State of Florida Correctional Medical Authority

2015-2016 Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons

DECEMBER 2016

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
Health Care Administration

Vacant
Representative Dental

Leigh-Ann Cuddy, MS
Representative
Mental Health

December 29, 2016

The Honorable Rick Scott
Governor of Florida

The Honorable Joe Negron, President
The Florida Senate

The Honorable Richard Corcoran, Speaker
Florida House of Representatives

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

In accordance with § 945.6031, Florida Statutes (F.S.), I am pleased to submit the Correctional Medical Authority's (CMA) 2015-16 Annual Report. This report summarizes the CMA's activities during the fiscal year and details the work of the CMA's governing Board, staff, and Quality Management Committee in fulfilling the agency's statutory responsibility to assure adequate standards of physical and mental health care are maintained in Florida's correctional institutions.

This report also summarizes the findings of CMA institutional surveys. During Fiscal Year (FY) 2015-16, the CMA conducted on-site physical and mental health surveys of 15 major correctional institutions, which included two reception centers and four institutions with annexes or separate units. Additionally, CMA staff conducted 42 corrective action plan assessments based on findings from this and previous year's surveys.

Pursuant to § 944.8041 F. S., Section 2 of this report includes the CMA's statutorily mandated report on the status and treatment of elderly offenders in Florida's prison system. The Update on the Status of Elderly Offenders in Florida's Prisons Report describes the elderly population admitted to Florida's prisons in FY 2015-16 and the elderly population housed in Florida Department of Corrections (FDC) institutions on June 30, 2016. The report also contains information related to the use of health care services by inmates age 50 and older and housing options available for elderly offenders.

The CMA continues to support the State of Florida in its efforts to assure the provision of adequate health care to inmates. 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

Jane Holmes-Cain, LCSW
Executive Director

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Introduction

About the Correctional Medical Authority

The Correctional Medical Authority (CMA) was created in July 1986 while Florida's prison health care 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 lawsuit brought by inmates alleging that their constitutional rights had been violated by inadequate medical care, insufficient staffing, overcrowding, and poor sanitation. The Florida Legislature enacted legislation that created the CMA based on recommendations of a Special Master and Court Monitor, appointed by the federal courts, to ensure that an "independent medical authority, designed to perform the oversight and monitoring functions that the court had exercised" be established. [1]

The CMA was created as part of the settlement of the Costello case and continues to serve as an independent monitoring body to provide oversight over the systems in place that provide health care to inmates in Florida Department of Corrections (FDC) institutions. 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 prison monitoring and oversight functions it had performed for the prior twenty years. The Court found that the CMA was capable of "performing an oversight and monitoring function over the Department to assure continued compliance with the orders entered in this case." Judge Black went on to write that "the CMA, with its independent board and professional staff, is a unique state effort to remedy the very difficult issues relating to correctional health care."[2]

Since 1986, the CMA carried out its mission to monitor and promote the delivery of cost-effective health care that meets accepted community standards for Florida's inmates until losing its funding on July 1, 2011. During the 2011 legislative session, two bills designed to repeal statutes related to the CMA and eliminate funding for the agency passed through the Florida House and Senate, and were sent to the Governor for approval. The Governor vetoed a conforming bill which would have eliminated the CMA from statute and requested that the agency's funding be restored. The Legislature restored the agency's funding effective July 1, 2012. The CMA was reestablished, and is now housed within the administrative structure of the Executive Office of the Governor as an independent state agency.

CMA Structure and Responsibilities

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, and is comprised of health care professionals from various administrative and clinical disciplines. The Board directs 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 of Florida's correctional institutions.

As an independent agency, the CMA's primary role is to provide oversight and monitoring of FDC's health care delivery system to ensure adequate standards of physical and mental health care are maintained in Florida's correctional institutions. FDC contracts with two private companies, Wexford Health Sources, Inc. and Corizon, Inc., to provide comprehensive health care services for inmates pursuant to Department expectations and standards. In May 2016, Centurion of Florida replaced Corizon, Inc. as FDC's contracted health services provider in Regions I, II, and III. Seven private correctional facilities are managed by the Department of Management Services (DMS). Health care is provided in

[1] Celestineo V. Singletary. United States District Court. 30 Mar. 1993. Print.

[2] Ibid.

these facilities by providers contracted by DMS.

The CMA advises the Governor and Legislature on the status of FDC's health care delivery system. It is important to note that 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 that an oversight agency with board review powers was needed. Therefore, the CMA's activities serve as an important risk management function for the State of Florida by ensuring constitutionally adequate health care is provided in FDC institutions.

Specific responsibilities and authority related to the statutory requirements of the CMA are described in § 945.601–945.6035, Florida Statutes (F.S.), and include the following activities:

- Reviewing and advising the Secretary of Corrections on FDC'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 FDC's health care delivery system, including cost containment measures and performance and financial audits.
- 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 FDC's quality management program to ensure coordination with the CMA.
- Reviewing amendments to the health care delivery system submitted by FDC prior to implementation.

2015-2016 Annual Report

The CMA is required by § 945.6031 F.S. to provide an annual report detailing the current status of FDC's health care delivery system. This report details CMA's activities during fiscal year (FY) 2015-16, provides an update on the status of FDC's health care services delivery system, summarizes findings of institutional surveys, provides an update regarding CMA's corrective action plan process, and provides CMA's overall assessment and recommendations regarding FDC's health care delivery system.

Key CMA Activities in Fiscal Year 2015-2016

CMA activities during FY 2015-16 focused on meeting the agency's statutorily required responsibilities. Key agency activities are summarized below:

CMA Board Meetings

The governing board of the CMA is composed of seven citizen volunteers appointed by the Governor and approved by the Senate. The 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. During the fiscal year, the Board held seven public meetings. In December 2015, the Board voted to transition from monthly board meetings, via conference call or in-person, to quarterly in-person meetings.

Health Care Standards Review

During FY 2015-16, the CMA reviewed and made recommendations, when necessary, for 39 FDC policies and procedures. According to § 945.6034 F.S., the CMA is required to review OHS's policies pertinent to health care and to 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 FDC's policies and procedures, as well as community standards of care.

Inmate Correspondence

Throughout the fiscal year, the CMA receives written correspondence from inmates and/or their families requesting assistance in resolving health care related issues. Monitoring inmate correspondence is an important risk management function for the CMA. During FY 2015-16, CMA staff responded to 72 letters concerning inmates at 26 correctional institutions.

Upon receiving a letter, CMA staff reviews, triages, and responds to inmate correspondence. The CMA is not authorized to direct staff in FDC institutions or require that specific actions be taken by the Department. Therefore, inmate letters are forwarded to OHS for investigation and response. CMA staff tracks the outcomes of these letters, and health care issues identified in inmate letters are subsequently reviewed during on-site surveys. At the close of the fiscal year, OHS provided a response and follow-up for all letters forwarded for review.

Quality Management Committee

Through its Quality Management Committee (QMC), the CMA operates as an oversight body of FDC's quality management program. The QMC is comprised of a licensed physician committee chair and three volunteer health care professionals including a representative from the CMA Board. The Committee's mission is to provide feedback to the Department regarding its quality management process and ensure that corrective actions and policy changes identified through the process are effective.

During FY 2015-16, the QMC continued to focus efforts on evaluating the effectiveness of FDC's mortality review process. All in-custody deaths, except executions, require a mortality review. Contracted health care providers conduct self-reviews of inmate mortalities to determine the appropriateness of care. The review is submitted to OHS which determines if there were any quality of care issues not identified by the contractor. The QMC then evaluates this review of mortality cases to facilitate improvements in inmate health care. QMC mortality reviews assess whether the mortality review process effectively identified any deficiencies in health care that may have contributed to death, and determine whether appropriate action was taken to prevent deficiencies from happening in the future.

The QMC met four times during the fiscal year, and reviewed a total of 17 cases. One of those meetings was dedicated to suicide mortalities and included a review of four cases. The format of the suicide mortality review meeting is similar to the regular mortality review process with the exception that a psychiatrist reviews and presents information to the committee.

It is important to note that the QMC's review of mortality cases is based on a non-random sample, and the intent of the review is not to generalize review findings to mortality cases as a whole. The QMC's mortality review process provides an opportunity to identify and correct clinical and health care management deficiencies that can lead to improvements across FDC's health care system. The overall goal of the QMC's mortality review process is to facilitate opportunities for improved care and outcomes.

Institutional Surveys

The CMA is required, per § 945.6031(2) F.S., to conduct triennial surveys of the physical and mental health care systems at each correctional institution and report survey findings to the Secretary of Corrections. The process is designed to assess whether inmates in FDC's correctional institutions have the ability to access medical, dental, and mental health care and to evaluate the clinical adequacy of the resulting care. To determine the adequacy of care, the CMA conducts clinical records reviews that assess the timeliness and appropriateness of both routine and emergency physical and mental health services. Additionally, administrative processes, institutional systems for informing inmates of their ability to request and receive timely care, and operational aspects of health care services are examined.

The CMA contracts with a variety of licensed community and public health care practitioners including physicians, psychiatrists, dentists, nurses, psychologists, and other licensed mental health professionals to conduct these surveys. Uniform survey tools, based on OHS policy and community health care standards, are used during record reviews to evaluate specific areas of physical and mental health care service delivery. CMA surveyors use these tools to assess compliance with commonly accepted policies and practices of medical record documentation. The CMA employs a record selection methodology which ensures a 15 percent margin of error and an 80 percent confidence level. Records are selected in accordance with the size of the clinic or assessment area being evaluated. CMA surveyors review selected records and, at the conclusion of each review, CMA staff analyzes each survey tool to determine if there are deficiencies that meet the criteria for a finding and whether or not require corrective action is required.

In FY 2015-16, 15 institutions were surveyed, including one female and 14 male institutions, two reception centers, and four institutions with main and annex units, with each unit being surveyed separately. Two of the male institutions surveyed were private facilities managed by DMS. A total of 725 institutional survey findings were identified. Of those findings, 371 (50 percent) were reportable physical health findings and 378 (50 percent) were mental health findings. The results of CMA surveys were formally reported to the Secretary of Corrections. Detailed reports for each institutional survey can be accessed on the CMA's website at http://www.flgov.com/correctional-medical-authority-cma.

A brief summary of medical and mental health grades[3], number of inmates housed, and survey findings identified is provided in Table 1 below. A detailed summary of findings from institutional surveys will be presented later in this report.

[3] Medical grades reflect the level of care inmates require. Grades range from M1, requiring the least level of medical care, to M5, requiring the highest level of care. Pregnant offenders are assigned to grade M9. Medical grades are as follows: M1, inmate requires routine care; M2, inmate is followed in a chronic illness clinic (CIC) but is stable and does not require CIC care more often than every six months; M3, inmate is followed in a CIC every three months, M4, inmate is followed in a CIC every three months and requires ongoing visits to the physician more often than every three months; M5, inmate requires long-term care (longer than 30 days) in inpatient, infirmary, or other designated housing.

Mental health grades reflect the level of psychological treatment inmates require. Grades range from S1, requiring the least level of psychological treatment, to S6, requiring the highest level of treatment. Mental health grades are as follows: S1, inmate requires routine care; S2, inmate requires ongoing services of outpatient psychology (intermittent or continuous); S3, inmate requires ongoing services of outpatient psychiatry (case management, group and/or individual counseling, as well as psychiatric or

Table 1. Summary of Fiscal Year 2015-2016 Institutional Surveys

Summary of Fiscal Year 2015-2016 Institutional Surveys									
Institution	Grades Served		Maximum Capacity	Census at Time of Survey	Infirmary Care	Inpatient Mental Health	Special Housing	Findings	
	Medical	Mental Health						Physical Health	Mental Health
Columbia CI-Main	M1-M5	S1-S3	1603	1384	Y	N	Y	40	23
Columbia CI-Annex	M1-M5	S1-S3	1644	1520	N	N	Y	25	29
Jackson CI	M1-M3	S1-S2	1382	1185	Y	N	Y	14	10
FWRC	M1-M3	S1-S6	1152	958	Y	Y	Y	52	59
RMC-Main	M1-M5	S1-S5	1503	1195	Y	Y	Y	19	47
RMC-West	M1-M3	S1-S3	1148	852	N	N	N	22	10
Dade CI	M1-M5	S1-S5	1406	1493	Y	Y	Y	15	21
Graceville CF	M1-M4	S1-S3	1884	1878	Y	N	Y	14	16
Gulf CI-Main	M1-M3	S1-S2	1407	1501	N	N	Y	7	0
Gulf CI-Annex	M1-M5	S1-S2	1227	1372	Y	N	Y	17	3
Okaloosa CI	M1-M4	S1-S2	1004	901	Y	N	Y	8	20
Walton CI	M1-M4	S1-S2	1362	1162	Y	N	Y	7	2
Madison CI	M1-M3	S1-S2	1351	1189	Y	N	Y	7	5
Franklin CI	M1-M5	S1-S2	1346	1384	Y	N	Y	15	23
Everglades CI	M1-M5	S1-S3	1788	1485	Y	N	Y	9	4
Apalachee CI-East	M1-M4	S1-S3	1322	1262	Y	N	Y	19	23
Apalachee CI-West	M1-M4	S1-S2	819	809	Y	N	Y	21	12
Century CI	M1-M3	S1-S2	1345	1370	Y	N	Y	24	26
Blackwater CF	M1-M3	S1-S3	2000	1993	Y	N	Y	36	45
								371	378

***Notes: Data presented in table was collected from Pre-Survey Questionnaires (PSQ) completed by institutional personnel. FWRC houses female offenders. Reception services are provided at RMC-Main and FWRC.**

Florida Women's Reception Center Emergency Notification

On September 15-17, 2015, the CMA conducted a survey of medical, dental, and mental health systems at Florida Women's Reception Center (FWRC). The survey included a review of records to evaluate the provision and documentation of care. Additionally, a review of administrative processes, a tour of the physical plant, and interviews with staff and inmates were also conducted. Based on the results of the CMA's survey activities, several findings were identified that were considered to be serious deficiencies, requiring immediate attention by FDC. As a result of those findings, the CMA issued an emergency notification, in accordance with § 945.6031 (3) F.S., to the Secretary of Corrections on September 22, 2015.

The emergency notification informed the Secretary that there were serious deficiencies related to significant delays in care and treatment. These delays in treatment affected multiple areas of inmate physical and mental health care which included medication administration, follow-up with on-site providers, delays in outside consultations, and clinical review including the timely follow-up of abnormal labs and diagnostic services. Of additional concern was the notable disorganization of medical records. Multiple portions, and in some cases, whole records could not be located during the survey. Other records were thinned, but not in compliance with Department policies and procedures. This made it difficult, or in some cases, impossible to follow the course of treatment or to verify that treatment was provided.

psychiatric ARNP care); S4, inmates are assigned to a Transitional Care Unit (TCU); S5, inmates are assigned to a Crisis Stabilization Unit (CSU); and S6, inmates are assigned to a corrections mental health treatment facility (MHTF).

On September 25, 2015, the Department provided CMA with an extensive corrective action plan (CAP) which outlined plans to address the findings identified in the emergency notification. The plan indicated issues that needed immediate attention would be addressed, then systems would be put in place to ensure inmate health care needs could be met on an ongoing basis.

On December 15, 2015, CMA staff conducted a site visit to ensure actions described in the Emergency CAP were being implemented. This was not a formal CAP assessment, rather a visit to ensure emergency findings were being addressed appropriately and monitoring efforts were conducted accurately. CMA staff and surveyors have conducted three formal CAP assessments as of the writing of this report. The results of these assessments can be located at http://www.flgov.com/correctional-medical-authority-cma/.

Union Correctional Institution Focused Review of Mental Health Services

In November 2015, a targeted review was conducted jointly by CMA staff, CMA surveyors, and FDC staff at Union Correctional Institution (UCI). The review consisted of items selected from CMA audit tools and focused on the delivery of mental health services in the inpatient units (U, V, and T) and special housing dorms (O and P), with an emphasis on inpatient psychiatric medication practices and the administration of medication. There were a total of 67 items reviewed that were applicable to inpatient mental health services. Of these 67 items, 47 fell at or below 80 percent compliance, resulting in an overall non-compliance rate of 70 percent. For outpatient mental health services, there were a total of 54 items reviewed. Of these 54 items, 29 fell at or below 80 percent compliance, resulting in an overall non-compliance rate of 54 percent.

In April 2016, an on-site CAP assessment at UCI was conducted jointly by CMA staff, CMA surveyors, and FDC staff. Based on the CAP assessment, of the 76 findings, 49 remained deficient. The status of each finding was based on the institutional monitoring reports and/or the review by the CMA/FDC monitoring team. FDC will continue to monitor the remaining findings until all deficiencies have been corrected and provide regular updates to the Board. The CMA will survey UCI in January 2017.

Corrective Action Plan (CAP) Assessments

Each time an institution is surveyed, a written report is published outlining noted findings and recommending corrective action. Within 30 days of receiving the survey report, institutional staff develops and submits a CAP to OHS for approval. CMA staff subsequently approves the CAP and monitoring begins. Approximately 30 days after the implementation of the CAP, CMA staff review monitoring documents and provide institutional staff with feedback and suggestions to ensure findings are monitored correctly. Usually four to five months after a CAP is implemented (but no less than three months), CMA staff evaluates the effectiveness of the corrective actions taken. These actions most often take the form of in-service trainings to applicable staff and internal records monitoring efforts to ensure staff are complying with the recommended changes. CMA staff and, when applicable, clinical surveyors review pertinent portions of medical records and documentation of corrective action. Findings deemed corrected are closed and monitoring is no longer required. Conversely, findings not corrected remain open. Institutional staff continue to monitor the open findings until the next assessment is conducted, typically within three to four months. This process continues until all findings are closed.

CMA staff completed 42 CAP assessments in FY 2015-16. This included three CAP assessments for institutions surveyed in FY 2013-14, 31 CAP assessments for institutions surveyed in FY 2014-15, and eight CAP assessments for institutions surveyed in FY 2015-16. At the end of the fiscal year, two CAPs from FY 2013-14 remained open and four were closed; four CAPs from FY 2014-15 remained open and 14 were closed; and one CAP from FY 2015-16 was closed. As of December 2016, an additional CAP from FY 2015-16 was closed.

Although this report highlights CMA activities during the fiscal year, a status summary of CAP assessments through December 2016 is provided in Tables 2a.-2c.

Table 2a. Fiscal Year 2013-2014 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2013-2014 Surveyed Institutions						
Institution	**Total Number of Physical Health Findings**	**Total Number of Mental Health Findings**	**Total Number of Open Physical Health CAP Findings**	**Total Number of Open Mental Health CAP Findings**	**Number of CAP Assessments**	**Open or Closed**
Suwanee CI-Main*	7	19	0	4	9	Open
Suwanee CI-Annex*	25	19	1	0	9	Open
SFRC-Main	47	24	N/A	N/A	7	Closed 6/8/16
Martin CI	42	13	N/A	N/A	7	Closed 4/18/16
Taylor CI-Main	49	27	N/A	N/A	4	Closed 9/24/15
South Bay CF	10	4	N/A	N/A	5	Closed 3/21/16

Table 2b. Fiscal Year 2014-2015 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2014-2015 Surveyed Institutions						
Institution	**Total Number of Physical Health Findings**	**Total Number of Mental Health Findings**	**Total Number of Open Physical Health CAP Findings**	**Total Number of Open Mental Health CAP Findings**	**Number of CAP Assessments**	**Open or Closed**
Lake CI*	24	48	0	5	6	Open
Tomoka CI*	30	20	0	1	5	Open
NWFRC-Main	43	8	N/A	N/A	3	Closed 7/28/15
NWFRC-Annex	34	15	N/A	N/A	3	Closed 12/23/15
Okeechobee CI	10	3	N/A	N/A	3	Closed 12/30/15
Moore Haven CF	12	18	N/A	N/A	3	Closed 11/24/15
Wakulla CI-Main	27	16	N/A	N/A	4	Closed 5/11/16
Wakulla CI-Annex	30	11	N/A	N/A	4	Closed 10/28/15
Avon Park CI	12	3	N/A	N/A	1	Closed 7/15/15
Polk CI	10	13	N/A	N/A	1	Closed7/2/15
Lowell CI-Main*	46	28	1	0	5	Open
Lowell CI-Annex*	54	32	7	0	5	Open
Liberty CI	15	8	N/A	N/A	1	Closed 12/9/15
Charlotte CI	9	31	N/A	N/A	2	Closed 2/10/16
Hamilton CI-Main	12	8	N/A	N/A	3	Closed 10/28/15
Hamilton CI-Annex	8	9	N/A	N/A	3	Closed 6/24/16
Holmes CI	8	0	N/A	N/A	1	Closed 12/2/15
Baker CI	9	7	N/A	N/A	2	Closed 4/11/16

Table 2c. Fiscal Year 2015-2016 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2015-2016 Surveyed Institutions						
Institution	**Total Number of Physical Health Findings**	**Total Number of Mental Health Findings**	**Total Number of Open Physical Health CAP Findings**	**Total Number of Open Mental Health CAP Findings**	**Number of CAP Assessments**	**Open or Closed**
Columbia CI-Main*	40	23	6	6	3	Open
Columbia CI-Annex*	25	29	0	3	3	Open
Jackson CI	14	10	N/A	N/A	2	Closed 5/1/16
FWRC*	52	59	17	22	3	Open
RMC-Main*	19	47	2	15	2	Open
RMC-West*	22	10	0	3	2	Open
Dade CI	15	21	9	20	1	Open
Graceville CF*	14	16	0	6	2	Open
Gulf CI-Main*	7	0	0	N/A	2	Closed 10/7/16
Gulf CI-Annex*	17	3	1	0	2	Open
Okaloosa CI*	8	20	0	12	2	Open
Walton CI	7	2	1	0	2	Open
Madison CI*	7	5	N/A	N/A	1	Closed 8/22/16
Franklin CI	15	23	1	13	1	Open
Everglades CI	9	4	0	1	1	Open
Apalachee CI-East*	19	23	4	8	1	Open
Apalachee CI-West*	21	12	0	4	1	Open
Century CI*	24	26	1	6	1	Open
Blackwater CF*	36	45	19	13	1	Open

**** Indicates institutions with CAP assessments completed after June 30, 2016.***

Summary of Fiscal Year 2015-2016 Institutional Survey Findings

The institutional survey process evaluates the quality of FDC's physical and mental health services, identifies significant deficiencies in care and treatment, and assesses institutional compliance with FDC's policies and procedures. The survey process also provides a performance snapshot of FDC's overall health care delivery system. Analyzing and comparing the results of institutional surveys has assisted the CMA in identifying system-wide trends and determining if FDC's health care standards and required practices are followed across institutions.

Institutional survey reports provide detailed information that include descriptions of findings and discussion points. In contrast to individual reports, the information presented in this section does not attempt to provide a detailed summary of all identified survey findings, nor does it attempt to compare institutions based on individual performance. The information presented summarizes overall performance and identifies significant findings from each service delivery area evaluated during physical and mental health surveys. These findings required corrective action and included only findings noted at three or more institutions, with the exception of findings for inpatient mental health services, psychiatric restraints, and reception services, as these assessment areas were only applicable for select institutions.

Physical Health Survey Findings

The physical health survey process is used to evaluate inmates' access to care, the provision and adequacy of episodic, chronic disease, dental care, and medical administrative processes and procedures. The following areas are evaluated during the physical health portion of surveys: chronic illness clinics, consultation requests, dental systems, emergency care, infection control, infirmary care, inmate requests, institutional tour, intra-system transfers, medication administration, periodic screenings, pharmacy, pill line administration, and sick call.

In FY 2015-16, there were 371 physical health findings which represented 50 percent of total survey findings. When compared to FY 2014-15, there was a 15 percent decrease in the number of physical health findings identified this fiscal year. Table 3 provides a description of each physical health assessment area, the total number of findings by area, and the total number of institutions with findings in each area. Table 4 provides a summary of findings by institution.

Table 3. Description of Physical Health Survey Assessment Areas

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Chronic Illness Clinics	Assesses care provided to inmates with specific chronic care issues. Clinical records reviews are completed for the following chronic illness clinics: cardiovascular, endocrine, gastrointestinal, immunity, miscellaneous, neurology, oncology, respiratory, and tuberculosis.	165 (44%)	19 (100%)
Consultation Requests	Assesses processes for approving, denying, scheduling services, and follow-up for specialty care services.	43 (12%)	16 (84%)
Dental Review	Assesses the provision of dental care and systems.	29 (8%)	13 (68%)
Emergency Care	Assesses emergency care processes for addressing urgent/emergent medical complaints.	4 (1%)	3 (16%)
Infection Control	Assesses compliance with infection control policies and procedures.	2 (0.54%)	2 (11%)
Infirmary Care	Assesses the provision of skilled nursing services in infirmary settings.	26 (7%)	9 (56%)*
Institutional Tour	Tour of medical, dental, and housing facilities.	33 (9%)	14 (74%)
Intra-System Transfers	Assesses systems and processes for ensuring continuity of care for inmates transferred between institutions.	8 (2%)	4 (21%)
Medical Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying physical health related inmate requests.	13 (4%)	10 (52%)
Medication Administration	Assesses the administration of medication and clinical documentation related to medication practices.	7 (2%)	6 (32%)
Periodic Screenings	Assesses the provision of periodic physical examinations and health screenings.	15 (4%)	9 (56%)
Pharmacy Services	Assesses compliance with FDC's policies and procedures for medication storage, inventory, and disposal.	3 (0.81%)	2 (11%)
Pill Line Administration	Assesses medication dispensing practices to ensure proper nursing practices and policies are followed.	7 (2%)	4 (21%)
Reception Process	Assesses compliance with FDC's policies and procedures for physical health screenings of new inmates.	4 (1%)	2 (100%)**
Sick Call	Assesses sick call processes to address acute and non-emergency medical complaints and inmate access to sick call.	6 (2%)	5 (26%)

Infirmary services are not provided at Columbia CI-Annex, RMC-West, and Gulf CI-Main

****Reception services are only provided at RMC-Main and FWRC.***

Table 4. Summary of Physical Health Survey Findings by Institution

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Care	Dental Systems	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Other Administrative Findings	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Total
Columbia CI-Main	17	4	0	0	0	0	9	1	2	1	1	0	4	0	0	N/A	1	**40**
Columbia CI-Annex	8	5	1	4	0	0	N/A	4	0	0	0	0	0	0	2	N/A	1	**25**
Jackson CI	8	2	0	1	0	0	0	2	0	0	1	0	0	0	0	N/A	0	**14**
FWRC	26	7	0	0	1	0	6	0	2	3	0	2	3	0	0	2	0	**52**
RMC-Main	8	1	0	2	0	0	0	3	0	0	0	0	0	0	3	2	0	**19**
RMC-West	14	0	0	0	0	0	N/A	2	0	1	0	0	1	2	2	N/A	0	**22**
Dade CI	9	2	0	0	0	0	1	0	0	1	1	0	1	0	0	N/A	0	**15**
Graceville CF	4	3	0	2	0	0	1	2	0	1	0	0	0	0	0	N/A	1	**14**
Gulf CI-Main	2	2	1	1	0	0	N/A	1	0	0	0	0	0	0	0	N/A	0	**7**
Gulf CI-Annex	7	1	1	1	0	0	2	3	0	2	0	0	0	0	0	N/A	0	**17**
Okaloosa CI	3	1	1	0	0	0	1	1	0	0	0	0	0	0	1	N/A	0	**8**
Walton CI	2	0	0	1	0	0	0	0	3	0	0	0	1	0	0	N/A	0	**7**
Madison CI	3	1	2	0	0	0	0	0	0	1	0	0	0	0	0	N/A	0	**7**
Franklin CI	5	1	1	2	2	0	0	1	1	0	2	0	0	0	0	N/A	0	**15**
Everglades CI	3	1	0	0	0	0	1	2	0	1	0	0	1	0	0	N/A	0	**9**
Apalachee CI-East	8	0	1	2	0	0	0	4	0	0	0	0	1	1	0	N/A	2	**19**
Apalachee CI-West	11	5	1	1	0	0	0	2	0	1	0	0	0	0	0	N/A	0	**21**
Century CI	10	4	0	3	0	1	2	0	0	0	1	0	1	0	1	N/A	1	**24**
Blackwater CF	17	3	0	0	1	1	3	3	0	1	1	4	2	0	0	N/A	0	**36**
	165	**43**	**9**	**20**	**4**	**2**	**26**	**31**	**8**	**13**	**7**	**6**	**15**	**3**	**9**	**4**	**6**	**371**

Chronic Illness Clinics

Based on an analysis of aggregate survey data, the majority (44 percent) of physical health survey findings were related to Chronic Illness Clinics (CIC). CIC findings were noted at all surveyed institutions. Table 5 summarizes CIC findings.

Table 5. Summary of Chronic Illness Clinic Findings

Chronic Illness Clinics	Total Findings	Institutions with Findings
Cardiovascular	7 (4%)	7 (37%)
Endocrine	25 (15%)	17 (68%)
Gastrointestinal	18 (11%)	10 (53%)
Immunity	8 (5%)	7 (37%)
Miscellaneous	19 (12%)	11 (58%)
Neurology	19 (12%)	13 (68%)
Oncology	12 (7%)	7 (37%)
Respiratory	19 (11%)	12 (63%)
Tuberculosis	10 (6%)	8 (42%)

In total, 165 CIC findings were identified across all 19 institutions. While CICs had findings specifically related to the delivery of care for that clinic, several common findings were identified across clinics. The most commonly reported findings across all clinics were related to: missing or incomplete CIC baseline documentation, inmates not being seen in a timely manner according to M-grade status, missing vaccinations, and abnormal labs not being addressed in a timely manner.

Below are common CIC findings noted for specific clinics:

- In the Endocrine Clinic, record reviews indicated that fundoscopic examinations were not completed annually, inmates with uncontrolled blood sugar levels were not seen at appropriate intervals, and diabetic inmates with cardiovascular risk factors were not placed on appropriate medication therapies.

- In the Miscellaneous Clinic, the control of diseases was not evaluated at each clinic visit.
- In the Neurology Clinic, seizures were not consistently classified by type.
- In the Oncology Clinic, missing or incomplete referrals to specialists for more in-depth treatment.
- In the Respiratory Clinic, the most common findings were related to reactive airway diseases not being classified and anti-inflammatory medication not being started for inmates with moderate to severe reactive airway disease.

Consultation Requests

Findings related to the consultation process were noted for 16 (84 percent) surveys. These findings represented 12 percent of physical health findings. The most common consultation findings across institutions included: delayed or incomplete incorporation of consultant's treatment recommendations and/or diagnostic testing, inadequate documentation of new diagnoses in the medical record, incomplete or missing documentation of consultation appointments, inadequate documentation of consultant's treatment recommendations in the medical record, missing or incomplete documentation of alternative treatment plans (ATP), and delayed or incomplete implementation of ATPs.

Dental Review

Dental review findings were noted at 13 (68 percent) institutions. There were 29 (8 percent) dental review findings; nine related to clinical care and 20 systems findings. Clinical care findings were related to incomplete and inaccurate charting of dental findings and inaccurate diagnosis and treatment plans. Systems findings were related to the disrepair, accessibility, and availability of dental equipment.

Emergency Care

Emergency care findings were noted for three (16 percent) surveys, with four (1 percent) findings. The most common finding was related to incomplete or missing vital signs.

Infection Control

Two (0.54 percent) findings related to infection control were noted for two (11 percent) surveys. However, no system-wide trends were identified.

Infirmary Care

Infirmary care findings were noted at 9 (56 percent) surveys. Clinical records reviews resulted in 26 (7 percent) findings. The most common findings across institutions included: incomplete clinician rounds for inpatient infirmary admissions and incomplete clinician weekend telephone rounds.

Institutional Tour

Institutional tour findings were noted for 14 (74 percent) institutions, and resulted in 33 (9 percent) findings, however, no system-wide trends were identified.

Intra-system Transfers

Eight (2 percent) findings related to intra-system transfers were noted for four (21 percent) surveys. No system-wide trends were identified.

Medical Inmate Requests

Ten (52 percent) institutions surveyed had findings related to medical inmate requests. In total, 13 (4 percent) findings were identified. The most common findings noted were related to: missing inmate request documentation, missing or incomplete incidental notes, and incomplete or missing follow-up for appointments/interviews.

Medication Administration Record Review and Pill Line Observation

Clinical record reviews related to medication administration resulted in seven (2 percent) findings across six (32 percent) institutions surveyed. Additionally, pill line observations of medication administration resulted in seven (2 percent) findings at four (21 percent) surveyed institutions. There were no system-wide issues related to medication administration and pill line observation.

Periodic Screenings

Fifteen (4 percent) periodic screening findings were noted at nine (56 percent) institutions. The most common findings identified were related to: incomplete periodic screenings, untimely or incomplete diagnostic testing, and incomplete or missing documentation of health education.

Pharmacy Services

Findings related to pharmacy services were noted for two (11%) institutions, with three (0.81 percent) findings. No system-wide issues were identified.

Sick Call

There were six (2 percent) findings related to the sick call process, and five (26 percent) institutions had findings in this area. Inadequate and untimely follow-up visits was the only system-wide issue identified across institutions.

Reception Process

Reception services were provided at two institutions, and four (1 percent) findings were noted. No system-wide issues were identified.

Mental Health Survey Findings

Mental health surveys assess inmate's access to mental health services, the provision and adequacy of outpatient and inpatient mental health services, and administrative processes and procedures. The following areas are evaluated during mental health surveys: discharge planning, inpatient mental health services, inpatient psychiatric medications, mental health inmate requests, mental health systems, psychiatric restraints, psychological emergencies, outpatient mental health services, outpatient psychiatric medications, the reception process, self-injury/suicide prevention, access to care in special housing, and use of force. There were 378 mental health findings in FY 2015-16 that represented 50 percent of total survey findings. The total number of FY 2015-16 mental health findings increased by 30 percent when compared to FY 2014-15.

Based on an analysis of aggregate survey data, the majority of findings were noted in the area of outpatient mental health services (23 percent). There were also a significant number of findings in the areas of outpatient psychiatric medications, self-injury/suicide prevention, special housing, and inpatient mental health services.

It is important to note that some mental health assessment areas were not applicable for all institutions. Record reviews for self-injury/suicide prevention, psychiatric restraint, and use of force were completed for institutions that had applicable episodes for review. Outpatient psychiatric medication and discharge planning record reviews were only applicable for institutions housing inmates who have mental health grades of S3 and above. Additionally, special housing

reviews were applicable for institutions with confinement. Lastly, inpatient mental health services were provided at three institutions.

Table 6 below provides a description of each mental health assessment area, the total number of findings by area, and the total number of institutions with findings in each area, while Table 7 summarizes mental health survey findings across institutions.

Table 6. Description of Mental Health Survey Assessment Area

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Discharge Planning	Assesses processes for ensuring the continuity of mental health care for inmates within 180 days of end of sentence.	13 (13%)	10 (50%)*
Inpatient Mental Health Services	Assesses the provision of mental health care in inpatient settings.	20 (5%)	3 (100%)**
Inpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in inpatient settings.	16 (4%)	3 (100%)**
Mental Health Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying mental health related inmate requests.	12 (3%)	9 (47%)
Mental Health Systems Reviews	Assesses systems and processes related to mental health staff training, clinical supervision, and other administrative functions.	22 (6%)	13 (68%)
Psychiatric Restraints	Assesses compliance with FDC's policies and procedures for psychiatric restraints.	11 (3%)	2 (100%)***
Psychological Emergencies	Assesses the process for responding to inmate mental health emergencies.	13 (3%)	6 (30%)
Outpatient Mental Health Services	Assesses the provision of mental health services in an outpatient setting.	88 (23%)	14 (74%)
Outpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in outpatient settings.	56 (15%)	10 (90%)****
Reception Process	Assesses compliance with FDC's policies and procedures for mental health screenings of new inmates.	8 (20%)	2 (100%)*****
Self-Injury/ Suicide Prevention	Assesses compliance with FDC's policies and procedures for self-injury and suicide prevention.	77 (20%)	17 (100%)******
Special Housing	Assesses compliance with FDC's policies and procedures for providing mental health services to inmates assigned to confinement, protective management, or close management.	26 (7%)	15 (83%)*******
Use of Force	Assesses compliance with FDC's use of force policies and procedures following use of force episodes for inmates on the mental health caseload.	11 (3%)	8 (67%)********

Discharge Planning is provided at institutions housing inmates with grades S3 and higher.
****Inpatient Mental Health Services and Inpatient Psychiatric Medications are provided at FWRC, RMC-Main, and Dade CI.***
*****There were only two institutions with applicable Psychiatric Restraint episodes.***
******Outpatient Psychiatric Medication is provided at institutions housing inmates with grades of S-3. Ten institutions were assessed.***
*******Reception Services are only provided at RMC-Main and FWRC.***
********RMC-West and Gulf CI-Main do not house inmates for Self-Injury/Suicide Prevention.***
*********RMC-West does not provide special housing.***
**********There were only 8 institutions with applicable use of force episodes.***

Table 7. Summary of Mental Health Survey Findings by Institution

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Other Administrative Findings	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Columbia CI-Main	0	N/A	N/A	1	3	N/A	0	0	3	8	N/A	7	1	0	**23**
Columbia CI-Annex	2	N/A	N/A	0	2	N/A	0	0	7	7	N/A	8	2	1	**29**
Jackson CI	N/A	N/A	N/A	1	2	N/A	0	0	3	N/A	N/A	1	1	2	**10**
FWRC	2	10	7	2	1	8	0	1	9	5	4	7	2	1	**59**
RMC-Main	3	7	6	1	0	N/A	1	1	8	9	4	3	3	1	**47**
RMC-West	3	N/A	N/A	1	0	N/A	N/A	0	0	6	N/A	N/A	N/A	N/A	**10**
Dade CI	0	3	3	0	1	3	4	0	1	1	N/A	3	1	1	**21**
Graceville CF	0	N/A	N/A	0	1	N/A	0	0	3	4	N/A	4	2	2	**16**
Gulf CI-Main	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	N/A	0	N/A	**0**
Gulf CI-Annex	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	3	0	N/A	**3**
Okaloosa CI	N/A	N/A	N/A	1	2	N/A	2	0	10	N/A	N/A	4	1	N/A	**20**
Walton CI	N/A	N/A	N/A	0	1	N/A	0	0	0	N/A	N/A	1	0	N/A	**2**
Madison CI	N/A	N/A	N/A	0	0	N/A	0	0	1	N/A	N/A	3	1	N/A	**5**
Franklin CI	N/A	N/A	N/A	1	2	N/A	2	0	11	N/A	N/A	4	3	0	**23**
Everglades CI	0	N/A	N/A	0	0	N/A	1	0	0	0	N/A	2	1	0	**4**
Apalachee CI-East	0	N/A	N/A	0	1	N/A	0	0	5	8	N/A	7	2	0	**23**
Apalachee CI-West	N/A	N/A	N/A	0	1	N/A	0	0	5	N/A	N/A	5	1	N/A	**12**
Century CI	N/A	N/A	N/A	2	1	N/A	3	2	10	N/A	N/A	6	1	1	**26**
Blackwater CF	3	N/A	N/A	2	4	N/A	0	1	12	8	N/A	9	4	2	**45**
Total Findings	**13**	**20**	**16**	**12**	**22**	**11**	**13**	**5**	**88**	**56**	**8**	**77**	**26**	**11**	**378**

Discharge Planning

Record reviews for discharge planning were completed at 10 institutions, and of those institutions, five (50 percent) had findings. Thirteen (3 percent) findings were identified and the most common findings were related to: incomplete discharge planning documentation and the timeliness of applying for Social Security benefits for eligible inmates.

Mental Health Inmate Requests

Mental health inmate request findings were noted at nine (35 percent) institutions, and 12 (3 percent) findings were identified. Across institutions, the most common findings were related to: requests not being present in the medical record, untimely follow-up to requests, and incomplete or missing follow-up for referrals/interviews.

Mental Health Services

Inpatient Mental Health Services

Inpatient mental health services were provided at three surveyed institutions and record reviews for these institutions resulted in 20 (5 percent) findings. The most common findings noted at two or more institutions where inpatient mental health services are provided were related to: missing or incomplete risk assessments for violence, missing or untimely Individualized Service Plan (ISP) documentation, inconsistent and/or non-compliant planned structured therapeutic services, incomplete and/or missing nursing evaluations, missing and/or untimely behavioral level assessments, and missing and/or incomplete discharge summary documentation.

Outpatient Mental Health Services

The bulk of mental health survey findings were in the area of outpatient mental health services, with 88 (23 percent) findings. Across the 14 (74 percent) institutions with findings, the most common were related to: missing or incomplete intra-system transfer documentation, untimely mental health screening evaluations, incomplete, inadequate,

and/untimely initial and follow-up ISP documentation, failure to provide the services listed on the ISPs, incomplete problem list documentation, and missing, inadequate, or untimely counseling services.

Mental Health Systems Reviews

Mental health systems findings were noted at 13 (68 percent) institutions, and 22 (6 percent) findings were identified. The lack of psychiatric restraint equipment was a common finding across institutions.

Psychiatric Medication Practices

Inpatient Psychiatric Medication Practices Findings

Inpatient psychiatric medication practice record reviews were completed for three institutions and resulted in 16 (4 percent) findings. The following findings were identified at two or more institutions: incomplete follow-up labs, untimely follow-up sessions, and incomplete emergency treatment order (ETO) documentation.

Outpatient Psychiatric Medication Practices Findings

Outpatient psychiatric medication practice record reviews were completed for 10 (52 percent) institutions, and resulted in 56 (15 percent) findings. Across institutions the most common findings were related to incomplete and/or missing initial labs, incomplete follow-up treatment and/or referrals for abnormal labs, incomplete follow-up labs, medications not given as ordered and/or missing documentation for medication refusals, nursing staff failing to meet with inmates who refused medication for two consecutive days, incomplete documentation for consecutive medication refusals, untimely follow-up sessions, and untimely Abnormal Involuntary Movement Scale (AIMS) assessments.

Psychiatric Restraints

During the fiscal year, psychiatric restraint episodes were available for review at two institutions and, based on those episodes, 11 (3 percent) findings were identified. There were findings at both institutions related to: failure to use the least restrictive means of behavioral control prior to the use of restraints, incomplete and/or missing documentation of vital signs following release from restraints, and incomplete and/or missing referrals to the Risk Assessment Team (RAT) and the inmate's Multidisciplinary Service Team (MDST).

Psychological Emergencies

Psychological emergency findings were noted for six (30 percent) institutions and resulted in 13 (37 percent) findings. The most common findings identified included untimely response to emergencies and incomplete and/or missing documentation regarding consideration of the inmate's prior mental health history.

Reception Process

Two reception centers were surveyed during the fiscal year, and resulted in eight (2 percent) reception process findings. No system-wide trends were identified.

Self-injury/Suicide Prevention

Self-harm observation status (SHOS) findings were identified for 17 (100 percent) surveys with applicable SHOS episodes for review, resulting in 77 (20 percent) findings. The most commonly identified findings across institutions were related to missing and/or incomplete emergency evaluations, incomplete and/or missing clinician orders for observation frequency, untimely admission documentation, non-compliance with SHOS management guidelines, non-compliance with clinician orders for SHOS observation frequency, incomplete and/or missing nursing evaluations, missing daily rounds by attending clinicians, non-fulfillment of daily counseling by mental health staff, missing clinician evaluations for discharge, missing post-discharge follow-up, and incomplete SHOS documentation.

Special Housing

Special housing was provided at 18 institutions. Findings were noted at 15 (83 percent) of these institutions, resulting in 26 (7 percent) findings. The most common findings were related to incomplete special housing health appraisals, interruption in psychotropic medications and outpatient treatment, and untimely mental status exams.

Use of Force

There were applicable use of force episodes for review at twelve institutions during the fiscal year. Findings were noted at eight of those institutions, which resulted in 11 (3 percent) findings. The most common findings were related to incomplete referrals to mental health services from nursing staff and untimely mental health assessments following use of force episodes.

Summary of System-Wide Trends and Recommendations

System-Wide Trends

Tables 8 and 9 below summarize system-wide findings identified during FY 2015-16 physical and mental health surveys. These findings were not noted at all institutions, however, they were noted at three or more institutions, with the exception of inpatient mental health, psychiatric restraints, and reception findings.

Table 8. Physical Health Survey: System-Wide Trends

Assessment Area	Physical Health Survey System-Wide Areas of Concern
Chronic Illness Clinics	• Baseline information (history, physical examination, labs, etc.) was incomplete or missing. • Patient education was incomplete or missing. • Inmates were not seen timely according to M-grade status. • No evidence of vaccinations or refusals. • Abnormal labs were not addressed in a timely manner. • There was no evidence of fundoscopic examinations. • There was no evidence that inmates with HgbA1c over 8.0 were seen at least every three months. • There was no evidence that aspirin therapy was initiated for inmates with vascular disease or risk for vascular disease. • There was no evidence that the control of the disease was documented at each clinic visit. • There was no evidence of referrals to a specialist for more in-depth treatment, when indicated. • There was no evidence reactive airway diseases were classified as mild, moderate, or severe. • There was no evidence that inmates with moderate to severe reactive airway disease were started on anti-inflammatory medications.
Consultation Requests	• There was no evidence of an incidental note which addressed consultant's treatment recommendations. • New diagnoses were not reflected on problem lists. • There was no evidence consultant's recommendations were incorporated into treatment plans. • The Consultation Appointment Log was incomplete. • There was no evidence that ATPs were documented in the medical record. • There was no evidence that ATPs were implemented.
Dental Review	• Dental equipment was not in working order or not accessible. • There was no evidence of complete and accurate charting of dental findings. • There was no evidence of accurate diagnoses and appropriate treatment plans.
Emergency Care	• Vital signs were incomplete or missing.
Infirmary Care	• There was no evidence of clinician rounds as required. • There was no evidence of clinician weekend telephone rounds.
Medical Inmate Requests	• Copies of the inmate request were not present in medical records. • Incidental notes regarding responses were incomplete or missing. • There was no evidence that interviews/appointments indicated in the response occurred as intended.
Periodic Screenings	• Periodic screenings did not contain all required components. • There was no evidence that all required diagnostic tests were performed prior to screening. • Health education was incomplete or missing.
Sick Call	• There was no evidence that follow-up visits occurred as indicated in a timely manner.

Table 9. Mental Health Survey: System-Wide Trends

Assessment Area	Mental Health Survey System-Wide Areas of Concern
Discharge Planning	• The "Summary of Outpatient Mental Health Care" was not completed within 30 days of end of sentence (EOS). • Assistance with social security benefits was not provided within 30 days of EOS for eligible inmates.
Inpatient Mental Health Services	• ISPs were not initiated or reviewed within the appropriate time frame and/or signed by the inmate. • Required hours of planned structured therapeutic services were not provided. • Documentation of progress towards meeting treatment goals was missing or not completed within the required time frame. • Inmate weight was not recorded weekly. • Behavioral level assessments were missing and/or not reviewed within the required time frame.
Inpatient Psychiatric Medication Practices	• Follow-up labs were not completed. • Inmates did not receive medication as prescribed and/or documentation of refusal was not present. • There was no evidence that nursing staff met with inmates who refused medication for two consecutive days. • AIMS assessments were not administered within the appropriate time frame.
Mental Health Inmate Requests	• Follow-up interviews or referrals did not take place as indicated.
Psychiatric Restraints	• Physician's orders did not specify the maximum duration of restraint episodes. • Inmate behavior was not documented every 15 minutes on the "Restraint Observation Checklist." • Inmates were not released from restraints after 30 minutes of calm behavior.
Outpatient Mental Health Services	• Intra-system transfer documentation was incomplete or missing. • Mental health screening evaluations were not completed within 14 days of arrival. • Sex offender screenings were not completed. • Initial ISPs were not completed within 30 days of initiating mental health services. • ISPs were not individualized and/or lacked pertinent information. • ISPs were not signed by all members of the MDST and/or inmate, or inmate refusal was not documented. • ISPs were not reviewed or revised at the 180 day interval. • Mental health problems were not recorded on the problem list. • There was no documentation that inmates received all services listed on the ISP.
Outpatient Psychiatric Medication Practices	• Abnormal labs were not followed-up with appropriate treatment and/or referral in a timely manner. • Follow-up labs were not completed. • Inmates did not receive medications as prescribed and/or there was no documentation of refusal. • There was no evidence that nursing staff met with inmates who refused medication for two consecutive days. • A "Refusal of Health Care Services" form was not signed after three consecutive medication refusals or five refusals in one month. • Consent forms were not present or did not reflect information relevant to prescribed medications. • Follow-up psychiatric contacts were not conducted at appropriate intervals. • Documentation of follow-up psychiatric contacts did not contain the required clinical information. • AIMS were not administered within the appropriate time frame.
Self-Injury/ Suicide Prevention	• Emergency evaluations were not completed by mental health or nursing staff prior to admissions. • "Infirmary/Hospital Admission Nursing Evaluations" were not completed within two hours of SHOS admission. • Guidelines for SHOS management were not observed. • There was no documented evidence that inmates were observed at the frequency ordered by clinicians. • "Mental Health Daily Nursing Evaluations" were not completed once per shift, as required. • Daily rounds were not conducted by attending clinicians. • Daily counseling by mental health staff did not occur. • There was no evidence that attending clinicians conducted a face-to-face evaluation prior to discharge.
Special Housing	• There were interruptions in outpatient treatmetn and psychotropic medications for inmates held in special housing. • Mental status exams were not completed within the required time frame.
Use of Force	• Untimely mental health assessments following use of force episodes. • Following use of force episodes, there was no evidence of a referral from physical health staff. • There was no evidence that post use of force evaluations were conducted as required.

Recommendations

When looking at survey finding data across physical and mental health assessment areas, four topics of concern were identified: insufficient and/or missing documentation, treatment delays, inadequate administrative processes, and issues related to the assessment and treatment of inmates at risk of harm to self or others. These issues reflect significant areas where system-wide improvements are needed. Based on the system-wide issues identified, the CMA makes the following recommendations:

Insufficient and/or Missing Documentation

Incomplete or missing documentation was related to several findings across institutions. During some surveys, CMA surveyors cited disorganized records and illegible clinical notes as an issue. While FDC policies provide specific guidelines for records management and clinical documentation, non-compliance was noted at many institutions surveyed. To improve issues related to clinical documentation and keeping medical records, the following strategies are recommended:

- Provide routine and on-going training on medical records management practices and clinical documentation requirements to all health services staff. Training should reinforce the importance of avoiding risk management issues associated with inadequate, disorganized, illegible, and missing clinical documentation.
- Determine a method to guarantee problem lists are current and complete so they can be used as an ongoing guide for reviewing physical and mental status and for planning care.
- FDC should explore information technology solutions for an electronic medical record and determine the fiscal impact of implementing an electronic system. The implementation of an electronic system, in a system as large as FDC, would greatly improve administrative and clinical efficiencies.

Treatment Delays

Across assessment areas, several findings referenced untimely care, follow-up, and a lack of referrals for higher level care. Failure to provide timely health care screenings, evaluations, and referrals for higher level care and assessment may impact access to care for inmates. Providing care in a timely manner can diminish inmates' risks for poor health outcomes. To improve issues related to delays in care and treatment, the following strategies are recommended:

- Provide additional training for clinicians and clinical associates regarding timely follow-up of consultations.
- Provide training for clinicians regarding timely supervisory reviews of consultations, past due appointment logs, and/or emergency and sick call encounters to ensure appropriate follow-up.
- Ensure required hours of planned structured therapeutic services in inpatient units are provided and documented according to protocol.
- Provide training to staff to ensure that mental status exams for inmates in confinement are completed within the required time frame.
- Ensure inmates on the mental health caseload are evaluated in a timely manner and provided the services listed on their ISPs.

Inadequate Administrative Processes

FDC provides specific guidelines for administrative policies and practices. Across assessment areas, several findings were noted due to non-compliance with FDC policies and/or practices. To improve issues related to inadequate administrative processes, the following strategies are recommended:

- Improve administrative systems to track the timeliness of diagnostic testing, receipt of laboratory results, and follow-up care.
- Develop a system-wide method to document the distribution of keep-on-person (KOP) medication in the medical record. This would allow a service provider, such as a prescribing professional or case manager, to assess the KOP process and any system barriers to timely distributions of the medication.
- Develop and implement a standardized tracking system to document use of force episodes to ensure inmates on the mental health case load are referred for evaluation to determine if additional mental health interventions are needed.

Issues Related to the Assessment and Treatment of Inmates at Risk for Harm to Self or Others

Findings were noted at each institution surveyed where SHOS is provided. Inmates are placed in an acute care setting to prevent harm to self or others. To improve services to this vulnerable population, the following strategies are recommended:

- Provide training to medical and security staff to ensure proper procedures are followed and subsequent documentation is complete and accurate.
- Review staffing levels for psychiatry, mental health professionals, and mental health nursing.
- Continue to expand specialized mental health programs for high risk inmates.

Section 2

2015-2016
Update on the Status of Elderly Offenders in Florida

Introduction

Since 2001, the CMA has reported annually on the status of elderly offenders in Florida's prisons to meet statutory requirements outlined in § 944.8041 F.S. that mandates the agency submit an annual report on the status of elderly offenders to the Florida Legislature. In this annual update, data obtained from FDC's Bureau of Research and Data Analysis is used to provide a comprehensive profile of Florida's elderly offenders by presenting two sets of data: (1) characteristics of all elderly offenders admitted during Fiscal Year 2015-16, and (2) a snapshot of the elderly offender population on June 30, 2016. The profile includes demographic, sentencing, health utilization, and housing data. Also included in this update are CMA's recommendations for elderly offenders.

Profile of Florida's Elderly Offenders

Defining Elderly Offenders

In correctional settings, the age threshold for classifying offenders as elderly is lower than the commonly accepted age for elderly persons in the community. Outside of corrections, age 65 is generally considered to be the age at which persons are classified as elderly, however, at least 20 state departments of corrections and the National Commission on Correctional Health Care have set the age cutoff for elderly offenders at 50 or 55.[4] Correctional experts share a common view that many incarcerated persons experience accelerated aging as a result of poor health, lifestyle risk factors, and limited health care access prior to incarceration. Many inmates have early-onset chronic medical conditions, untreated mental health issues, and unmet psychosocial needs that make them more medically and socially vulnerable to experience chronic illness and disability approximately 10-15 years earlier than the rest of the population. [5]

In Florida, elderly offenders are defined by § 944.02 F.S. as "prisoners age 50 or older in state correctional institutions or facilities operated by the Department of Corrections." [6] Therefore, elderly offenders are defined in this report as inmates age 50 and older.

[4] Williams, Brie A., James S. Goodwin, Jacques Baillargeon, Cyrus Ahalt, and Louise C. Walter. "Addressing the Aging Crisis in U.S. Criminal Justice Health Care." *Journal of the American Geriatrics Society J Am Geriatric Society* 60.6 (2012): 1150-156. Web. 3 Nov. 2015.

[5] Ibid., 1151.

[6] Florida Department of Corrections Report," *Elderly Inmates, 2013-2014 Agency Annual Report*

Fiscal Year 2015-2016 Admissions

Demographic Characteristics

In FY 2015-16, elderly offenders accounted for 13 percent of 30,289 inmates admitted to FDC institutions. Males represented 91 percent (3,461) of elderly offender admissions, while females age 50 and older accounted for 9 percent (354) of admissions. When looking at racial/ethnic demographics for newly admitted inmates age 50 and older, 39 percent (1,497) were black, 58 percent (2,209) were white, and 3 percent (109) were classified as other. Eighty percent (3,066) of newly admitted elderly offenders were between the ages of 50 and 59. The average age at time of admission for males was age 55, and for females age 54. The oldest male offender admitted in FY 2015-16 was age 87 while the oldest female admitted was age 73. Demographic data is summarized in Table 10 below:

Table 10. Fiscal Year 2015-2016 FDC Elderly Offender Admissions Demographics

Fiscal Year 2015-2016 Admissions: Demographics				
Demographics	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	26,684 (88%)	23,223 (88%)	3,461 (91%)	**13%**
Female	3,605 (12%)	3,251 (12%)	354 (9%)	**10%**
Total	**30,289**	**26,474**	**3,815**	**13%**
Race/Ethnicity				
Black	12,994 (43%)	11,497 (43%)	1,497 (39%)	**12%**
White	16,177 (53%)	13,968 (53%)	2209 (58%)	**14%**
Other	1,118 (4%)	1,009 (4%)	109 (3%)	**10%**
Total	**30,289**	**26,474**	**3,815**	**13%**
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	3,066 (80%)	**10%**		
60-69	665 (17%)	**2%**		
70+	84 (2%)	**0.28%**		
Total	**3,815**			

Commitments, Primary Offenses, and Sentences

Most (35 percent or 1,320) of the elderly offenders admitted to FDC in FY 2015-16 had no prior commitments, while 18 percent (660) had one, 11 percent (412) had two, 9 percent (322) had three, and 28 percent (1,044) had four or more prior FDC commitments. The average age of elderly offenders entering FDC in FY 2015-16 was age 56.

Among new admissions, 28 percent (1,079) of inmates age 50 and older were incarcerated for violent crimes, 31 percent (1,189) for property crimes, 22 percent (848) for drug offenses, and 17 percent (642) were incarcerated for offenses classified as other. Inmates age 50 and older serving sentences for murder/manslaughter and sexual/lewd behavior were serving sentences of 27 years for murder/manslaughter and 15 years for sexual/lewd behavior, which were longer sentences compared to other offenses. Table 11 below summarizes previous FDC commitments for elderly offenders and their average age at the time of admission by offense type. Table 12 provides a summary of average sentence length by primary offense category, and Table 13 summarizes primary offense categories for all ages.

Table 11. Fiscal Year 2015-16 Admissions: Summary of Previous FDC Commitments and Average Age at Time of Admission by Offense Type

Fiscal Year 2015-2016 Admissions: Previous FDC Commitments	
Previous Number of Commitments	Total Number of Elderly Offenders
0	1,320 (35%)
1	660 (18%)
2	412 (11%)
3	322 (9%)
4+	1,044 (28%)
Unknown	57 (1%)
Total Number of Previous Commitments	3,815
Fiscal Year 2015-2016 Admissions: Average Age at Time of FDC Admission by Offense Type	
Primary Offense Type	Average Age at Admission
Murder/Manslaughter	58
Sexual/Lewd Behavior	58
Robbery	54
Violent, Other	56
Burglary	55
Property Theft/ Fraud/ Damage	55
Drugs	56
Weapons	56
Other	56
All Primary Offense Types	56

Table 12. Fiscal Year 2015-16 Admissions: Summary of Average Sentence Length by Primary Offense Category

Fiscal Year 2015-2016 Admissions: Average Sentence Length by Primary Offense Type			
Primary Offense Type	15-49	50+	Average Sentence Length
Murder/Manslaughter	25	27	**26**
Sexual/Lewd Behavior	13	15	**14**
Robbery	8	7	**8**
Violent, Other	5	4	**5**
Burglary	5	4	**5**
Property Theft/ Fraud/ Damage	2	3	**3**
Drugs	3	5	**4**
Weapons	4	3	**4**
Other	3	3	**3**

Table 13. Fiscal Year 2015-16 Admissions: Summary of Primary Offense Categories by Age

Fiscal Year 2015-2016 Admissions: Summary of Primary Offense Type							
Primary Offense Type	Total Inmates	15-49	50-59	60-69	70+	Total Inmates Age 50+	Pecentage of Inmates Age 50+
Murder/Manslaughter	987	869	83	29	6	**118**	**12%**
Sexual/Lewd Behavior	1,718	1,370	233	86	29	**348**	**20%**
Robbery	1,915	1,818	89	7	1	**97**	**5%**
Violent, Other	4,414	3,876	424	104	10	**538**	**12%**
Burglary	4,773	4,329	379	62	3	**444**	**9%**
Property Theft/ Fraud/ Damage	5,008	4,238	651	112	7	**770**	**15%**
Drugs	6,708	5,860	689	147	12	**848**	**13%**
Weapons	1,706	1,560	113	29	4	**146**	**9%**
Other	2,532	2,083	363	75	11	**449**	**18%**
Unknown	528	471	42	14	1	**57**	**11%**
Total	30,289	26,474	3,066	665	84	3,815	

Inmate Mortality

It is estimated that two percent (614) of inmates admitted in FY 2015-16 will die while incarcerated and elderly offenders accounted for 28 percent (172) of these inmates.

June 30, 2016, Population

Demographic Characteristics

At the end of FY 2015-16, 23 percent of Florida's 99,119 general prison population was age 50 and older. Males accounted for 95 percent (21,249) of the June 30, 2016 elderly offender population and represented 21 percent of the total male inmate population. Female elderly offenders accounted for 5 percent (1,209) of inmates age 50 and over on June 30th, and represented 18 percent of the total female inmate population. The racial/ethnic demographics for the June 30, 2016 elderly offender population are as follows: 42 percent (9,477) were black, 54 percent (12,166) were white, 3 percent (714) were Hispanic, and 0.13 percent (98) were classified as other. Elderly offenders between the ages of 50-59 represented 71 percent (15,849) of inmates age 50 and older. The average age of elderly offenders housed on June 30, 2016 was 56. Two 94-year-old offenders were the oldest males incarcerated on June 30, 2016. The oldest female offender was age 84. Table 14 below summarizes the demographics of the June 30, 2016 inmate population.

Table 14. June 30, 2016 Population Demographics

June 30, 2016 Population: Demographics				
Demographics	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	92,289 (93%)	71,040 (93%)	21,249 (95%)	**21%**
Female	6,830 (7%)	5,621 (7%)	1,209 (5%)	**18%**
Total	**99,119**	**76,661**	**22,458**	**23%**
Race/Ethnicity				
Black	47,625 (48%)	38,148 (50%)	9,477 (42%)	**20%**
White	47,036 (47%)	34,870 (45%)	12,166 (54%)	**26%**
Hispanic	4,038 (4%)	3,323 (4%)	714 (3%)	**18%**
Other	407 (0.41%)	309 (0.41%)	98 (0.13%)	**24%**
Unavailable	13 (0.01%)	11 (0.01%)	2 (0.015)	**15%**
Total	**99,119**	**76,661**	**22,458**	**23%**
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	15,849 (71%)	**16%**		
60-69	5,306 (24%)	**5%**		
70+	1,303 (6%)	**1%**		
Total	**22,458**			

Commitments, Primary Offenses, and Sentences

Forty-five percent (10,185) of elderly offenders housed on June 30, 2016 had no prior FDC commitments. The remaining 54 percent (12,240) of elderly offenders were repeat offenders with one or more previous FDC commitments. Among the June 30, 2016 population, the average age at the time of FDC admission for inmates age 50 and older was age 47. The majority of the June 30, 2016 elderly offender population, 63 percent (14,221), were incarcerated for violent crimes, 17 percent (3,880) for property crimes, 12 percent (2,693) for drug offenses, and 7 percent (1,660) for crimes classified as other. Table 15 summarizes the previous FDC commitments and average age at time of admission by offense type for the June 30, 2016 population.

When comparing the average sentence length of elderly offenders to the average sentence length of inmates under the age of 50, elderly inmates were more likely to be serving longer sentences. Additionally, inmates age 50 and older were more likely to be serving longer sentences for murder/manslaughter, sexual/lewd behavior, and robbery. The average sentence for elderly inmates was 43 years for murder/manslaughter, 31 years for sexual/lewd behavior, and 37 years for robbery. Table 16 summarizes average length of sentence by primary offense category and Table 17 summarizes the primary offense categories by age of the June 30, 2016, population.

Table 15. June 30, 2016 Population: Previous FDC Commitments and Average Age at Time of Admission by Offense Type

June 30, 2016 Population: Previous FDC Commitments	
Previous Number of Commitments	Total Number of Elderly Offenders
0	10,185 (45%)
1	3,536 (16%)
2	2,413 (11%)
3	1,916 (9%)
4+	4,375 (19%)
Unknown	33 (0.15%)
Total Number of Previous Commitments	22,458
June 30, 2016 Population: Average Age at Time of FDC Admission by Offense Type	
Primary Offense Type	Average Age at Admission
Murder/Manslaughter	38
Sexual/Lewd Behavior	47
Robbery	39
Violent, Other	49
Burglary	46
Property Theft/ Fraud/ Damage	53
Drugs	51
Weapons	50
Other	52
All Primary Offense Types	47

Table 16. June 30, 2016 Population: Summary of Average Sentence Length by Primary Offense Category

June 30, 2016 Population: Average Sentence Length by Primary Offense Type			
Primary Offense Type	15-49	50+	Average Sentence Length
Murder/Manslaughter	30	43	**36**
Sexual/Lewd Behavior	17	31	**24**
Robbery	17	37	**20**
Violent, Other	11	19	**13**
Burglary	11	25	**13**
Property Theft/ Fraud/ Damage	4	9	**5**
Drugs	6	12	**8**
Weapons	7	13	**8**
Other	5	10	**7**

Table 17. June 30, 2016: Population: Primary Offense Categories by Age

June 30, 2016 Population: Summary of Primary Offense Type							
Primary Offense Type	Total Inmates	15-49	50-59	60-69	70+	Total Inmates Age 50+	Percentage of Inmates Age 50+
Murder/Manslaughter	14,722	9,999	2,840	1,433	450	**4,723**	**32%**
Sexual/Lewd Behavior	12,465	7,562	2,944	1,413	546	**4,903**	**39%**
Robbery	12,737	10,628	1,546	475	88	**2,109**	**17%**
Violent, Other	12,093	9,900	1,683	445	65	**2,193**	**18%**
Burglary	16,214	13,453	2,278	456	27	**2,761**	**17%**
Property Theft/ Fraud/ Damage	7,738	6,107	1,307	292	32	**1,631**	**21%**
Drugs	14,671	11,978	2,118	516	59	**2,693**	**18%**
Weapons	3,955	3,507	361	77	10	**448**	**11%**
Other	4,486	3,493	768	199	26	**993**	**22%**
Unknown	38	34	4	0	0	**4**	**11%**
Total	99,119	76,661	15,849	5,306	1,303	22,458	

Inmate Mortality

FDC reported 360 inmate deaths in FY 2015-16, and elderly offenders accounted for 76 percent (273) of those deaths. It is estimated that 14 percent (14,449) of inmates housed on June 30, 2016, will die while incarcerated. Elderly offenders account for 48 percent (6,987) of those expected to die in prison.

Health Services Utilization

To address the complex health needs of elderly offenders, FDC provides comprehensive medical and mental health care that includes special accommodations and programs, medical passes, skilled nursing services for chronic and acute conditions, and palliative care for terminally ill inmates.

Medical and Mental Health Classifications

Among the June 30, 2016 total inmate population, elderly offenders accounted for 10 percent (6,263) of inmates classified as M1, 40 percent (11,801) as M2, and 46 percent (4,105) as M3. Inmates age 50 and older represented the majority of all inmates with M4 and M5 classifications. Elderly offenders accounted for 55 percent (46) of M4 inmates and 82 percent (152) of M5 inmates.

Inmates age 50 and older were more likely to have mental health classifications of S1. They accounted for 22 percent (18,121) of all inmates with S1 classifications. The remaining mental health classifications for elderly offenders is as follows: 21 percent (1,034) S2 classification, 26 percent (2,985) S3 classification, 28 percent (172) S4 classification, 19 percent (38) S5 classification, and 12 percent (10) S6 classification.

A summary of health classifications is provided in Table 18 below.[7]

Table 18. Medical and Mental Health Classifications

June 30, 2016 Population: Medical Grade Classifications				
Medical Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
M1	59,908	53,645	6,263	**10%**
M2	29,259	17,458	11,801	**40%**
M3	8,890	4,785	4,105	**46%**
M4	84	38	46	**55%**
M5	186	34	152	**82%**
M9	31	30	1	**3%**
Unknown	761	671	90	**12%**
Total	99,119	76,661	22,458	
June 30, 2016 Population: Mental Health Classifications				
Mental Health Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
S1	80,959	62,838	18,121	**22%**
S2	4,963	3,929	1,034	**21%**
S3	11,576	8,591	2,985	**26%**
S4	620	448	172	**28%**
S5	202	164	38	**19%**
S6	81	71	10	**12%**
S9	187	162	25	**13%**
Unknown	531	458	73	**14%**
Total	99,119	76,661	22,458	

Impairments and Assistive Devices

FDC assigns inmate impairment grades based on visual impairments, hearing impairments, physical limitations, and developmental disabilities. In FY 2015-16, there were 2,529 inmates with assigned impairment grades, with 70 percent (1,768) of assigned impairments being among elderly offenders. Inmates age 50 and older comprised 54 percent (209) of inmates with

[7] Medical and mental health classifications were unavailable for all inmates.

visual impairments, 67 percent (248) with hearing impairments, 73 percent (1,271) with physical impairments, and 56 percent (40) with developmental impairments.

Inmates requiring special assistance or assistive devices are issued special passes to accommodate their needs. FDC issued 22,096 passes for special assistance and/or assistive devices in FY 2015-16, and 45 percent (10,026) of those passes were issued to elderly offenders. Low bunk passes were the most frequently issued pass for inmates age 50 and older.

Table 19. Summary of FDC Impairment Grade Assignments and Assistive Devices/Special Passes Issued in FY 2015-2016

Impairment Grade Assignments				
Impairments	15-49	50+	Total Population	Percentage of Total Population Age 50+
Visual	129	209	338	**54%**
Hearing	122	248	370	**67%**
Physical	478	1,271	1,749	**73%**
Developmental	32	40	72	**56%**
Total	**761**	**1,768**	**2,529**	
Assistive Devices/Special Passes				
Assistive Devices/Special Passes	15-49	50+	Total Population	Percentage of Total Population Age 50+
Adaptive Device Assigned	1,334	1,309	2,643	**50%**
Attendant Assigned	55	125	180	**69%**
Low Bunk Pass	10,261	7,784	18,045	**43%**
Guide Assigned	3	10	13	**77%**
Hearing Aid Assigned	18	82	100	**82%**
Pusher Assigned	34	72	106	**68%**
Prescribed Special Shoes	189	202	391	**52%**
Wheelchair	176	442	618	**72%**
Total	**12,070**	**10,026**	**22,096**	

Health Service Encounters: Sick Call, Emergency Care, and Chronic Illness Clinic Utilization

FDC reported 467,770 sick call, emergency care, and chronic illness clinic encounters for FY 2015-16. Elderly offenders accounted for 35 percent (165,737) of health services encounters while comprising only 23 percent of the FDC total inmate population on June 30, 2016.

Sick Call and Emergency Care Encounters

There were 305,195 reported sick call encounters in FY 2015-16 and elderly offenders accounted for 31 percent (94,893) of these encounters. Sick call encounters represented the greatest proportion of health service encounters for elderly offenders during the fiscal year.

Table 20 summarizes all sick call and emergency care encounters during Fiscal Year 2015-16.

Table 20. Summary of Fiscal Year 2015-2016 Sick Call and Emergency Care Encounters

Sick Call and Emergency Care Encounters		
Age Group	Total Sick Call Encounters	Total Emergency Care Encounters
15-49	210,302 (69%)	20,768 (79%)
50+	94,893 (31%)	5,606 (21%)
Total	**305,195**	**26,374**

Chronic Illness Clinic Encounters

In FY 2015-16, 65,080 inmates were enrolled in CICs, and inmates age 50 and older accounted for 47 percent (30,469) of enrolled inmates. Elderly offenders accounted for 50 percent or more of inmates in five clinics. Inmates age 50 and older comprised the majority of inmates assigned to the cardiovascular, endocrine, renal, miscellaneous, and oncology clinics. Tables 21 summarizes CIC enrollment.

Table 21. Summary of Fiscal Year 2015-2016 Chronic Illness Clinic Enrollment

Chronic Illness Clinic Enrollment										
Chronic Clinic	Total Assigned Inmates	15-19	20-29	30-39	40-49	50-59	60-69	70+	Total Number of Inmates 50+	Pecentage of Total Assigned Inmates Age 50+
Cardiovascular	27,644	19	1,469	4,656	7,268	8,956	4,071	1,205	**14,232**	**51%**
Endocrine	8,972	5	518	1,421	2,254	2,985	1,341	448	**4,774**	**53%**
Gastrointestinal	9,259	4	918	2,200	1,864	2,864	1,300	109	**4,273**	**46%**
Immunity	2,867	2	216	555	920	946	214	14	**1,174**	**41%**
Renal	38	0	1	3	10	15	6	3	**24**	**63%**
Miscellaneous	2,728	1	240	447	609	801	438	192	**1,431**	**52%**
Neurology	3,310	10	584	998	871	631	174	42	**847**	**26%**
Oncology	783	2	35	59	120	238	210	119	**567**	**72%**
Respiratory	7,549	67	1,334	1,728	1,642	1,679	802	297	**2,778**	**37%**
Tuberculosis	1,930	32	575	533	421	278	77	14	**369**	**19%**
Total	**65,080**	**142**	**5,890**	**12,600**	**15,979**	**19,393**	**8,633**	**2,443**	**30,469**	**47%**

There were 136,201 reported CIC encounters during the fiscal year and inmates age 50 and older accounted for 48 percent (65,238) of CIC visits. In six clinics, elderly offenders accounted for 50 percent or more of visits in FY 2015-16. Table 22 provides a breakdown of CIC encounters for elderly offenders by clinic.

Table 22. Summary of Fiscal Year 2015-2016 Chronic Illness Clinic Encounters

Chronic Illness Clinic Encounters						
Chronic Clinic	Total Number of Clinic Visits	50-59	60-69	70+	Total Number of Clinic Visits Inmates 50+	Pecentage of Total Clinic Visits Inmates Age 50+
Cardiovascular	54,410	18,126	8,493	2,620	**29,239**	**54%**
Endocrine	18,612	6,373	2,985	994	**10,352**	**56%**
Gastrointestinal	17,052	5,732	2,736	251	**8,719**	**51%**
Immunity	8,647	2,953	658	46	**3,657**	**42%**
Renal	59	23	10	3	**36**	**61%**
Miscellaneous	4,903	1,501	854	388	**2,743**	**56%**
Neurology	6,110	1,220	374	88	**1,682**	**28%**
Oncology	1,633	503	451	249	**1,203**	**74%**
Respiratory	14,392	3,353	1,666	649	**5,668**	**39%**
Tuberculosis	10,383	1,506	360	73	**1,939**	**19%**
Total	**136,201**	**41,290**	**18,587**	**5,361**	**65,238**	**48%**

Housing Elderly Offenders

Out of 56 major FDC correctional institutions and facilities, two institutions reported housing no inmates age 50 and older on June 30, 2016. Inmates age 50 and older represented 20 percent or more of the total institution population at 19 institutions, and 25 percent or more of the total population at 16 institutions. Table 23 displays the ten institutions with the greatest concentration of inmates age 50 and older.

Table 23. FDC Institutions with the Greatest Concentration of Elderly Offenders

FDC Institutions with the Greatest Concentration of Elderly Offenders			
Institutions	Institution Population	Total 50+ Population	Percentage of Inmates 50+
Union CI	2,342	**1,470**	**63%**
Zephyrhills CI	1,011	**415**	**41%**
Everglades CI	1,614	**620**	**38%**
South Florida Reception Center	2,022	**777**	**38%**
Dade CI	1,591	**586**	**37%**
Hernando CI	393	**131**	**33%**
Hardee CI	1,706	**531**	**31%**
Okeechobee CI	1,660	**498**	**30%**
South Bay CF	1,939	**565**	**29%**
Wakulla CI	2,786	**791**	**28%**

FDC does not house inmates based solely on age, therefore, elderly offenders are housed in most of the Department's major institutions. All inmates, including elderly offenders, who have significant limitations performing activities of daily living or serious physical conditions, may be housed in institutions that have the capacity to meet their needs. Listed below are FDC institutions that currently have the capacity to provide specialized services to elderly offenders.[8]

- **Reception and Medical Center (RMC):** has an on-site 100-bed licensed hospital with the capacity to provide care for chronically ill inmates. It also has special dorms where nursing care is provided mainly to infirm elderly offenders and inmates requiring long-term nursing care.
- **Central Florida Reception Center-South Unit**: specifically designated for special needs inmates including the elderly as well as inmates receiving palliative care.
- **Zephyrhills Correctional Institution:** has two dorms specifically designed for elderly inmates as well as inmates with complex medical needs.
- **Lowell Correctional Institution:** has a dorm specifically designated for female inmates with complex medical needs including the elderly.
- **South Florida Reception Center-F-Dorm:** this dorm features 84 beds designated for palliative and long-term care. The facility also provides step down care for inmates who can be discharged from hospitals but are not ready for an infirmary level of care at an institution.

[8]Florida Department of Corrections Report

Characteristics of Florida's Elderly Offenders

Based on the data present in this report, the following facts summarize the status of elderly offenders housed in FDC institutions during FY 2015-16:

- Elderly offenders represented 23 percent of Florida's 99,119 general prison population.
- Elderly offenders entering FDC in FY 2015-16 were more likely to be white, male, age 55, first-time offenders, and incarcerated for property crimes.
- Elderly offenders housed in FDC institutions on June 30, 2016, were more likely to be white, male, age 55, repeat offenders with one or more FDC admissions, admitted to FDC at age 47, and incarcerated for a violent crime.
- Inmates age 50 and older represented the majority of all inmates with M4 and M5 health classifications. They represented 55 percent of M4 inmates and 82 percent of M5 inmates.
- Elderly offenders accounted for the majority of inmates with assigned impairments with 45 percent of assistive devices and special passes being issued to inmates age 50 and older.
- Inmates age 50 and older consumed a third of FDC health services during the fiscal year and they accounted for almost half of all inmates enrolled in CICs and CIC encounters.
- Inmates age 50 and older comprised 72 percent of inmates assigned to oncology clinics, 63 percent of inmates assigned to renal clinics, and 53 percent of inmates assigned to endocrine clinics.
- Elderly offenders represented 20 percent or more of the total population at 35 FDC institutions and facilities.
- FDC estimates that elderly offenders will account for 30 percent of its June 30, 2016, inmate population expected to die in prison.

CMA Recommendations

As Florida's elderly offender population continues to grow, FDC will be faced with operational and fiscal challenges as the agency works to meet the demands of caring for this population. To meet those demands, FDC must be proactive and identify fiscal, programmatic, system, and policy solutions that can alleviate the burden of providing care to a growing elderly population. Detailed below are the CMA's recommendations for addressing Florida's elderly offender population:

- Continue efforts to expand FDC's housing and facilities to accommodate elderly offender populations.
- Policymakers and FDC should review conditional medical release policies to identify and address procedural barriers that impact the release of elderly offenders.
- In response to the complications of poor health associated with accelerated aging, FDC should explore the feasibility and health benefits of providing additional preventive health screenings for inmates age 45 to 49.
- Develop or enhance geriatric training programs for institutional staff. Training should address common health conditions and psychosocial needs of elderly offenders and be offered on a routine basis.
- FDC should review and revise existing agency plans that address the needs of elderly offenders. Plans should be updated to address FDC's current and projected populations of elderly offenders and provide strategic goals, objectives, and activities across FDC's continuum of care for elderly offenders.
- Mental health policies and procedures should be reviewed to ensure they include guidance for detecting and addressing changes in cognitive functioning for inmates age 50 and older. Additionally, training and education regarding detecting cognitive impairment among elderly offenders should be offered to staff.