and House of Representatives Committee on Corrections study of elderly and aging inmates required that the Correctional Medical Authority (CMA) and the Department of Corrections (DOC) submit annual reports to the Legislature providing information on elderly offenders (age 50 and over) within the correctional system. Pursuant to section 944.8041, Florida Statutes, this report provides a description of the status and treatment of Florida's elderly inmate population. The data presented on Florida inmates in this report is provided by DOC's Bureau of Research and Data Analysis and the Office of Health Services.

Status of Elderly Inmates

As of June 30, 2014, the total inmate population in Florida was 100,942 with more than 20% (20,753) of these inmates age 50 and over. Nationally, the elderly population makes up only 16% of the 2.5 million inmates in the United States[5]. Of the elderly inmates currently in the Florida prison system, 6,300 are projected to die while incarcerated. In FY 2013-14, there were 3,748 aging inmates admitted to DOC accounting for over 11.5% of all admissions. A look at the past ten years of elderly admissions reveals an ongoing trend of an increasingly older inmate population.



[5] Florida Tax Watch Research Institute, Inc. (2014). *Florida's Aging Prisoner Problem* (September 2014). Tallahassee, FL: McCarthy, Dan.

2013-14 Elderly Admissions

In FY 2013-14, the typical elderly admission was a white male almost 56 years of age. The majority of admissions had previous contact with DOC, and most of the commitments were for non-violent offenses, often relating to drug charges. There were no significant changes noted in the typical elderly admissions from the previous year. The table below is an illustration of the elderly admissions for FY 2013-14.

2013-14 Elderly Admissions	
Type	**Percentage**
Male	91%
Female	9%
Prior Admissions	62%
Violent/Sexual Offenses	29%
Non-violent Offenses	71%
White	57%
Black	40%
Other Races	3%

2013-14 Elderly Population

In FY 2013-14, the population of elderly inmates consisted of predominantly white males between the ages of 50 and 60. Almost half of the older population had no prior prison commitments. These trends are similar to the published data from the last fiscal year. The demographics of this elderly population are presented in the following tables:

Elderly Population		
Category	**June 30, 2014**	
Gender	**20,753**	**100.0%**
Male	19,624	94.6%
Female	1,129	5.4%
Race		
White	11,340	57.8%
Black	8,728	44.5%
Other	685	3.5%

Elderly Population		
Age Breakdown		
50-55	10,767	54.9%
56-60	5,125	26.1%
61-65	2,270	11.6%
66-70	1,701	8.7%
71-75	563	2.9%
76+	327	1.7%
Prior DC Prison Commitments		
0	9,590	46.2%
1	3,298	15.9%
2	2,220	10.7%
3	1,778	8.6%
4+	3,849	18.6%
Data Unavailable	18	

Elderly Population by Offense Type on June 30, 2014		
Type of Offense	**Number**	**Percent**
Murder, Manslaughter	4,325	20.8%
Sexual Offenses	4,479	21.6%
Robbery	1,938	9.3%
Violent Personal Offenses	1,988	9.6%
Burglary	2,494	12.0%
Theft/Forgery/Fraud	1,510	7.3%
Drug Offenses	2,670	12.9%
Weapons	402	2.0%
Other	944	4.6%

Elderly inmates are housed in the majority of institutions based on their custody level and medical status and typically remain a part of the general population. The chart below lists the institutions with the largest population of elderly inmates.

Largest Elderly Population by Institution			
Institution	**Total Population**	**Over 50**	**Percent**
Blackwater CF	1,993	425	21.3%
South Bay CF	1,893	456	24.1%
Union CI	1,869	1393	74.5%
Okeechobee CI	1,790	470	26.3%
Everglades CI	1,636	569	34.8%
Wakulla Annex	1,630	428	26.3%
Hardee CI	1604	506	31.5%
Dade CI	1,562	581	37.2%
Wakulla CI	1,485	433	29.2%
SFRC South	561	404	72.0%

Treatment of Elderly Inmates

DOC reports that the elderly population accounts for close to half of all episodes of care while representing just over 20% of the total prison population. Below is a breakdown of impairments in elderly inmates.

Elderly Population Impairment Breakdown						
Impairment	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Visual	41	18	27	18	18	122
Hearing	40	30	33	21	25	149
Physical	225	202	163	98	176	864
Developmental	15	8	1	4	4	32
Total	**321**	**258**	**224**	**141**	**223**	**1,167**

Florida's prison system provides comprehensive medical care to elderly inmates within the correctional system. Care includes special accommodations and programs, medical passes, and skilled nursing services for chronic and acute conditions as well as palliative care for terminally ill inmates. The table below illustrates the type and number of medical services provided to elderly inmates in FY 2013-14.

Active Medical Passes for Elderly Population						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Adaptive Devices	567	442	320	178	244	1,751
Attendant	21	22	24	20	25	112
Low Bunk	3,919	2,881	1,650	816	644	9,910
Guide	15	8	1	4	4	32
Hearing Aid	2	5	5	6	8	26
Pusher	19	10	18	6	13	66
Special Shoes	109	69	46	29	27	280
Wheelchairs	95	98	90	60	103	446
Total	**4,747**	**3,535**	**2,154**	**1,119**	**1,068**	**12,623**

Inmates with chronic illnesses are enrolled in various specialty clinics that provide ongoing monitoring and treatment for chronic conditions. Over 40% of those assigned to chronic illness clinics are age 50 or older. The elderly population accounts for almost 30% of all sick call visits and approximately half of emergency visits. These percentages remain consistent with clinic enrollments and health care contacts over the past five years. The tables below show the total number of clinic visits for all age groups in the elderly population.

Elderly Inmates Assigned to Chronic Illness Clinics						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Cardiovascular	4,444	3,428	2,110	1,163	936	12,081
Endocrine	1,408	1,106	673	414	354	3,955
Gastrointestinal	1,510	1,343	745	229	88	3,915
Immunity	568	307	135	43	9	1,062
Miscellaneous	423	339	225	147	161	1,295
Neurology	350	197	98	37	29	711
Oncology	102	121	97	87	93	500
Respiratory	863	638	424	230	213	2368
Tuberculosis	234	147	63	21	20	485
Total	**9,902**	**7,626**	**4,570**	**2,371**	**1,903**	**26,372**

Elderly Inmates Health Care Contacts						
Type	**Age Group**					
	50-54	**55-59**	**60-64**	**65-69**	**70+**	**Total**
Multiple Clinics	2,693	2,223	1,415	759	644	7,734
Sick Call Visits	115,284	80,454	45,835	22,480	18,904	282,957
Emergency Visits	1,830	1,336	778	400	426	4,770
Total	**119,807**	**84,013**	**48,028**	**23,639**	**19,974**	**295,461**

Findings and Recommendations

The CMA's report on the status of elderly offenders continues to show that older inmates have more health problems and generally consume more health care services than younger inmates. The demands of caring for the elderly continue to have an impact on corrections' health care costs. According to The National Institute of Corrections, the overall cost of incarceration for inmates over 50 is as much as three times higher than for the younger population mostly due to the difference in health care costs.[6] Across the country the impact of rising health care costs, especially for elderly inmates, is similar to the impact in Florida.

Florida's elderly prison population has increased almost 5% over the last 5 years and is expected to gain over 6,000 inmates by the end of the next fiscal year. Considering the trend of increasing elderly inmate populations and health care costs, the CMA supports medical passes and special accommodations (e.g., low bunks, special shoes, wheelchairs, etc.) provided to older inmates housed in DOC's general population. DOC policies ensuring periodic screenings, regularly scheduled clinic visits, and the establishment of specific facilities for elderly inmates in need of a higher level of care improves the health of elderly inmates. Improved health status within the aging population will serve as a positive cost-containment measure.

It is recommended that DOC continue to examine and consider the needs of inmates over 50 when establishing standards of care criteria for the private health care providers. Additionally, reporting of detailed health care costs for aging inmates would be beneficial for analysis of projected needs to adequately care for the elderly population in the coming years.

[6] Florida Tax Watch Research Institute, Inc. (2014). *Florida's Aging Prisoner Problem* (September 2014). Tallahassee, FL: McCarthy, Dan.