STATE OF FLORIDA CORRECTIONAL MEDICAL AUTHORITY

2016-2017 Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons

STATE OF FLORDA 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

Kris-Tena Albers, ARNP
Representative
Nursing

Lee B. Chaykin
Representative
Health Care Administration

Richard Huot, DDS
Representative
Dental

Leigh-Ann Cuddy, MS
Representative
Mental Health

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

December 27, 2017

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) 2016-17 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 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) 2016-17, the CMA conducted on-site physical and mental health surveys of 17 major correctional institutions, which included one reception center and three institutions with annexes or separate units. Additionally, CMA staff conducted 50 corrective action plan assessments based on findings from this and the previous year's surveys.

Pursuant to § 944.8041 F. S., Section Two of this report includes the CMAs' 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 2016-17 and the elderly population housed in Florida Department of Corrections (FDC) institutions on June 30, 2017. 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
Executive Director

TABLE OF CONTENTS

SECTION ONE

2016-2017 Correctional Medical Authority Annual Report

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.

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

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. Since 2012, FDC has relied on contracted health services providers to provide comprehensive health care services. In January 2016, FDC contracted with Centurion of Florida, LLC to provide health care services in Regions I, II, and III. Wexford Health Sources, Inc., was contracted to provide health care services for Region IV until June 2016. In June 2016, FDC terminated their health services contract with Wexford Health Resources, Inc. and entered into another contract with Centurion of Florida, LLC to provide health care services for Region IV. Seven private correctional facilities are managed by the Department of Management Services (DMS). Health care is provided in 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.

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) 2016-17, 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 2016-2017

CMA activities during FY 2016-17 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. At the end of the fiscal year, five of seven board seats were filled. Appointments were pending for persons nominated to fill the remaining two seats.

A major area of focus of the Board during FY 2016-17 was the corrective action plan (CAP) process. Board members raised concerns regarding the number of CAP findings that remained open from previous fiscal years and the number of assessments that it took for all findings to be closed. At the beginning of FY 2016-17, there were open CAP findings at two institutions surveyed in FY 2013-14 while four institutions surveyed in FY 2014-15 had open CAP findings. Additionally, three institutions surveyed in FY 2015-16 were slated to have their fourth CAP assessment. Because of the number of open CAP findings from previous fiscal years, a motion was made and passed, recommending the Department request health services providers provide a plan of action to address institutions with excessive CAPs (institutions with three or more CAPs assessments).

In response to the Board's motion, Centurion brought together multi-disciplinary teams that developed detailed action plans to address each open CAP finding at institutions with four or more CAP assessments. The action plans focused on specific issues that contributed to the inability to correct findings. Detailed CAP response plans were created for Columbia CI, Florida Women's Reception Center (FWRC), Lake CI, Lowell CI, and Suwannee CI.

Centurion updated the Board regarding their action plan development process and progress towards closing CAP findings. Centurion noted that some CAP findings remained open due to factors outside of health care contractor's control. External factors, such as security staffing shortages, impact the provider's ability to provide all required medical and mental health services. Board members acknowledged that some CAP findings remain open due to factors outside of the Department and health care contractors' control, however, stressed that the Board's expectation that deficiencies should be corrected by the third CAP assessment.

During the fiscal year, two Board members accompanied CMA staff on CAP assessments. Visits were made to FWRC and Lake CI. During the visits, Board members toured the institution and received an in-depth overview of physical health and mental health services provided.

HEALTH CARE STANDARDS REVIEW

According to § 945.6034 F.S., the CMA is required to review FDC policies pertinent to health care and to provide qualified professional advice regarding that care. During the fiscal year, the CMA reviewed and made recommendations, when necessary, for 55 FDC policies and procedures. This included 30 existing health services bulletins (HSB), 13 procedures, two newly created HSBs, and 10 Reception and Medical Hospital policies.

INMATE CORRESPONDENCE

CMA staff responded to 69 inmate letters during FY 2016-17. Responding to inmate correspondence is a valuable risk management function of the CMA. Because the CMA is not authorized to direct staff in FDC institutions or require that specific actions be taken by the Department, inmate letters are forwarded to OHS for investigation and response. In cases relating to security or other issues, letters are referred to the Department's Inspector General or General Counsel. CMA staff tracks the outcome of these letters and subsequently review health care issues identified in inmate letters during on-site surveys.

QUALITY MANAGEMENT COMMITTEE

The CMA's Quality Management Committee (QMC) is comprised of a licensed physician committee chair and three volunteer health care professionals including a representative from the CMA Board. The mission of the QMC is to provide feedback to OHS regarding its quality management process and to assure that corrective actions and policy changes identified through the process are effective. The primary focus of the QMC during FY 2016-17 was a quality review of OHS's mortality review process.

All in-custody deaths, except executions, require a mortality review. 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.[3] The administrative systems involved in providing care are also reviewed during this process.

The QMC's mortality review process is intended to function as an educational tool when areas of deficiency are identified, whether they are clinical or administrative in nature. Education may be limited to the health care professional that provided the care or extended to a group of health care professionals where a systems deficiency existed or the deficiency can potentially happen across institutions. The purpose of mortality review is to improve the quality of service across FDC's system of care, while providing for professional growth and development.

During the fiscal year, QMC members often commented that they saw significant improvements in the quality of mortality review documentation and corrective action plans implemented because of institutional mortality reviews. OHS has worked collaboratively with health care contractors to help facilitate these improvements. During the fiscal year, OHS's Mortality Review Coordinator visited institutions to provide in-person technical assistance during institutional mortality review meetings. In addition, at a minimum, the Mortality Review Coordinator holds bi-weekly conference calls with health care contractors to discuss all open mortality cases.

[3] 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 all mortality cases.

The QMC met four times during the fiscal year and reviewed 19 cases. One meeting was dedicated to suicide mortalities and six suicide mortalities were reviewed. The format of the suicide mortality review meeting was similar to the regular mortality review process, with the exception that a psychiatrist reviews and presents information to the committee. An additional meeting was dedicated to the review of mortalities occurring at private correctional facilities. This review was the first time that the QMC conducted a review with private correctional facility contractors.

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 can 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 surveys.

In FY 2016-17, 17 institutions were surveyed. This included nine institutions previously surveyed as a result of the CMA's triennial survey schedule (Jefferson CI, Martin CI, Santa Rosa CI-Main, Santa Rosa CI-Annex, South Florida Reception Center (SFRC), SFRC-South, Suwannee CI-Main, Suwannee CI-Annex, and Union CI). One reception center (SFRC); three institutions with main and annex units (Santa Rosa CI, SFRC, Suwannee CI), with each unit being surveyed separately; five institutions with inpatient mental health units (Santa Rosa CI-Annex, Suwannee CI-Main, Union CI, SFRC, and Zephyrhills CI); and three institutions with close management housing (Santa Rosa CI-Annex, Suwannee CI-Main, and Union CI). One surveyed institution (Bay CF) was a private facility managed by DMS.

A total of 495 institutional survey findings were identified, which represents a 32 percent decrease in findings from FY 2015-16. Of reportable findings, 226 (46 percent) were physical health findings and 269 (54 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 summary of medical and mental health grades[4],

[4] 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 requires care every six to twelve months; M3, inmate is followed in a CIC every three months; M4, inmate is followed in a CIC every three months and requires on-going 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; 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).

number of inmates housed, and survey findings identified are provided in Table 1 below. A detailed summary of findings from institutional surveys will be presented later in this report.

Table 1. Summary of Fiscal Year 2016-2017 Institutional Surveys

Summary of Fiscal Year 2016-2017 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
Martin CI	M1-M3	S1-S3	2483	2409	Yes	No	Yes	7	19
Bay CF	M1-M3	S1-S3	985	974	No	No	Yes	11	16
Desoto Annex	M1-M3	S1-S2	1722	1852	Yes	No	Yes	9	7
Hardee CI	M1-M3	S1-S2	1515	1783	Yes	No	Yes	16	1
Santa Rosa CI-Main	M1-M5	S1-S3	1349	1196	Yes	No	Yes	8	28
Santa Rosa CI-Annex	M1-M5	S1-S5	1478	1273	No	Yes	Yes	13	24
Jefferson CI	M1-M4	S1-S3	1319	1266	Yes	No	Yes	12	13
Union CI	M1-M4	S1-S5	2456	2171	No	Yes	Yes	19	48
Suwannee CI-Main	M1-M5	S1-S6	1499	1049	Yes	Yes	Yes	20	39
Suwannee CI-Annex	M1-M3	S1-S3	1346	1212	Yes	No	Yes	17	9
Calhoun CI	M1-M3	S1-S2	1585	1617	Yes	No	Yes	11	3
Mayo CI	M1-M5	S1-S2	1740	1414	Yes	No	Yes	16	11
SFRC-Main	M1-M5	S1-S5	1201	755	Yes	Yes	Yes	19	20
SFRC-South Unit	M1-M3	S1-S2	889	634	No	No	No	17	0
Putnam CI	M1-M2	S1-S2	458	447	No	No	Yes	2	2
Lancaster CI	M1-M3	S1-S3	1237	1171	No	No	Yes	12	3
Zephyrhills CI	M1-M5	S1-S5	924	977	Yes	Yes	Yes	17	26
								226	**269**

SOUTH FLORIDA RECEPTION CENTER EMERGENCY NOTIFICATION

On April 11-13, 2017, CMA staff and licensed professional surveyors conducted a survey of physical and mental health care services provided at SFRC. A thorough review of SFRC's health care delivery system, which encompassed chart reviews and interviews with staff and inmates, revealed several deficiencies in the care of inmates receiving inpatient mental health services. These deficiencies were related to psychiatric medication practices, the use of psychiatric restraints when less restrictive alternatives were available, and the assessment and treatment of inmates at imminent risk of self-harm. Interviews with inmates and institutional staff indicated that these issues had been on-going and systemic.

Due to the severity of the identified clinical deficiencies, in combination with the inherent risks of potential harm to the inpatient inmate population at SFRC, CMA did not believe these issues could be properly addressed with the standard corrective action process. The CMA considered these findings to be serious deficiencies, requiring immediate attention by FDC. On April 18, 2017, the CMA issued an emergency notification, in accordance with § 945.6031 (3) F.S., to the Secretary of Corrections.

In response to the emergency notification, FDC immediately dispatched the Department's Mental Health Ombudsmen and a team of mental health professionals to SFRC. On April 21, 2017, FDC provided CMA with an extensive CAP which outlined plans to address the findings identified in the emergency notification.

On July 12, 2017, 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 verify emergency findings were being addressed appropriately and monitoring efforts were conducted accurately. CMA staff and surveyors conducted a formal CAP assessment of SFRC on November 2, 2017. The results of the assessment can be located at http://www.flgov.com/correctional-medical-authority-cma/.

CORRECTIVE ACTION PLAN ASSESSMENTS

Within 30 days of receiving the final copy of the CMA's survey report, institutional staff must develop and submit a CAP that addresses the deficiencies outlined in the report. The CAP is submitted to OHS for approval before it is subsequently reviewed and approved by CMA staff. Once approved, institutional staff implement and monitor the CAP. 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. 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 50 CAP assessments in FY 2016-17. The results of CAP assessments for the last four years are summarized below in Tables 2a-2d.

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

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	8	Open
Tomoka CI	30	20	0	1	7	Closed 5/4/17
Lowell CI-Main	46	28	0	0	6	Closed 3/22/17
Lowell CI-Annex	54	32	1	0	8	Open

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	0	0	5	Closed 6/13/17
Columbia CI-Annex	25	29	0	1	6	Open
FWRC	52	59	4	2	5	Open
RMC-Main	19	47	0	2	5	Open
RMC-West	22	10	0	0	4	Closed 6/13/17
Dade CI	15	21	0	5	4	Open
Graceville CF	14	16	0	0	3	Closed 6/13/17
Gulf CI-Annex	17	3	0	0	3	Closed 2/27/17
Okaloosa CI	8	20	0	0	3	Closed 5/3/17
Walton CI	7	2	0	0	2	Closed 2/27/17
Franklin CI**	15	23	0	0	4	Closed 9/17/17
Everglades CI	9	4	0	1	4	Open
Apalachee CI-East	19	23	0	1	1	Open
Apalachee CI-West	21	12	0	0	2	Closeed 2/28/17
Century CI	24	26	0	0	2	Closed 6/27/17
Blackwater CF**	36	45	0	0	1	Closed 9/21/17

Table 2d. Fiscal Year 2016-2017 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2016-2017 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
Martin CI	7	19	0	1	3	Open
Bay CF	11	16	0	0	2	Closed 5/4/17
Desoto Annex	9	7	0	5	2	Open
Hardee CI	16	1	0	0	1	Closed 6/8/17
Santa Rosa CI-Main	8	28	0	14	2	Open
Santa Rosa CI-Annex	13	24	0	5	2	Open
Jefferson CI	12	13	1	1	2	Open
Union CI	19	48	6	5	1	Open
Suwannee CI-Main	20	39	10	16	1	Open
Suwannee CI-Annex	17	9	6	1	1	Open
Calhoun CI**	11	3	0	0	1	Closed 9/26/17
Mayo CI	16	11	3	7	1	Open
SFRC-Main	19	20	4	9	1	Open
SFRC-South Unit	17	0	1	0	1	Open
Putnam CI	2	2	2	2	0	Open
Lancaster CI	12	3	12	3	0	Open
Zephyrhills CI	17	26	17	26	0	Open

Institutions will be re-surveyed in FY 2017-18.

****Indicates institutions with CAP assessments completed after June 30, 2017.***

Summary of Fiscal Year 2016-2017 Institutional Survey Findings

The institutional survey process evaluates the quality of physical and mental health services provided by contracted health services providers, 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, except for findings for reception services because only one reception center was surveyed during the fiscal year.

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 (CIC), consultation requests, dental systems and care, 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 2016-17, there were 226 physical health findings which represented 46 percent of total survey findings. When compared to FY 2015-16, there was a 39 percent decrease in the number of physical health findings. 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.	101 (45%)	17 (100%)
Consultation Requests	Assesses processes for approving, denying, scheduling services, and follow-up for specialty care services.	22 (10%)	14 (82%)
Dental Review	Assesses the provision of dental care and systems.	31 (14%)	11 (65%)
Emergency Care	Assesses emergency care processes for addressing urgent/emergent medical complaints.	2 (0.88%)	2 (12%)
Infection Control	Assesses compliance with infection control policies and procedures.	0 (0%)	0 (0%)
Infirmary Care	Assesses the provision of skilled nursing services in infirmary settings.	15 (7%)	6 (55%)*
Institutional Tour	Tour of medical, dental, and housing facilities.	19 (8%)	8 (47%)
Intra-System Transfers	Assesses systems and processes for ensuring continuity of care for inmates transferred between institutions.	3 (1%)	3 (18%)
Medical Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying physical health related inmate requests.	5 (2%)	4 (24%)
Medication Administration	Assesses the administration of medication and clinical documentation related to medication practices.	4 (2%)	3 (18%)
Periodic Screenings	Assesses the provision of periodic physical examinations and health screenings.	14 (6%)	10 (59%)
Pharmacy Services	Assesses compliance with FDC's policies and procedures for medication storage, inventory, and disposal.	0 (0%)	0 (0%)
Pill Line Administration	Assesses medication dispensing practices to ensure proper nursing practices and policies are followed.	1 (0.44%)	1 (6%)
Reception Process	Assesses compliance with FDC's policies and procedures for physical health screenings of new inmates.	1 (0.44%)	1 (100%)**
Sick Call	Assesses sick call processes to address acute and non-emergency medical complaints and inmate access to sick call.	4 (2%)	4 (24%)

Infirmary services were not provided at Bay CF, Santa Rosa CI-Annex, Union CI, SFRC-South Unit, Putnam CI, and Lancaster CI.

****Reception services were only provided at SFRC.***

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	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Total
Martin CI	1	0	0	0	0	0	2	4	0	0	0	0	0	0	N/A	0	**7**
Bay CF	6	1	1	0	1	0	N/A	2	0	0	0	0	0	0	N/A	0	**11**
Desoto Annex	4	0	1	0	0	0	1	0	0	0	0	2	0	1	N/A	0	**9**
Hardee CI	6	1	3	2	0	0	0	2	0	1	0	1	0	0	N/A	0	**16**
Santa Rosa CI-Main	0	4	1	3	0	0	0	0	0	0	0	0	0	0	N/A	0	**8**
Santa Rosa CI-Annex	5	1	2	1	1	0	N/A	3	0	0	0	0	0	0	N/A	0	**13**
Jefferson CI	3	2	1	2	0	0	0	3	0	0	0	0	0	0	N/A	1	**12**
Union CI	11	1	2	0	0	0	N/A	2	0	0	1	2	0	0	N/A	0	**19**
Suwannee CI-Main	6	1	1	2	0	0	7	0	1	0	1	1	0	0	N/A	0	**20**
Suwannee CI-Annex	11	1	1	0	0	0	2	0	0	0	0	1	0	0	N/A	1	**17**
Calhoun CI	3	2	2	3	0	0	0	0	0	0	0	1	0	0	N/A	0	**11**
Mayo CI	8	3	0	0	0	0	0	2	1	0	0	1	0	0	N/A	1	**16**
SFRC-Main	11	1	0	0	0	0	2	0	0	1	0	1	0	0	2	1	**19**
SFRC-South Unit	9	1	0	0	0	0	N/A	0	0	2	2	3	0	0	N/A	0	**17**
Putnam CI	2	0	0	0	0	0	N/A	0	0	0	0	0	0	0	N/A	0	**2**
Lancaster CI	7	1	0	0	0	0	N/A	1	1	1	0	1	0	0	N/A	0	**12**
Zephyrhills CI	8	2	2	1	0	0	1	3	0	0	0	0	0	0	N/A	0	**17**
	101	**22**	**17**	**14**	**2**	**0**	**15**	**22**	**3**	**5**	**4**	**14**	**0**	**1**	**2**	**4**	**226**

CHRONIC ILLNESS CLINICS

As in previous years, an analysis of aggregate survey data revealed that the majority (45 percent) of physical health survey findings were related to CICs. 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	6 (7%)	5 (29%)
Endocrine	19 (22%)	10 (59%)
Gastrointestinal	5 (6%)	5 (29%)
Immunity	7 (8%)	5 (29%)
Miscellaneous	13 (15%)	9 (53%)
Neurology	14 (16%)	12 (71%)
Oncology	7 (8%)	5 (29%)
Respiratory	7 (8%)	5 (29%)
Tuberculosis	10 (11%)	7 (41%)

In total, 101 CIC findings were identified across all 17 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 at the required intervals according to M-grade status, missing vaccinations, and abnormal labs not being addressed timely. These findings were consistent with those of previous fiscal years. However, the total number of reported occurrences were significantly reduced during this fiscal year.

Common CIC findings for specific clinics are detailed below:

- Endocrine Clinic: record reviews indicated that fundoscopic examinations were not completed annually and inmates with uncontrolled blood sugar levels were not seen at required intervals
- Miscellaneous Clinic: examinations were not appropriate and sufficient to assess conditions
- Neurology Clinic: seizures were not consistently classified by type
- Respiratory Clinic: reactive airway diseases were not classified

CONSULTATION REQUESTS

Consultation findings represented ten percent of physical health findings. Findings were noted for 14 (82 percent) surveys. The most common consultation findings across institutions were incomplete or missing documentation of consultation appointments and incomplete or missing documentation of new diagnoses on problem lists.

DENTAL REVIEW

Dental review findings were noted at 11 (65 percent) institutions. There were 31 (14 percent) dental review findings. Seventeen related to clinical care and 14 systems findings. Clinical care findings were related to

incomplete and untimely referrals for higher levels of care. Systems findings were related to the disrepair, accessibility, and availability of dental equipment.

EMERGENCY CARE

Emergency care findings were noted for two (12 percent) surveys, with two (0.88 percent) findings. No system-wide trends were identified.

INFECTION CONTROL

There were no findings related to infection control.

INFIRMARY CARE

Infirmary care was provided at 11 of 17 surveyed institutions. Findings were noted at 6 (55 percent) institutions. Clinical records reviews resulted in 15 (7 percent) findings. The most common finding across institutions was related to incomplete or missing nursing discharge notes.

INSTITUTIONAL TOUR

Institutional tour findings were noted for eight (47 percent) institutions, and resulted in 19 (8 percent) findings. No system-wide trends were identified.

INTRA-SYSTEM TRANSFERS

Three (1 percent) findings related to intra-system transfers were noted for three (18 percent) surveys. No system-wide trends were identified.

MEDICAL INMATE REQUESTS

Four (24 percent) institutions surveyed had findings related to medical inmate requests. In total, 5 (2 percent) findings were identified. The most common finding noted was related to missing inmate request documentation.

MEDICATION ADMINISTRATION RECORD REVIEW AND PILL LINE OBSERVATION

Clinical record reviews related to medication administration resulted in four (two percent) findings across three (18 percent) institutions surveyed. There was only one (0.44 percent) finding resulting from pill line observations of medication administration. There were no system-wide issues related to medication administration and pill line observation.

PERIODIC SCREENINGS

Fourteen (6 percent) periodic screening findings were noted at 10 (59 percent) institutions. The most common finding was untimely or incomplete diagnostic testing.

PHARMACY SERVICES

There were no findings related to Pharmacy Services.

SICK CALL

There were four (2 percent) findings related to the sick call process. Four (24 percent) institutions had reportable findings. Inadequate and untimely follow-up visits was the only system-wide issue identified across institutions.

RECEPTION PROCESS

Reception services were provided at one institution, and one (0.44 percent) finding was noted.

Mental Health Survey Findings

Mental health surveys assess inmates' 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 medication practices, mental health inmate requests, mental health systems, psychiatric restraints, psychological emergencies, outpatient mental health services, outpatient psychiatric medication practices, the reception process, self-injury/suicide prevention, access to care in special housing, and use of force.

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. Psychiatric medication practices 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 and inpatient mental health services were provided at five institutions.

There were 269 mental health findings in FY 2016-17 that represented 54 percent of total survey findings. The total number of FY 2016-17 mental health findings decreased by 28 percent when compared to FY 2015-16. As in previous fiscal years, outpatient mental health services findings represented the majority (15 percent) of reported mental health findings. Findings in the areas of outpatient psychiatric medication practices and self-injury/suicide prevention also continued to represent a significant portion of mental health findings.

There were also a significant number of findings related to inpatient mental health services and psychiatric medication practices. Union CI accounted for 47 percent (15) of inpatient mental health services and 33 percent (13) of inpatient psychiatric medication practices findings. At the time of CMA's survey of Union CI, inpatient mental health services were provided in two Transitional Care Units (TCU) and one Crisis Stabilization Unit (CSU). Each dorm was surveyed as an individual inpatient unit; however, the findings for each survey are reported as a whole for this report. Due to duplicate findings across dorms, Union CI inpatient mental health services findings were excluded from the analysis of the most common findings across 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.	16 (6%)	8 (73%)*
Inpatient Mental Health Services	Assesses the provision of mental health care in inpatient settings.	32 (12%)	5 (100%)**
Inpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in inpatient settings.	40 (15%)	5 (100%)**
Mental Health Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying mental health related inmate requests.	6 (2%)	5 (29%)
Mental Health Systems Reviews	Assesses systems and processes related to mental health staff training, clinical supervision, and other administrative functions.	13 (5%)	10 (59%)
Psychiatric Restraints	Assesses compliance with FDC's policies and procedures for psychiatric restraints.	10 (4%)	3 (75%)***
Psychological Emergencies	Assesses the process for responding to inmate mental health emergencies.	4 (1%)	3 (20%)****
Outpatient Mental Health Services	Assesses the provision of mental health services in an outpatient setting.	41 (15%)	13 (76%)
Outpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in outpatient settings.	39 (14%)	10 (90%)*****
Reception Process	Assesses compliance with FDC's policies and procedures for mental health screenings of new inmates.	2 (0.74%)	1 (100%)******
Self-Injury/ Suicide Prevention	Assesses compliance with FDC's policies and procedures for self-injury and suicide prevention.	37 (14%)	15 (93%)*******
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.	15 (6%)	8 (50%)********
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.	14 (5%)	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 Santa Rosa CI-Annex, Union CI, Suwannee CI-Main, SFRC-Main, and Zephyrhills CI.***
*****There were only four institutions with applicable Psychiatric Restraint episodes.***
******There were no applicable Psychological Emergencies for review at Putnam CI and SFRC-South Unit***
*******Outpatient Psychiatric Medication is provided at institutions housing inmates with grades of S-3. Eleven institutions were assessed.***
********Reception Services are only provided at SFRC-Main.***
*********SFRC-South and Putnam CI do not house inmates for Self-Injury/Suicide Prevention.***
**********SFRC-South does not provide special housing.***
***********There were only 12 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	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Martin CI	1	N/A	N/A	0	2	N/A	0	6	4	N/A	3	3	0	**19**
Bay CF	1	N/A	N/A	0	2	N/A	0	1	2	N/A	7	2	1	**16**
Desoto Annex	N/A	N/A	N/A	1	0	N/A	0	5	N/A	N/A	1	0	0	**7**
Hardee CI	N/A	N/A	N/A	0	1	N/A	0	0	N/A	N/A	0	0	0	**1**
Santa Rosa CI-Main	2	N/A	N/A	1	2	N/A	1	8	5	N/A	4	3	2	**28**
Santa Rosa CI-Annex	0	5	8	0	1	0	0	1	5	N/A	2	0	2	**24**
Jefferson CI	3	N/A	N/A	0	1	N/A	0	2	4	N/A	2	0	1	**13**
Union CI *	2	15	13	1	1	5	2	1	5	N/A	2	1	0	**48**
Suwannee CI-Main	3	9	6	0	0	N/A	0	6	7	N/A	2	2	4	**39**
Suwannee CI-Annex	3	N/A	N/A	1	1	N/A	0	0	1	N/A	1	0	2	**9**
Calhoun CI	N/A	N/A	N/A	0	0	N/A	0	0	N/A	N/A	2	0	1	**3**
Mayo CI	N/A	N/A	N/A	0	0	N/A	0	3	N/A	N/A	7	0	1	**11**
SFRC-Main	1	2	3	2	1	2	1	4	0	2	1	1	N/A	**20**
SFRC-South Unit	N/A	N/A	N/A	0	0	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	**0**
Putnam CI	N/A	N/A	N/A	0	0	N/A	N/A	2	N/A	N/A	N/A	0	N/A	**2**
Lancaster CI	0	N/A	N/A	0	0	N/A	0	0	1	N/A	1	1	N/A	**3**
Zephyrhills CI	0	1	10	0	1	3	0	2	5	N/A	2	2	N/A	**26**
Total Findings	**16**	**32**	**40**	**6**	**13**	**10**	**4**	**41**	**39**	**2**	**37**	**15**	**14**	**269**

**** Union CI's three inpatient dorms were individually surveyed. The findings from each unit are combined into an overall total.***

DISCHARGE PLANNING

Record reviews for discharge planning were completed at 11 institutions, and of those institutions, eight (73 percent) had findings. Sixteen (6 percent) findings were identified and the most common findings were related to: inadequate or incomplete aftercare planning documentation, missing or incomplete consent for release of confidential information, incomplete discharge planning documentation, and the timeliness of applying for Social Security benefits for eligible inmates.

MENTAL HEALTH INMATE REQUESTS

Five institutions (29 percent) had mental health inmate request findings, with six (2 percent) reportable findings. The most common finding was copies of inmate requests were not present in the medical record.

MENTAL HEALTH SERVICES

INPATIENT MENTAL HEALTH SERVICES

Inpatient mental health services were provided at five surveyed institutions. Findings were noted at each institution and resulted in 32 (12 percent) findings. The most common findings noted were missing or untimely Individualized Service Plan (ISP) documentation and inconsistent and/or inadequate planned structured therapeutic services.

OUTPATIENT MENTAL HEALTH SERVICES

Findings related to outpatient mental health services accounted for 15 percent (41) of mental health survey findings. Thirteen (76 percent) institutions had reportable findings. The most common findings were related to: untimely mental health screening evaluations, incomplete, inadequate, and/or untimely ISP documentation, and incomplete problem list documentation. Missing, inadequate, and/or untimely counseling for inmates on close management (CM) status was noted at the two applicable institutions surveyed.

MENTAL HEALTH SYSTEMS REVIEWS

Mental health systems findings were noted at 10 (59 percent) institutions, and 13 (5 percent) findings were identified. The lack of psychiatric restraint equipment was a common finding across institutions.

PSYCHIATRIC MEDICATION PRACTICES

INPATIENT PSYCHIATRIC MEDICATION PRACTICES

Inpatient psychiatric medication practice record reviews were completed for five institutions and resulted in 40 (15 percent) findings. The following findings were most commonly reported across institutions: incomplete and/or missing initial labs, medications not given as ordered, and missing documentation for medication refusals.

OUTPATIENT PSYCHIATRIC MEDICATION PRACTICES

Ten (59 percent) institutions had outpatient psychiatric medication practice findings and 39 (14 percent) findings were identified. Across institutions, the most common findings were related to 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, incomplete and/or missing medication consent forms, untimely follow-up psychiatric contacts, and untimely Abnormal Involuntary Movement Scale (AIMS) assessments.

PSYCHIATRIC RESTRAINTS

During the fiscal year, psychiatric restraint episodes were available for review at three institutions and, based on those episodes, 10 (4 percent) findings were identified. No system-wide trends were noted.

PSYCHOLOGICAL EMERGENCIES

Psychological emergency findings were noted for three (20 percent) institutions and resulted in 4 (1 percent) findings. No system-wide trends were identified.

RECEPTION PROCESS

One reception center was surveyed during the fiscal year, resulting in two (0.74 percent) reception process findings. No system-wide trends can be determined.

SELF-INJURY/SUICIDE PREVENTION

Self-harm observation status (SHOS) findings were identified for 15 (93 percent) surveys with applicable SHOS episodes for review, resulting in 37 (14 percent) findings. The most commonly identified findings across institutions were related to missing and/or incomplete emergency evaluations, noncompliance with SHOS management guidelines, noncompliance with clinician orders for observation frequency, incomplete and/or missing nursing evaluations, missing daily rounds by the attending clinician and mental health staff, and missing post-discharge follow-up.

SPECIAL HOUSING

Special housing findings were noted at eight (50 percent) surveyed institutions. There were 15 (6 percent) reportable findings. The most common findings were related to incomplete special housing health appraisals and outpatient mental health treatment.

USE OF FORCE

There were applicable use of force episodes for review at 12 institutions surveyed during the fiscal year. Findings were noted at eight (67 percent) of those institutions, which resulted in 14 (5 percent) findings. The most common findings were related to incomplete referrals to mental health from nursing staff and incomplete and/or missing post use of force evaluations.

SUMMARY OF SYSTEM-WIDE TRENDS AND RECOMMENDATIONS

Tables 8 and 9 below summarize system-wide findings identified during FY 2016-17 physical and mental health surveys. These findings were not noted at all institutions; however, they were noted at three or more institutions.

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 • 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% were seen at least every three months • There was no evidence that the control of the disease was documented at each clinic visit • There was no evidence examinations were appropriate and sufficient to assess condition • There was no evidence of referrals to a specialist for more in-depth treatment, when indicated • Seizures were not classified by nomenclature • There was no evidence reactive airway diseases were classified as mild, moderate, or severe
Consultation Requests	• New diagnoses were not reflected on problem lists • The Consultation Appointment Log was incomplete
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 that consultation or specialty services were requested in a reasonable timeframe
Emergency Care	• No trends identified
Infirmary Care	• There was no evidence of a nursing discharge note.
Medical Inmate Requests	• Copies of the inmate request were not present in medical records
Periodic Screenings	• There was no evidence that all required diagnostic tests were performed prior to screening
Sick Call	• There was no evidence that follow-up assessments were completed

Table 9. Mental Health Survey: System-Wide Trends

Assessment Area	Mental Health Survey System-Wide Areas of Concern
Discharge Planning	• Aftercare planning was not addressed on the Individualized Service Plan (ISP) within 180 days of expiration of sentence (EOS) • Consent to release information for continuity of care was missing or incomplete • 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
Inpatient Psychiatric Medication Practices	• Initial labs were not ordered • Inmates did not receive medication as prescribed and/or documentation of refusal was not present
Mental Health Inmate Requests	• A copy of the inmate request form was not present in the medical record
Psychiatric Restraints	• No trends identified
Outpatient Mental Health Services	• Mental health screening evaluations were not completed within 14 days of arrival • Bio-psychosocial Assessments (BPSA) were not approved by all members of the multidisciplinary services team (MDST) within 30 days of initiating treatment • 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 • Inmates on Close Management Status (CM) did not receive at least one hour of group or individual counseling each week
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 • Consent forms were not present or did not reflect information relevant to prescribed medications • Follow-up psychiatric contacts were not conducted at appropriate intervals • 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 • 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 mental health staff provided post-discharge follow-up within seven days
Special Housing	• "Special Housing Health Appraisals" were incomplete • There were interruptions in outpatient treatment and psychotropic medications for inmates held in special housing
Use of Force	• 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

THREE-YEAR INSTITUTIONAL SURVEY COMPARISION

During the 2012 legislative session, funding for CMA was authorized and the agency was re-established. In October 2012, an Interim Executive Director was appointed and by March 2013 the CMA was fully staffed. In May 2013, CMA staff resumed conducting triennial physical and mental health surveys of correctional institutions.

During FY 2016-17, nine institutions were re-surveyed as a part of the CMA's triennial survey schedule. These institutions were first surveyed in FY 2012-13 and 2013-14. The tables below provide a comparison of survey findings from the first survey cycle and FY 2016-17 survey findings. While a side by side comparison is provided, it is important to note that new survey tools have been implemented since 2013. The CMA routinely updates survey tools as FDC policies and procedures are written, revised, and implemented. Additionally, CMA creates or revises tools to increase efficiency and accuracy of the survey process. The number of findings related to chronic illness clinics and medical inmate requests were impacted by these changes.

PHYSICAL HEALTH FINDINGS

Table 10a. Fiscal Years 2012-2013 and 2013-2014 Surveyed Institutions Physical Health Findings

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Review	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Total
Jefferson CI	56	3	1	3	0	7	2	0	N/A	0	0	0	0	N/A	1	**73**
Martin CI	19	3	0	1	0	2	10	0	N/A	4	2	0	0	0	1	**42**
Santa Rosa CI-Main	2	0	0	0	0	0	5	0	N/A	1	0	1	0	N/A	1	**10**
Santa Rosa CI-Annex	26	1	1	0	0	N/A	5	0	N/A	1	1	3	0	N/A	0	**38**
SFRC-Main	29	4	0	0	0	6	3	2	N/A	0	3	0	0	0	0	**47**
SFRC-South	15	3	1	N/A	0	N/A	3	0	N/A	0	1	0	0	N/A	0	**23**
Suwannee CI-Main	2	0	0	0	0	0	2	0	N/A	1	1	0	1	N/A	0	**7**
Suwannee CI-Annex	17	1	0	0	0	0	1	0	N/A	0	3	0	2	N/A	1	**25**
Union CI	16	2	0	1	0	N/A	0	0	N/A	1	0	0	0	N/A	1	**21**
Zephyrhills CI	4	0	2	0	0	0	1	0	N/A	3	0	0	0	N/A	0	**10**

Table 10b. Fiscal Year 2016-2017 Surveyed Institutions Physical Health Findings

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Review	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Total
Jefferson CI	3	2	3	0	0	0	3	0	0	0	0	0	0	N/A	1	**12**
Martin CI	1	0	0	0	0	2	4	0	0	0	0	0	0	N/A	0	**7**
Santa Rosa CI-Main	0	4	4	0	0	0	0	0	0	0	0	0	0	N/A	0	**8**
Santa Rosa CI-Annex	5	1	3	0	0	N/A	3	0	0	0	0	0	0	N/A	0	**12**
SFRC-Main	11	1	0	0	0	2	0	0	1	0	1	0	0	2	1	**19**
SFRC-South	9	1	0	0	0	N/A	0	0	2	2	3	0	0	N/A	0	**17**
Suwannee CI-Main	6	1	3	0	0	7	0	1	0	1	1	0	0	N/A	0	**20**
Suwannee CI-Annex	11	1	1	0	0	2	0	0	0	0	1	0	0	N/A	1	**17**
Union CI	11	1	2	0	0	N/A	2	0	0	1	2	0	0	N/A	0	**19**
Zephyrhills CI	8	2	3	0	0	1	3	0	0	0	0	0	0	N/A	0	**17**

MENTAL HEALTH FINDINGS

Table 10c. Fiscal Years 2012-2013 and 2013-2014 Surveyed Institutions Mental Health Findings

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Jefferson CI	0	N/A	N/A	1	2	N/A	0	16	6	N/A	4	3	2	34
Martin CI	0	N/A	N/A	0	0	4	0	0	3	N/A	4	1	1	13
Santa Rosa CI-Main	0	N/A	N/A	0	0	N/A	0	2	3	N/A	4	0	0	9
Santa Rosa CI-Annex	4	1	3	0	0	5	0	1	0	N/A	3	1	1	19
SFRC-Main	1	4	4	0	2	5	0	2	5	1	0	0	0	24
SFRC-South	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	N/A	N/A	0
Suwannee CI-Main	0	2	7	0	0	N/A	0	1	2	N/A	6	0	1	19
Suwannee CI-Annex	2	N/A	N/A	1	0	0	1	6	6	N/A	0	3	0	19
Union CI*	0	7	6	1	5	5	0	1	0	N/A	3	0	3	31
Zephyrhills CI	0	2	0	0	3	0	0	2	0	N/A	0	0	N/A	7

Inpatient mental health units were not surveyed as individual units during the CMA's FY 2012-13 survey of Union CI.

Table 10d. Fiscal Year 2016-2017 Surveyed Institutions Mental Health Findings

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Jefferson CI	3	N/A	N/A	0	1	N/A	0	2	4	N/A	2	0	1	13
Martin CI	1	N/A	N/A	0	2	N/A	0	6	4	N/A	3	3	0	19
Santa Rosa CI-Main	2	N/A	N/A	1	2	N/A	1	8	5	N/A	4	3	2	28
Santa Rosa CI-Annex	0	5	8	0	1	0	0	1	5	N/A	2	0	2	24
SFRC-Main	1	2	3	2	1	2	1	4	0	2	1	1	N/A	20
SFRC-South	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	N/A	N/A	0
Suwannee CI-Main	3	9	6	0	0	N/A	0	6	7	N/A	2	2	4	39
Suwannee CI-Annex	3	N/A	N/A	1	1	N/A	0	0	1	N/A	1	0	2	9
Union CI*	2	15	13	1	1	5	2	1	5	N/A	2	1	0	48
Zephyrhills CI	0	1	10	0	1	3	0	2	5	N/A	2	2	N/A	26

During the CMA's 2016-17 survey of Union CI, the institution's two TCUs and CSU were surveyed as individual inpatient units. The findings from each unit are combined into an overall total.

CMA Recommendations

Institutional surveys for FY 2016-17 continued to reveal FDC generally has in place an overall adequate structure for the delivery of health care services. However, deficiencies were noted at all institutions, and a wide variability of care exists at the institutional level. At one institution, serious mental health deficiencies with respect to the psychiatric management of the institution's mentally ill population required emergency notification to the Secretary of Corrections. This year's report reiterates concerns surfaced in previous annual reports. Detailed below are the CMA's recommendations to address areas of concern.

INSUFFICENT AND/OR MISSING CLINICAL DOCUMENTATION

Incomplete or missing documentation continued to be a system-wide issue noted in several assessment areas. Complete and accurate clinical documentation is a critical component for the delivery of health care services. Additionally, clinical documentation ensures that continuity of care is maintained. To improve issues related to clinical documentation, 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 and missing clinical documentation.
- FDC should continue to explore information technology solutions for an electronic medical record and determine the fiscal impact of implementing an electronic system. The implementation of an electronic medical record, in a system as large as FDC, could improve administrative and clinical efficiencies.
- 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.

DIAGNOSTIC DELAYS

Findings related to incomplete and/or untimely initial and follow-up diagnostic testing was noted as a system-wide trend for multiple assessment areas. Diagnostic testing serves as a useful tool to identify issues early in the disease process. Failure to provide or interpret diagnostic testing can put inmates at risk for adverse health outcomes due to delayed diagnosis and treatment. To improve issues related to diagnostic delays, the following strategies are recommended:

- Improve administrative systems to track the timeliness of diagnostic testing, receipt of laboratory results, and follow-up care.
- Identify a system or process to provide clinicians with notification reminders to order periodic screening diagnostic tests within the required timeframe.
- Ensure indicated laboratory studies are ordered for inmates prescribed psychiatric medication and steps are taken to address abnormal results in a timely manner.
- Review staffing levels for physical health staff, including physicians, mid-level practitioners, and nursing staff.

MENTAL HEALTH TREATMENT DELAYS

Without timely treatment, inmates living with mental illness can suffer from the adverse effects of delayed care. Inconsistent treatment can lead to worsening symptoms and the possibility of decreased baseline functioning. To improve issues related to delays in mental health treatment, the following strategies are recommended:

- Ensure required hours of planned structured therapeutic services in inpatient units are provided and documented according to protocol.
- Ensure inmates on the mental health caseload are evaluated in a timely manner and provided the services listed on their ISPs, including inmates housed in confinement.
- Develop and implement a standardized tracking system to document use of force episodes to ensure inmates on the mental health caseload are referred for evaluation to determine if additional mental health interventions are needed.
- Review staffing levels for psychiatry, mental health professionals, and mental health nursing.

SELF-HARM OBSERVATION STATUS ASSESSMENT AND TREATMENT

SHOS findings were noted at ninety-three percent (15) of surveyed institutions. Inmates are placed in an acute care setting to prevent harm to self or others. To improve services to this vulnerable population, the following strategy is recommended:

- Provide training to medical and security staff to ensure proper procedures are followed and subsequent documentation of the psychological emergency is complete and accurate.
- Develop a tracking mechanism to ensure inmates in need of referral to a higher level of care are evaluated.

SECTION TWO

2016-2017

Update on the Status of Elderly Offenders in Florida's Prisons

INTRODUCTION

In 2008, 13,549 elderly offenders were housed in FDC institutions and represented 14 percent of Florida Department of Corrections' (FDC) total prison population. On June 30, 2017, elderly offenders represented 24 percent (97,794) of Florida's general prison population. This was a 69 percent increase in the number of elderly offenders since 2008. Over the next five years, it is projected that Florida's elderly offender population will grow to represent 29 percent of the total inmate population.[5]

Elderly offenders have complex health care needs that are often significantly different and costlier than those of younger offenders. In FY 2014-15, elderly offenders accounted for 43% of all outpatient episodes of care and 50% of all inpatient hospital days.[6] A 2014 Florida Tax Watch Report, estimated that, on average, the cost of providing health care to elderly offenders is $11,000 per inmate per year, compared to $2,500 per inmate for inmates under the age of 50.[7] These figures help highlight the fiscal impact that elderly offenders have on the FDC health care service delivery system and emphasize the need for sound programmatic and fiscal planning to address this population. Therefore, it is important to assess the health care status of elderly offenders to provide policymakers with reliable information that can be used to help inform budgetary, policy, and programmatic decision making.

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 Florida Statutes (F.S.) that requires the agency to submit, each year to the Florida Legislature, an annual report on the status of elderly offenders. Utilizing data from FDC's Bureau of Research and Data Analysis, a comprehensive profile of Florida's elderly offenders will be detailed in this report. This update for FY 2016-17 will include demographic, sentencing, health utilization, and housing information for elderly offenders. Also included are the CMA's recommendations related to Florida's elderly population.

[5] Florida Department of Corrections, Bureau of Research and Data Analysis, October. 2017
[6] Florida Department of Corrections Report," *Elderly Inmates, 2014-2015 Agency Annual Report". Web. 2 Nov. 2017.*
[7] McCarthy, Dan. "Florida's Aging Prisoner Population." Florida Tax Watch Research Institute, Inc., (2014): 6-7. Web. 3 Nov. 2015.

PROFILE OF FLORIDA'S ELDERLY OFFENDERS

DEFINING ELDERLY OFFENDERS

Correctional experts share a common view that many incarcerated persons experience accelerated aging because 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. [8]

Outside of correctional settings, age 65 is generally considered to be the age at which persons are classified as elderly. However, at least 20 state department of corrections and the National Commission on Correctional Health Care have set the age cutoff for elderly offenders at 50 or 55.[9] In Florida, elderly offenders are defined as "prisoners age 50 or older in a state correctional institution or facility operated by the Department of Corrections."[10] Therefore, elderly offenders are defined in this report as inmates age 50 and older.

Elderly offenders can be categorized into one of three groups of offenders. The first group are those offenders incarcerated after the age of 50, often for the first time. These offenders are described as later-life offenders. The second group of elderly offenders are those who are described as "career criminals," who consistently continue to offend and serve time. Lastly, the third and largest category of elderly offenders are those inmates who were incarcerated prior to age 50 and have aged in prison due to serving long prison sentences.[11]

FISCAL YEAR 2016-2017 ADMISSIONS

DEMOGRAPHIC CHARACTERISTICS

In FY 2016-17, elderly offenders accounted for 13 percent (3,693) of 28,783 inmates admitted to FDC institutions. Males represented 90 percent (3,317) of elderly offender admissions, while females age 50 and older accounted for 10 percent (376) of admissions. When looking at racial/ethnic demographics for newly admitted inmates age 50 and older, 38 percent (1,403) were black, 10 percent (359) were Hispanic, 52 percent (1,920) were white, and 0.30 percent (11) were classified as other. Table 11 further details racial/ethnic demographics by gender.

Seventy-nine percent (2,934) 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 53. The oldest male offender admitted in FY 2016-17 was age 87, while the oldest female admitted was age 76. Demographic data is summarized in Table 11 below:

[8] Williams, Brie A., et al. "Addressing the Aging Crisis in U.S. Criminal Justice Health Care." Journal of the American Geriatrics Society, vol. 60, no. 6, 2012, pp. 1150–1156.
[9] Ibid., 1151.
[10] Florida Department of Corrections Report," Elderly Inmates, 2014-2015 Agency Annual Report." Web. 2 Nov. 2017.
[11] National Institute of Corrections, "Managing the Elderly in Corrections." Web. 6 Dec. 2017.

Table 11. Fiscal Year 2016-2017 FDC Elderly Offender Admissions Demographics

Fiscal Year 2016-2017 Admissions: Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	25,273 (88%)	21,956 (88%)	3,317 (90%)	**13%**
Female	3,510 (12%)	3,134 (12%)	376 (10%)	**11%**
Total	28,783	25,090	3,693	13%
Race/Ethnicity				
Black Female	822 (3%)	720 (3%)	102 (3%)	**12%**
Black Male	11,254 (39%)	9,953 (40%)	1,301 (35%)	**12%**
Hispanic Female	194 (0.67%)	183 (0.73%)	11 (0.30%)	**6%**
Hispanic Male	3,049 (11%)	2,701 (9%)	348 (9%)	**11%**
White Female	2,483 (9%)	2,223 (9%)	260 (7%)	**0.10%**
White Male	10,900 (38%)	9,240 (37%)	1,660 (45%)	**15%**
Other Female	11 (0.04%)	8 (0.03%)	3 (0.08%)	**27%**
Other Male	70 (0.24%)	62 (0.25%)	8 (0.22%)	**11%**
Total	28,783	25,090	3,693	13%
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	2,934 (79%)	**10%**		
60-69	670 (18%)	**2%**		
70+	89 (2%)	**0.31%**		
Total	3,693			

COMMITMENTS, PRIMARY OFFENSES, AND SENTENCES

Most (35 percent or 1,307) of the elderly offenders admitted to FDC in FY 2016-17 had no prior commitments, while 15 percent (571) had one, 11 percent (395) had two, 9 percent (322) had three, and 29 percent (1,045) had four or more prior FDC commitments. Among new admissions, 30 percent (1,096) of inmates age 50 and older were incarcerated for violent crimes, 29 percent (1,082) for property crimes, 17 percent (852) for drug offenses, and 17 percent (610) were incarcerated for offenses classified as other. Table 12 summarizes previous FDC commitments for elderly offenders. Table 13 summarizes primary offense types.

Among inmates entering FDC in FY 2016-17, those serving sentences related to murder/manslaughter and sexual/lewd behavior, on average, were sentenced to serve longer terms when compared to other offenses. Inmates incarcerated for murder/manslaughter, on average, were sentenced to 24 years with the average age at time of admission being 33 years. For sexual/lewd behavior, the average sentence length was 13 years with the average age at time of admission being 39 years. For these inmates, it is expected that they will age into the elderly offender category before being released from prison.

When looking specifically at inmates age 50 and older entering FDC in FY 2016-17, inmates incarcerated for murder/manslaughter and sexual/lewd behavior were serving sentences of 23 years for murder/manslaughter and 15 years for sexual/lewd behavior, which were longer sentences when compared to other offenses.

Table 14 summarizes the average sentence length and age at time of admission by primary offense category for the total inmate population and elderly offenders.

Table 12. Fiscal Year 2016-17 Admissions: Summary of Previous FDC Commitments

Fiscal Year 2016-2017 Admissions: Previous FDC Commitments For Inmates Age 50 and Older	
Previous Number of Commitments	**Total Number of Elderly Offenders**
0	1,307 (35%)
1	571 (15%)
2	395 (11%)
3	322 (9%)
4+	1,045 (29%)
Unknown	53 (1%)

Table 13. Fiscal Year 2016-17 Admissions: Summary of Primary Offense Categories

Fiscal Year 2016-2017 Admissions: Primary Offense Categories					
Primary Offense Type	**50-59**	**60-69**	**70+**	**Total Inmates Age 50+**	**Percentage of Total Population Age 50+**
Violent	802 (27%)	239 (36%)	55 (62%)	**1,096**	**30%**
Property	925 (32%)	150 (22%)	7 (8%)	**1,082**	**29%**
Drugs	685 (23%)	162 (24%)	5 (6%)	**852**	**17%**
Other	475 (16%)	114 (17%)	21 (24%)	**610**	**17%**
Unknown	47 (2%)	5 (1%)	1 (1%)	**53**	**1%**
Total	**2,934**	**670**	**89**	**3,693**	

Table 14. Fiscal Year 2016-17 Admissions: Summary of Sentence Length and Age at Admission by Primary Offense Type

Fiscal Year 2016-2017 Admissions: Average Sentence Length and Age At Admission by Primary Offense Type, General Population				
Primary Offense Type	**Total Offenses**	**Percentage of Total Inmates**	**Average Sentence Length in Years**	**Average Age at Admission**
Murder/Manslaughter	973	3%	24	33
Sexual/Lewd Behavior	1,605	6%	13	39
Robbery	1,769	6%	9	28
Violent, Other	4,455	15%	4	35
Burglary	4,462	16%	5	31
Theft/Forgery/Fraud	4,505	16%	2	37
Drugs	6,390	22%	3	37
Weapons	1,834	6%	3	32
Other	2,278	8%	3	38
Unknown	509	2%	N/A	N/A
Total	**28,780**			
Fiscal Year 2016-2017 Admissions: Average Sentence Length and Age At Admission by Primary Offense Type, Inmates 50+				
Primary Offense Type	**Total Offenses**	**Percentage of Inmates Age 50+**	**Average Sentence Length in Years**	**Average Age at Admission**
Murder/Manslaughter	119	3%	23	58
Sexual/Lewd Behavior	363	10%	15	59
Robbery	76	2%	11	55
Violent, Other	551	15%	4	56
Burglary	394	11%	6	55
Theft/Forgery/Fraud	720	19%	3	55
Drugs	852	23%	3	56
Weapons	149	4%	4	56
Other	416	11%	3	56
Unknown	53	1%	N/A	N/A
Total	**3,693**			

INMATE MORTALITY

It is estimated that two percent (540) of inmates admitted in FY 2016-17 will die while incarcerated and elderly offenders will account for 28 percent (149) of these inmates.

JUNE 30, 2017 POPULATION

DEMOGRAPHIC CHARACTERISTICS

At the end of FY 2016-17, 24 percent (22,985) of Florida's 97,794 general prison population was age 50 and older. Males accounted for 95 percent (21,742) of the June 30, 2017, elderly offender population and represented 24 percent of the total male inmate population. Female elderly offenders accounted for 5 percent (1,243) of inmates age 50 and over on June 30th and represented 18 percent (6,721) of the total female inmate population. The racial/ethnic demographics for the June 30, 2017, elderly offender population are as follows: 42 percent (9,746) were black, 54 percent (12,380) were white, 3 percent (739) were Hispanic, and 0.52 percent (98) were classified as other.

Elderly offenders between the ages of 50-59 represented 69 percent (15,826) of inmates age 50 and older. The average age of elderly offenders housed on June 30, 2017, was 58. Two 95-year-old offenders were the oldest males incarcerated on June 30, 2017. The oldest female offender was age 85.

Below Table 15 summarizes the demographics of the June 30, 2017, inmate population.

Table 15. Fiscal Year 2016-2017 FDC Elderly Offender June 30, 2017, Demographics

June 30, 2017 Population: Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	91,073 (93%)	69,331 (93%)	21,742 (95%)	**24%**
Female	6,721 (7%)	5,478 (7%)	1,243 (5%)	**18%**
Total	97,794	74,809	22,985	24%
Race/Ethnicity				
Black Female	1,959 (2%)	1,590 (2%)	369 (2%)	**19%**
Black Male	44,464 (45%)	35,237 (47%)	9,227 (40%)	**21%**
Hispanic Female	414 (0.42%)	346 (0.46%)	68 (0.30%)	**16%**
Hispanic Male	11,735 (12%)	9,253 (12%)	2,482 (11%)	**21%**
White Female	4,316 (4%)	3,521 (5%)	795 (3%)	**18%**
White Male	34,570 (35%)	24,619 (33%)	9,951 (43%)	**29%**
Other Female	32 (0.03%)	21 (0.03%)	11 (0.05%)	**31%**
Other Male	304 (0.31%)	222 (0.30%)	82 (0.36%)	**27%**
Total	97,794	74,809	22,985	24%
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	15,826 (69%)	**16%**		
60-69	5,685 (25%)	**6%**		
70+	1,474 (6%)	**2%**		
Total	22,985			

COMMITMENTS, PRIMARY OFFENSES, AND SENTENCES

Forty-five percent (10,352) of elderly offenders housed on June 30, 2017, had no prior FDC commitments. The remaining 55 percent (12,633) of elderly offenders were repeat offenders with one or more previous FDC commitments. The majority of the June 30, 2017, elderly offender population, 64 percent (14,729), was incarcerated for violent crimes, 17 percent (3,878) for property crimes, 12 percent (2,695) for drug offenses, and 7 percent (1,683) for crimes classified as other. When looking at specific offense types, 43 percent (9,918) of elderly offenders were serving sentences related to murder/manslaughter or sexual/lewd behavior. Elderly offenders sentenced for these crimes were more likely to be serving longer average sentences when compared to the general inmate population. The average sentence for murder/manslaughter for inmates age 50 and over is 43 years and 32 years for sexual/lewd behavior. Among the total June 30, 2017, population, the average length of sentence for murder/manslaughter was 36 years and 24 years for sexual/lewd behavior.

Among the June 30, 2017, population, the average age at the time of FDC admission for inmates age 50 and older was age 48. The average age at time of admission for inmates serving sentences related to theft/forgery/fraud, drugs, weapons, and other was over the age of 50. Of elderly offenders sentenced for offenses classified as violent/other and burglary, the average age at time of admission was over the age of 40.

Table 16 summarizes previous FDC commitments for inmates age 50 and over, while Table 17 summarizes primary offense types. Table 18 summarizes the average sentence length and age at time of admission by primary offense category for the June 30, 2017, population and elderly offenders.

Table 16. June 30 ,2017, Population: Summary of Previous FDC Commitments

June 30, 2017, Population: Previous FDC Commitments For Inmates Age 50 and Older	
Previous Number of Commitments	Total Number of Elderly Offenders
0	10,352 (45%)
1	3,606 (16%)
2	2,454 (11%)
3	2,004 (9%)
4+	4,536 (20%)
Unknown	33 (0.14%)

Table 17. June 30, 2017 Population: Summary of Primary Offense Categories

June 30, 2017, Population: Primary Offense Categories					
Primary Offense Type	50-59	60-69	70+	Total Inmates Age 50+	Percentage of Total Population Age 50+
Violent	9,337 (59%)	4,090 (72%)	1,302 (88%)	14,729	64%
Property	3,159 (20%)	669 (12%)	50 (3%)	3,878	17%
Drugs	2,070 (13%)	564 (10%)	61 (4%)	2,695	12%
Other	1,260 (8%)	362 (6%)	61 (4%)	1,683	7%
Total	15,826	5,685	1,474	22,985	

Table 18. June 30, 2017, Population: Summary of Sentence Length and Age at Admission by Primary Offense Type

June 30, 2017: Average Sentence Length and Age At Admission by Primary Offense Type, General Population				
Primary Offense Type	Total Offenses	Percentage of Total Inmates	Average Sentence Length in Years	Average Age at Admission
Murder/Manslaughter	14,888	15%	36	31
Sexual/Lewd Behavior	12,480	13%	24	38
Robbery	12,465	13%	21	28
Violent, Other	12,182	12%	13	33
Burglary	15,857	16%	13	32
Theft/Forgery/Fraud	7,257	7%	5	38
Drugs	14,176	14%	8	37
Weapons	4,168	4%	8	32
Other	4,319	4%	7	38
Total	97,792			

June 30, 2017: Average Sentence Length and Age At Admission by Primary Offense Type, Inmates 50+				
Primary Offense Type	Total Offenses	Percentage of Inmates Age 50+	Average Sentence Length in Years	Average Age at Admission
Murder/Manslaughter	4,877	21%	43	39
Sexual/Lewd Behavior	5,041	22%	32	47
Robbery	2,201	10%	37	39
Violent, Other	2,276	10%	26	49
Burglary	2,817	12%	26	46
Theft/Forgery/Fraud	1,613	7%	9	53
Drugs	2,695	12%	12	52
Weapons	490	2%	13	51
Other	975	4%	10	53
Total	22,985			

INMATE MORTALITY

FDC reported 386 inmate deaths in FY 2016-17, and elderly offenders accounted for 69 percent (267) of those deaths. It is estimated that 15 percent (14,576) of inmates housed on June 30, 2017, will die while incarcerated. Elderly offenders account for 50 percent (7,257) of those expected to die in prison.

HEALTH SERVICES UTILIZATION

Like their community counterparts, elderly offenders are highly susceptible to age related chronic illnesses and are more likely to have one or more chronic health conditions or disabilities. To address the complex health needs of elderly offenders, FDC provides comprehensive medical and mental health care. This includes special accommodations and programs, medical passes, skilled nursing services for chronic and acute conditions, and palliative care for terminally ill inmates.

In addition to routine care, inmates age 50 and over receive annual periodic screenings and dental periodic oral examinations. Elderly offenders are also screened for signs of dementia and other cognitive impairments as a part of FDC's health care screening process.[12]

MEDICAL AND MENTAL HEALTH CLASSIFICATIONS

Among the June 30, 2017, total inmate population, elderly offenders accounted for 11 percent (6,384) of inmates classified as M1, 41 percent (12,541) as M2, and 49 percent (3,729) as M3. Inmates age 50 and older represented the majority of all inmates with M4 and M5 classifications. Elderly offenders accounted for 69 percent (61) of M4 inmates and 79 percent (223) of M5 inmates.[13]

Inmates age 50 and older were more likely to have mental health classifications of S1. They accounted for 23 percent (18,464) of all inmates with S1 classifications. The remaining mental health classifications for elderly offenders are as follows: 21 percent (1,040) S2 classification, 26 percent (3,222) S3 classification, 31 percent (147) S4 classification, 16 percent (26) S5 classification, and 21 percent (29) S6 classification. [14]

A summary of health classifications is provided in Tables 19a and 19b below.[15]

[12]Florida Department of Corrections Report," Elderly Inmates, 2014-2015 Agency Annual Report." Web. 2 Nov. 2017.

[13] 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 requires care every six to twelve months; M3, inmate is followed in a CIC every three months; M4, inmate is followed in a CIC every three months and requires on-going 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.

[14] 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; 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).

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

Table 19a. June 30, 2017, Population: Medical Grade Classifications

June 30, 2017: Medical Grade Classifications							
Medical Grade	Total Population	Females		Males		Total Population 50+	Percentage of Total Population Age 50+
		15-49	50+	15-49	50+		
M1	58,761	2,448	200	49,929	6,184	6,384	11%
M2	30,398	2,555	884	15,302	11,657	12,541	41%
M3	7,611	214	138	3,668	3,591	3,729	49%
M4	88	5	1	22	60	61	69%
M5	284	4	11	57	212	223	79%
M9	36	35	0	1	0	0	0%
Unknown	616	217	9	352	38	47	8%
Total	97,794	5,478	1,243	69,331	21,742	22,985	24%

Table 19b. June 30, 2017, Population: Mental Health Grade Classifications

June 30, 2017: Mental Health Classifications							
Mental Health Grade	Total Population	Females		Males		Total Population 50+	Percentage of Total Population Age 50+
		15-49	50+	15-49	50+		
S1	79,262	3,063	678	57,735	17,786	18,464	23%
S2	4,963	599	119	3,324	921	1,040	21%
S3	12,271	1,734	434	7,315	2,788	3,222	26%
S4	474	10	4	317	143	147	31%
S5	166	6	2	134	24	26	16%
S6	137	8	0	100	29	29	21%
S9	80	16	2	50	12	14	18%
Unknown	441	42	4	356	39	43	10%
Total	97,794	5,478	1,243	69,331	21,742	22,985	24%

IMPAIRMENTS AND ASSISTIVE DEVICES

FDC assigns inmate impairment grades based on visual impairments, hearing impairments, physical limitations, and developmental disabilities. All FDC institutions have impaired inmate committees that develop, implement, and monitor individualized service plans for all impaired inmates.[16]

In FY 2016-17, there were 2,784 inmates with assigned impairment grades, with 72 percent (2,000) of assigned impairments being among elderly offenders. Inmates age 50 and older comprised 67 percent (249) of inmates with visual impairments, 70 percent (272) with hearing impairments, 74 percent (1,446) with physical impairments, and 51 percent (33) with developmental impairments.

Inmates requiring special assistance or assistive devices are issued special passes to accommodate their needs. FDC issued 23,702 passes for special assistance and/or assistive devices in FY 2016-17, and 45 percent (10,776) of those passes were issued to elderly offenders. Pushers (76 percent), hearing aids (73 percent), and wheelchair (71 percent) passes were the three most frequently issued passes for inmates age 50 and older.

[16] Florida Department of Corrections Report," Elderly Inmates, 2014-2015 Agency Annual Report." Web. 2 Nov. 2017.

A summary of impairments and assistive devices is provided in Tables 20 and 21.

Table 20. Summary of Fiscal Year 2016-2017 FDC Impairment Grade Assignments

Impairment Grade Assignments				
Impairments	15-49	50+	Total Population	Percentage of Total Population Age 50+
Visual	121	249	370	67%
Hearing	115	272	387	70%
Physical	516	1,446	1,962	74%
Developmental	32	33	65	51%
Total	784	2,000	2,784	

Table 21. Summary of Fiscal Year 2016-2017 Issued Assistive Devices/Special Passes

Assistive Devices/Special Passes				
Assistive Devices/Special Passes	15-49	50+	Total Population	Percentage of Total Population Age 50+
Adaptive Device Assigned	1,473	1,224	2,697	45%
Attendant Assigned	71	74	145	51%
Low Bunk Pass	10,901	8,545	19,446	44%
Guide Assigned	4	7	11	64%
Hearing Aid Assigned	23	61	84	73%
Pusher Assigned	34	105	139	76%
Prescribed Special Shoes	202	234	436	54%
Wheelchair Assigned	218	526	744	71%
Total	12,926	10,776	23,702	

HEALTH SERVICES UTILIZATION: SICK CALL, EMERGENCY CARE, AND CHRONIC ILLNESS CLINICS

FDC reported 460,923 sick call, emergency care, and chronic illness clinic encounters for FY 2016-17. Elderly offenders accounted for 37 percent (169,172) of health service encounters while comprising only 24 percent of the FDC total inmate population on June 30, 2017.

SICK CALL AND EMERGENCY CARE ENCOUNTERS

There were 451,183 sick call and emergency encounters in FY 2016-17. Elderly offenders accounted for 28 percent (124,566) of those encounters. Sick call represented the greatest proportion of those encounters. There were 96,175 (32 percent) sick call encounters for inmates age 50 and older.

Table 22 summarizes all sick call and emergency care encounters during FY 2016-17.

Table 22. Summary of Fiscal Year 2016-2017 Sick Call and Emergency Care Encounters

Sick Call and Emergency Care Encounters							
Encounter Type	Total Encounters	Females		Males		Total Encounters 50+	Percentage of Total
		15-49	50+	15-49	50+		
Sick Call	298,444	24,416	7,923	177,853	88,252	96,175	32%
Emergency	152,739	12,684	2,715	111,664	25,676	28,391	19%
Total	451,183	37,100	10,638	289,517	113,928	124,566	28%

CHRONIC ILLNESS CLINICS

In FY 2016-17, 65,654 inmates were enrolled in CICs, and inmates age 50 and older accounted for 48 percent (31,542) of enrolled inmates. Elderly offenders accounted for 50 percent or more of inmates in five clinics. Inmates age 50 and older comprised 50 percent or more of inmates assigned to the cardiovascular, endocrine, renal, miscellaneous, and oncology clinics. Additionally, elderly offenders accounted for 57 percent (9,450) of 16,459 inmates enrolled in multiple clinics. Table 23 summarizes CIC enrollment.

Table 23. Summary of Fiscal Year 2016-2017 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+	Percentage of Total Assigned Inmates Age 50+
Cardiovascular	27,792	17	1,392	4,517	7,139	8,978	4,377	1,372	14,727	53%
Endocrine	9,248	9	491	1,404	2,249	3,027	1,537	531	5,095	55%
Gastrointestinal	9,507	1	997	2,426	1,846	2,685	1,412	140	4,237	45%
Immunity	2,780	3	221	536	825	949	227	19	1,195	43%
Renal	9	0	0	0	1	5	3	0	8	89%
Miscellaneous	2,790	2	241	459	564	785	500	239	1,524	55%
Neurology	3,293	11	541	1,014	834	660	180	53	893	27%
Oncology	810	2	31	78	103	246	222	128	596	74%
Respiratory	7,679	70	1,299	1,756	1,637	1,729	870	318	2,917	38%
Tuberculosis	1,746	28	505	498	365	243	93	14	350	20%
Total	65,654	143	5,718	12,688	15,563	19,307	9,421	2,814	31,542	48%

There were 135,535 reported CIC encounters during the fiscal year and inmates age 50 and older accounted for 49 percent (67,045) of CIC visits. In five clinics, elderly offenders accounted for 50 percent or more of visits in FY 2016-17. Table 24 provides a breakdown of CIC encounters for elderly offenders by clinic.

Table 24. Summary of Fiscal Year 2016-2017 Chronic Illness Clinic Encounters

Chronic Illness Clinic Encounters					
Chronic Illness Clinic	Total Number of Clinic Visits	Females 50+	Males 50+	Total Encounters 50+	Percentage of Total Encounters Population Age 50+
Cardiovascular	54,629	1,724	28,589	30,313	55%
Endocrine	19,197	782	10,212	10,994	57%
Gastrointestinal	17,319	537	8,026	8,563	49%
Immunity	7,686	204	3,231	3,435	45%
Renal	19	0	16	16	84%
Miscellaneous	4,955	164	2,716	2,880	58%
Neurology	6,138	170	1,606	1,776	29%
Oncology	1,772	55	1,300	1,355	76%
Respiratory	14,594	547	5,481	6,028	41%
Tuberculosis	9,226	76	1,606	1,682	18%
Total	135,535	4,259	62,783	67,042	49%

HOUSING ELDERLY OFFENDERS

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. Inmates who have visual or hearing impairments, require walkers or wheelchairs, or who have more specialized needs are assigned to institutions designated for assistive devises for ambulating.

Listed below are FDC institutions that currently have the capacity to provide specialized services to elderly offenders.[17]

- **Reception and Medical Center (RMC):** has an on-site 120-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 (SFRC):** SFRC's F-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. Additionally, the South Unit has 487 beds for inmates age 50 and older
- **Union Correctional Institution:** has 156 beds designated for inmates age 50 and older
- **Transitional Care Units:** FDC has 10 Transitional Care Units (TCU), inpatient mental health units where elderly offenders with mental and cognitive impairments receive care

Out of 86 major FDC correctional institutions and facilities, inmates age 50 and older represented 20 percent or more of the total institution population at 39 institutions (45 percent). Table 25 displays the ten institutions with the greatest concentration of inmates age 50 and older.

Table 25. FDC Institutions with the Greatest Concentration of Elderly Offenders

FDC Institutions with the Greatest Concentration of Elderly Offenders			
Institutions	**Institution Total Population**	**Total 50+ Population**	**Percentage of Inmates 50+**
Union CI	1,649	**1,351**	**82%**
Zephyrhills CI	964	**382**	**40%**
Everglades CI	1,867	**720**	**39%**
Dade CI	1,565	**594**	**38%**
South Florida Reception Center	1,913	**708**	**37%**
Hardee CI	1,312	**446**	**34%**
South Bay CF	1,941	**610**	**31%**
Hernando CI	389	**122**	**31%**
Okeechobee CI	1,701	**507**	**30%**
Tomoka CI	1,634	**486**	**30%**

[17]Florida Department of Corrections Report," Elderly Inmates, 2014-2015 Agency Annual Report." Web. 2 Nov. 2017.

CHARACTERISTICS OF FLORIDA'S ELDERLY OFFENDERS

Based on the data presented in this report, the following facts summarize the status of elderly offenders housed in FDC institutions during FY 2016-17:

- Elderly offenders represented 24 percent of Florida's 97,794 general prison population.
- Elderly offenders entering FDC in FY 2016-17 were more likely to be white, male, age 55, first-time offenders, and incarcerated for a violent crime.
- Elderly offenders housed in FDC institutions on June 30, 2017, were more likely to be white, male, age 58, repeat offenders with one or more FDC admissions, and incarcerated for a violent crime.
- Elderly offenders accounted for the majority of inmates with assigned impairments, and 45 percent of assistive devices and special passes were issued to inmates age 50 and older.
- Inmates age 50 and older consumed 37 percent 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 50 percent or more of all inmates in the cardiovascular, endocrine, renal, miscellaneous, and oncology clinics.
- Elderly offenders represented 20 percent or more of the total population at 39 FDC institutions and facilities.
- FDC estimates that 50 percent of elderly offenders housed on June 30, 2017, are expected to die in prison.

CMA RECOMMENDATIONS

Previous CMA reports have included numerous recommendations for addressing Florida's elderly offender population. Within the resources available, the Department has taken steps to develop programs that address the needs of older inmates such as consolidation of older inmates at certain institutions and palliative care units. While FDC has taken steps to better meet the needs of Florida's elderly offender population, additional system, policy, and programmatic changes are needed. Detailed below are the CMA's recommendations for addressing Florida's elderly offender population.

EXPAND THE USE OF CONDITIONAL MEDICAL RELEASE

In 1992, the Florida Legislature created the Conditional Medical Release program. The program is a discretionary release program that allows terminally ill or permanently incapacitated inmates to be released under supervision. The program is administered through the Florida Commission on Offender Review. According to the Commission's 2016 Annual Report, conditional medical release was granted for 29 of 51 (57 percent) inmates recommended by FDC for release. Over the last three fiscal years, FDC has recommended 107 inmates for release, and the commission has granted release to 52 (49 percent) of those recommended.[18]

As of June 30, 2014, the ten oldest male inmates in FDC custody range in age from 90-95 years, and for female offenders 76-85 years of age. The designations for inmates that are eligible for conditional medical release are those deemed to be terminally ill or permanently incapacitated. According to § 947.149 F.S., an inmate is deemed to be permanently incapacitated if they have a condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, renders the inmate permanently and irreversibly physically incapacitated to the extent that the inmate does not pose a threat to themselves or others. It can be reasoned that there are elderly offenders within FDC that could meet this criterion.

Several states have adopted specific programs for early release of elderly offenders or compassionate release programs. In 2010, the Vera Institute conducted a statutory review of geriatric release policies in correctional systems. It was reported that 15 states and the District of Columbia have some type of compassionate, medical, or geriatric release policy.[19] Legislation in California was passed in October 2017 that established an Elderly Parole Program for inmates who are at least 60 years old and have served a minimum of 25 years of continuous incarceration. While release policies such as these can significantly help to reduce the numbers of incarcerated elderly offenders, they are often underutilized and have complicated procedures and review processes.

Despite the challenges associated with compassionate release, the CMA recommends that FDC conducts a feasible study to determine how many offenders would meet the designations outlined in § 947.149 F.S. and determine potential costs savings of increasing the use of conditional medical release, without compromising public safety. Additionally, the CMA recommends that FDC works the Florida Commission on Parole to identify and address procedural barriers that impact inmates being able to apply for conditional medical release and being approved for release.

[18] "2016 Annual Report - Florida Commission on Offender Review." Https://www.fcor.state.fl.us/.
[19] "It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release." Vera Institute of Justice, Center on Sentencing and Corrections, www.vera.org/publications.

INCREASED PREVENTATIVE SCREENINGS

The average age of a male inmate entering FDC in FY 2016-17 was age 35. Because of mandatory minimum sentences, sentence enhancements, and statutory time-served requirements, inmates in Florida serve significantly more time in prison than inmates in other states. Average sentence lengths for inmates have grown 22 percent over the last decade from 59.5 months to 72.9 months.[20] Given the average age of inmates entering FDC, it can be expected that inmates will eventually become members of Florida's elderly offender population.

As discussed earlier in this report, many incarcerated persons experience accelerated aging due to poor health and limited health care access. Inmates between the ages of 40-49 accounted for 24 percent of inmates enrolled in CICs during FY 2016-17. Given the number of inmates aged 40-49 enrolled in chronic illness clinics, it can be assumed that these inmates will have increasing health care needs as they age. Preventive health care services can reduce the risk of worsening disease complications and prevent the development of diseases.

FDC policy requires that inmates receive annual preventative screening. Inmates under the age of 50 receive periodic health screenings every 5 years while inmates age 50 and over are screened annually. Due to inmates being at higher risk for accelerated aging and poor health outcomes, the CMA recommends that FDC explore the feasibility of providing periodic screenings every three years beginning at age 40.

In addition to investigating the feasibility of increasing the frequency of preventive health screenings, the CMA also recommends that FDC review their current mental health policies and procedures to ensure processes are in place to detect age-related declines in cognitive functioning.

GERIATRIC SPECIFIC TRAINING

The needs of elderly offenders are often different than those of younger offenders. Elderly offenders are also more likely to develop mobility impairments, hearing and vision loss, and cognitive impairments including dementia. They tend to suffer from illnesses that are often chronic in nature and progressive, requiring extended treatment and recovery time. Providing care and treatment for these illnesses often involves surgeries, medication therapies, and specialized medical treatments from a variety of medical specialists.[21]

Given the complex needs of elderly offenders, it is essential that correctional and health services staff are knowledgeable of the changing physical and mental health needs of this population. The CMA recommends that FDC continue efforts to develop and enhance geriatric training programs. These trainings should address common health conditions, age-related physical impairments, age-related cognitive impairments, mental health, and the psychosocial needs of elderly offenders.

[20] Contracted Study: An Examination of Florida's Prison Population Trends, Crime and Justice Institute, www.oppaga.state.fl.us/Summary.aspx?reportNum=17-CRJ.
[21] Fellner, Jamie, and Patrick Vinck. Old behind Bars: The Aging Prison Population in the United States. New York, NY: Human Rights Watch, 2012. Print.