State of Florida Correctional Medical Authority

2014-2015 Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons

DECEMBER 2015

State of Florida Correctional Medical Authority

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

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

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

Katherine E. Langston, MD
Representative
Florida Medical Association

Ryan D. Beaty
Representative
Florida Hospital Association

Joyce A. Phelps, ARNP
Representative
Nursing

Lee B. Chaykin
Representative
Health Care Administration

Harvey R. Novack, DDS
Representative
Dentistry

Leigh-Ann Cuddy, MS
Representative
Mental Health

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

December 30, 2015

The Honorable Rick Scott
Governor of Florida

The Honorable Andy Gardiner, President
The Florida Senate

The Honorable Steve Crisafulli, Speaker
Florida House of Representatives

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

In accordance with § 945.6031, Florida Statutes (F.S.), I am pleased to submit the Correctional Medical Authority's (CMA) 2014-15 Annual Report. This report summarizes the CMA's activities during the fiscal year and details the work of the CMA's governing Board, staff, Quality Management Committee, and Budget and Personnel Workgroup 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) 2014-15, the CMA conducted on-site physical and mental health surveys of 16 major correctional institutions, which included one reception center and three institutions with annexes or separate units. Additionally, CMA staff conducted 47 corrective action plan assessments based on findings from this and the previous year's surveys.

Pursuant to § 944.8041 F. S., Section 2 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 2014-15 and the elderly population housed in Florida Department of Corrections (FDC) institutions on June 30, 2015. 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

Jane Holmes-Cain, LCSW
Executive Director

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Introduction

About the Correctional Medical Authority

The Correctional Medical Authority (CMA) was created in July 1986 while Florida's prison health care system was under the jurisdiction of the federal court as a result of litigation that began in 1972. Costello v. Wainwright (430 U.S. 57 (1977)) was a class-action lawsuit brought by inmates alleging that their constitutional rights had been violated by inadequate medical care, insufficient staffing, overcrowding, and poor sanitation. The Florida Legislature enacted legislation that created the CMA based on recommendations of a Special Master and Court Monitor, appointed by the federal courts, to ensure that an "independent medical authority, designed to perform the oversight and monitoring functions that the court had exercised" be established. [1]

The CMA was created as part of the settlement of the Costello case and continues to serve as an independent monitoring body to provide oversight over the systems in place to 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]

From 1986 until July 1, 2011, 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. 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 the Senate, and were sent to the Governor for approval. The Governor vetoed a conforming bill which would have eliminated the CMA from statute and requested that the agency's funding be restored. The Legislature restored the agency's funding effective July 1, 2012. The CMA was reestablished, and is now housed within the administrative structure of the Executive Office of the Governor as an independent state agency.

CMA Structure and Responsibilities

The CMA is composed of a seven-member volunteer board, appointed by the Governor and confirmed by the Florida Senate for a term of four years, and is comprised of health care professionals from various administrative and clinical

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

[2] Ibid.

disciplines. The Board directs the activities of the CMA's staff. The CMA has a staff of six full-time employees and utilizes independent contractors to complete triennial health care surveys at each of Florida's correctional institutions.

As an independent agency, the CMA's primary role is to provide oversight and monitoring of FDC's health care delivery system to ensure adequate standards of physical and mental health care are maintained in Florida's correctional institutions. FDC contracts with two private companies, Wexford Health Sources, Inc. and Corizon, Inc., to provide comprehensive health care services for inmates pursuant to Department expectations and standards. 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.

2014-2015 Annual Report

The CMA is required by § 945.6031 F.S. to provide an annual report detailing the current status of FDC's health care delivery system. This report details CMA's activities during fiscal year (FY) 2014-15, provides an update on the status of FDC's health care services delivery system, summarizes findings of institutional surveys, provides an update regarding CMA's corrective action plan process, and provides CMA's overall assessment and recommendations regarding FDC's health care delivery system.

Key CMA Activities in Fiscal Year 2014-2015

CMA activities during (FY) 2014-15 focused on meeting the agency's statutorily required responsibilities. Key agency activities are summarized below.

CMA Board Meetings

Well-qualified board members with relevant experience and interest are essential to the effectiveness of CMA activities. In FY 2014-15, the CMA Board held nine public meetings. During board meetings, members received updates regarding institutional surveys and corrective action plan (CAP) assessments and reports from FDC's Office of Health Services (OHS) staff and FDC contracted providers regarding health services. CMA board meetings provided an opportunity for members to voice concerns related to FDC's health care delivery system and/or offer recommendations.

Health Care Standards Review

OHS is responsible for establishing health care standards for the delivery of the Department's health care services. These standards include guidelines related to the management of FDC's health care system and the provision of health services to inmates, health care policies and plans, quality management systems and procedures, Health Services Bulletins (HSB), and treatment protocols. Prior to the adoption of a health care standard, FDC is required to submit the proposed standard to the CMA for review. CMA staff review all proposed revisions to FDC's health care standards to determine if they conform to community standards of care, and when required, standards are forwarded to CMA board members and/or contracted licensed health care professionals for review and input.

During FY 2014-15, the CMA reviewed and made recommendations, when necessary, for 92 FDC policies and procedures. This included two FDC Nursing Manual updates, four Reception and Medical Center (RMC) policies, 13 FDC policies, and 73 HSBs.

Legislative Policy Review

During the 2015 legislative session, Senate Bill (SB) 7020, a comprehensive reform bill related to corrections, was filed. SB 7020 included provisions that would require FDC, in consultation with the CMA, to review inmate grievance procedures at each correctional institution or facility, and publish the joint findings of inmate grievance reviews on both entities' websites. SB 7020 proposed increasing the frequency of CMA surveys from triennially to every 18 months.

CMA staff were asked to submit an analysis of the bill regarding the potential effects and fiscal impact of the proposed provisions. Based on the analysis, the CMA concluded that the agency could review inmate grievance procedures at each correctional institution and private correctional facilities during regularly scheduled surveys, and determined there would be no fiscal impact. Additionally, the CMA concluded that the proposed increase in surveys would require additional

funding of $880,000 for staff, contracted surveyors (licensed health care professionals), travel expenditures, and administrative costs.

House Bill (HB) 7131 was filed as a companion bill to SB 7020. The bill did not include any proposed provisions related to the CMA. During the legislative session, both bills passed their respective chambers, but agreement could not be reached to reconcile the bills. As a result, neither bill was passed.

Inmate Correspondence

The CMA receives written correspondence from inmates and/or their families, requesting assistance resolving health care related issues. Monitoring inmate correspondence is an important risk management function for the CMA. As part of the CMA's mission of ensuring adequate standards of physical and mental health care are maintained at all correctional institutions, CMA staff reviews, triages, and responds to inmate correspondence. The CMA is not authorized to direct staff in FDC institutions or require that specific actions be taken by the Department, therefore, inmate letters are forwarded to OHS for investigation and response. CMA staff tracks the outcomes of these letters.

There was a significant increase in the number of inmate letters received by the CMA during the fiscal year. In FY 2013-14, the CMA responded to 24 letters regarding inmates at 11 correctional institutions. In FY 2014-15, CMA staff responded to 65 letters concerning inmates at 29 correctional institutions.

Quality Management Committee

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

During FY 2014-15, the QMC primarily focused their efforts on evaluating the effectiveness of FDC's mortality review process. All in-custody deaths, except executions, require a mortality review. Contracted health care providers conduct self-reviews of inmate mortalities to determine the appropriateness of care. The review is submitted to OHS, which determines if there were any quality of care issues not identified by the contractor. The QMC then evaluates this review of mortality cases to facilitate improvements in inmate health care.

The QMC met three times during the fiscal year and reviewed eight mortality cases. The reviews assessed whether the mortality review process effectively identified any deficiencies in health care that may have contributed to death, and determined whether appropriate action was taken to prevent deficiencies from happening in the future. It is important to note that the QMC's review of mortality cases is based on a non-random sample, and the intent of the review is not to generalize review findings to mortality cases as a whole. The QMC's mortality review process provides an opportunity to

identify and correct clinical and health care management deficiencies that can lead to improvements across FDC's health care system. The overall goal of the QMC's mortality review process is to facilitate opportunities for improved care and outcomes.

Detailed below are two examples of quality management issues that were identified and addressed as a result of the QMC's morality review process:

1. The QMC cited incomplete mortality review documentation as a common issue. The Committee suggested that FDC make revisions to mortality review forms to improve the accuracy and completeness of information. Also, a recommendation was made to provide training to health service contractors related to writing clinical summaries. In response to the QMC's recommendations, OHS made revisions to mortality review documents and created supplemental training material and a checklist for institutional staff to reference while completing mortality review documentation.
2. The committee made a recommendation that FDC revise its abdominal pain nursing protocol to ensure better assessment of abdominal related complaints. Subsequently, the protocol was revised to include the QMC's recommendations.

Budget and Personnel Workgroup

CMA's Budget and Personnel Workgroup reviews OHS's legislative budget request (LBR), provides recommendations regarding OHS funding to the Governor and Legislature, and reviews FDC's health care expenditures and cost management processes. The workgroup is comprised of a group of two citizen volunteers and a CMA board member, all who have expertise in hospital administration and government budgeting and accounting.

In FDC's FY 2014-15 LBR, the Department requested $356,808,439 for health services. The request included a price level increase of $1,331,495 for health service drug costs. Prior to this request, the Department had not requested a price level increase because drug costs were offset by cost savings from several factors: FDC's multi-year project to reduce pharmaceutical costs, the statewide implementation of the 340b Specialty Care (HIV/STD) Program, revisions of the mental health formulary (using less expensive brands), increased clinical oversight, and maximized clinician prescribing practices. However, despite FDC's cost saving measures, a price level increase was needed due to continuing drug price increases and the lack of remaining areas that could be targeted for major cost saving initiatives. Therefore, FDC requested a 5 percent increase based on the Consumer Price Index for medical goods, which includes drugs. The CMA believed this request was reasonable and submitted a letter to the Governor and Legislature recommending approval of FDC's request.

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 CMA contracts with a variety of licensed community and public health care practitioners, including physicians, psychiatrists, dentists, nurses,

psychologists, and other licensed mental health professionals to conduct these surveys. The survey process includes a clinical review of the physical, dental, and mental health care provided at each institution, as well as tours of facilities and interviews with inmates, medical staff, and security personnel.

To determine which institutions will be surveyed each year, staff analyzes data from FDC's Offender Based Information System (OBIS), institutional demographics, inmate medical and mental health grades[3], and the length of time since each institution's previous survey. Efforts are made to ensure a fair representation of institutions are selected from each region of the state. In FY 2014-15, 16 institutions were surveyed, including one female and 15 male institutions, one reception center, and three institutions with main and annex units, with each unit being surveyed separately. In total, the CMA conducted 20 surveys during the fiscal year.

The institutional survey process is designed to assess whether inmates in FDC's correctional institutions have the ability to access medical, dental, and mental health care, and to evaluate the clinical adequacy of the resulting care. To determine the adequacy of care, the CMA conducts clinical records reviews that assess the timeliness and appropriateness of both routine and emergency physical and mental health services. Additionally, administrative processes, institutional systems for informing inmates of their ability to request and receive timely care, and operational aspects of health care services are examined.

Uniform survey tools, based on OHS policy and community health care standards, are used during records reviews to evaluate specific areas of physical and mental health care service delivery. CMA surveyors use these tools to assess compliance with commonly accepted policies and practices of medical record documentation. The CMA employs a record selection methodology, which ensures a 15 percent margin of error and an 80 percent confidence level. Records are selected in accordance with the size of the clinic or assessment area being assessed. CMA surveyors review selected records, and at the conclusion of each review, CMA staff analyzes each survey tool to determine if there are deficiencies that meet the criteria for a finding and require corrective action.

In FY 2014-15, 725 institutional survey findings were identified. Of those findings, 439 (60 percent) were reportable physical health findings, and 286 (40 percent) were mental health findings. The results of CMA surveys were formally

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

Mental health grades reflect the level of psychological treatment inmates require. Grades range from S1, requiring the least level of psychological treatment, to S6, requiring the highest level of treatment. Mental health grades are as follows: S1, inmate requires routine care, S2, Inmate requires ongoing services of outpatient psychology (intermittent or continuous), S3, inmate requires ongoing services of outpatient psychiatry (case management, group and/or individual counseling, as well as psychiatric or psychiatric ARNP care), S4, inmates are assigned to a Transitional Care Unit (TCU), S5, inmates are assigned to a Crisis Stabilization Unit (CSU), and S6, inmates are assigned to a corrections mental health treatment facility (MHTF).

reported to the Secretary of Corrections. Detailed reports for each institutional survey can be accessed on the CMA's website at http://www.flgov.com/correctional-medical-authority-cma.

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

Table 1. Summary of Fiscal Year 2011-2015 Institutional Surveys

Summary of Fiscal Year 2014-2015 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
Sumter CI	M1-M3	S1-S2	1701	1268	Yes	No	Yes	14	3
Marion CI	M1-M3	S1-S2	1383	1346	Yes	No	Yes	32	5
Lake CI	M1-M5	S1-S6	1252	1105	Yes	Yes	Yes	24	48
Tomoka CI	M1-M4	S1-S3	1769	1648	Yes	No	Yes	30	20
NWFRC-Main	M1-M5	S1-S3	1930	1271	Yes	No	Yes	43	8
NWFRC-Annex*	M1-M5	S1-S3	1484	1366	Yes	No	Yes	34	15
Okeechobee CI	M1-M5	S1-S2	1918	1756	Yes	No	Yes	10	3
Moore Haven CF	M1-M4	S1-S3	1008	985	Yes	No	Yes	12	18
Wakulla CI-Main	M1-M5	S1-S2	1456	1280	Yes	No	No	27	16
Wakulla CI-Annex	M1-M5	S1-S3	2037	1963	No	No	Yes	30	11
Avon Park CI	M1-M3	S1-S2	1607	1557	Yes	No	Yes	12	3
Polk CI	M1-M4	S1-S2	1780	1720	Yes	No	Yes	10	13
Lowell CI-Main*	M1-M4	S1-S3	1440	1050	Yes	No	No	46	28
Lowell CI-Annex*	M1-M4	S1-S3	1500	1404	Yes	No	Yes	54	32
Liberty CI	M1-M3	S1-S2	2359	2151	Yes	No	Yes	15	8
Charlotte CI	M1-M5	S1-S5	1533	1388	Yes	Yes	Yes	9	31
Hamilton CI-Main	M1-M3	S1-S2	1177	1121	No	No	Yes	12	8
Hamilton CI-Annex	M1-M3	S1-S2	1408	1433	Yes	No	Yes	8	9
Holmes CI	M1-M3	S1-S2	1513	1445	Yes	No	Yes	8	0
Baker CI	M1-M3	S1-S2	1870	1503	Yes	No	Yes	9	7
								439	286

Notes: Lowell CI Main and Annex house female offenders. Reception services are provided at NWFRC-Annex.

Corrective Action Plan (CAP) Assessments

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

CMA staff completed 47 CAP assessments in FY 2014-15. This included three CAP assessments for institutions surveyed in FY 2012-13, 32 CAP assessments for institutions surveyed in FY 2013-14, and 12 CAP assessments for institutions surveyed in FY 2014-15. At the end of the fiscal year, all CAPs from FY 2012-13 were closed, 11 CAPS from FY 2013-14 were closed, and two CAPS from FY 2014-15 were closed. As of December 2015, five additional CAPs from FY 2014-15 were closed, and at least one CAP assessment has been completed for all institutions surveyed during FY 2014-15. A summary of CAP assessments is provided in Table 2.

Table 2. Summary of Corrective Action Plan Assessments

Institution	Fiscal Year	Total Physical Health Findings	Total Mental Health Findings	Number of CAP Assessments	Open or Closed
Zephyrhills CI	12-13	10	7	4	Closed 11/13/14
Union CI	12-13	21	31	3	Closed 9/23/14
Jefferson CI	13-14	73	34	5	Closed 6/26/15
Cross City CI	13-14	11	5	3	Closed 9/15/14
Suwanee CI-Main	13-14	7	19	6	Open
Suwanee CI-Annex	13-14	25	19	6	Open
Santa Rosa CI-Main	13-14	10	9	2	Closed 5/2/2014
Santa Rosa CI-Annex	13-14	38	9	4	Closed 5/22/15
SFRC-Main	13-14	47	24	5	Open
SFRC-South	13-14	23	0	3	Closed 1/29/15
Martin CI	13-14	42	13	6	Open
Homestead CI	13-14	20	2	3	Closed 12/23/14
Taylor CI-Main	13-14	49	27	4	Open
Taylor CI-Annex	13-14	45	22	3	Closed 5/15/15
CFRC-Main	13-14	26	25	3	Closed 3/16/15
CFRC-East	13-14	27	8	4	Closed 6/15/15
Hernando	13-14	33	13	2	Closed 1/5/15
FSP-Main	13-14	16	8	2	Closed 2/13/15
FSP-West	13-14	26	3	2	Closed 2/13/15
Gadsden CF	13-14	38	19	2	Closed 4/21/15
South Bay CF	13-14	10	4	4	Open
Sumter CI	14-15	14	3	3	Closed 6/29/15
Marion CI	14-15	31	5	2	Closed 4/17/15
Lake CI	14-15	24	48	2	Open
Tomoka CI	14-15	30	20	2	Open
NWFRC-Main	14-15	43	8	3	Open
NWFRC-Annex	14-15	34	15	3	Open
Okeechobee CI	14-15	10	3	3	Open
Moore Haven CF	14-15	12	18	3	Closed 11/24/15
Wakulla CI-Main	14-15	27	16	2	Open
Wakulla CI-Annex	14-15	30	11	2	Open
Avon Park CI	14-15	12	3	1	Closed 7/15/15
Polk CI	14-15	10	13	1	Closed7/2/15
Lowell CI-Main*	14-15	46	28	2	Open
Lowell CI-Annex*	14-15	54	32	2	Open
Liberty CI	14-15	15	8	1	Closed 12/9/15
Charlotte CI	14-15	9	31	1	Open
Hamilton CI-Main	14-15	12	8	1	Open
Hamilton CI-Annex	14-15	8	9	1	Open
Holmes CI	14-15	8	0	1	Closed 12/2/15
Baker CI	14-15	9	7	1	Open

The data included in this summary reflects the total number of CAP assessments completed through December 2015.

Summary of Fiscal Year 2014-2015 Institutional Survey Findings

The institutional survey process evaluates the quality of FDC's physical and mental health services, identifies significant deficiencies in care and treatment, and assesses institutional compliance with FDC 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 health care standards and required practices are followed across institutions.

Institutional survey reports provide detailed information that includes 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 include only findings noted at three or more institutions, with the exception of findings for inpatient mental health services, psychiatric restraints, and reception services, as these assessment areas were only applicable for select institutions.

Physical Health Findings

Physical health surveys assess inmate access to care, the provision and adequacy of episodic, chronic disease, and dental care, and medical administrative processes and procedures. The following areas are evaluated during the physical health portion of surveys: chronic illness clinics, consultation requests, dental systems, emergency care, infection control, infirmary care, inmate requests, institutional tour, intra-system transfers, medication administration, periodic screenings, pharmacy, pill line administration, and sick call. In FY 2014-15, there were 439 physical health findings, which represented 60 percent of total survey findings.

Based on an analysis of aggregate survey data, the majority (56 percent) of physical health survey findings were related to chronic illness clinics (CIC). The areas of infirmary care, consultations, dental systems, institutional tour, intra-system transfers, and periodic screenings also received significant numbers of findings. There were no identified findings in the area of infection control and reception processes.

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.	248 (56%)	20 (100%)
Consultation Requests	Assesses processes for approving, denying, scheduling services, and follow-up for specialty care services.	30 (7%)	18 (90%)
Dental Review	Assesses the provision of dental care and systems.	26 (6%)	15 (75%)
Emergency Care	Assesses emergency care processes for addressing urgent/emergent medical complaints.	9 (2%)	7 (35%)
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.	42 (10%)	11 (61%)*
Institutional Tour	Tour of medical, dental, and housing facilities.	25 (5%)	13 (65%)
Intra-System Transfers	Assesses systems and processes for ensuring continuity of care for inmates transferred between institutions.	14 (3%)	8 (40%)
Medical Inmate Requests	Assesses systems and processes for reviewing, approving, and denying physical health related inmate requests.	7 (2%)	4 (50%)*
Medication Administration	Assesses the administration of medication and clinical documentation related to medication practices.	4 (0.91%)	4 (20%)
Periodic Screenings	Assesses the provision of periodic physical examinations and health screenings.	14 (3%)	8 (40%)
Pharmacy Services	Assesses compliance with FDC policies and procedures for medication storage, inventory, and disposal.	3 (1%)	3 (15%)
Pill Line Administration	Assesses medication dispensing practices to ensure proper nursing practices and polices are followed.	3 (1%)	3 (15%)
Reception Process	Assesses compliance with FDC policies and procedures for physical health screenings of new inmates.	0 (0%)	0 (0%)
Sick Call	Assesses sick call processes to address acute and non-emergency medical complaints and inmate access to sick call.	7 (2%)	7 (35%)

Infirmary services were not provided at Wakulla CI-Annex and Hamilton CI-Annex.

****Medical Inmate Request reviews were completed for eight surveys.***

Table 4. Summary of Physical Health Survey Findings by Institution

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Systems	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Other Administrative Findings	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Total Findings
Sumter CI	6	1	0	0	0	5	0	0	N/A	0	0	0	0	1	N/A	1	**14**
Marion CI	22	3	1	1	0	3	1	1	N/A	0	0	0	0	0	N/A	0	**32**
Lake CI	14	1	3	0	0	2	1	0	N/A	0	0	3	0	0	N/A	0	**24**
Tomoka CI	14	1	2	1	0	6	1	1	N/A	0	0	2	0	1	N/A	1	**30**
NWFRC-Main	24	2	3	1	0	8	2	2	N/A	0	0	0	0	0	N/A	1	**43**
NWFRC-Annex	25	6	1	0	0	0	0	0	N/A	1	0	0	0	0	0	1	**34**
Okeechobee CI	5	2	1	0	0	2	0	0	N/A	0	0	0	0	0	N/A	0	**10**
Moore Haven CF	7	2	0	1	0	0	0	1	N/A	0	0	0	0	0	N/A	1	**12**
Wakulla CI-Main	22	1	1	0	0	2	1	0	N/A	0	0	0	0	0	N/A	0	**27**
Wakulla CI-Annex	19	1	1	3	0	N/A	0	1	N/A	1	0	2	1	0	N/A	1	**30**
Avon Park CI	4	1	3	0	0	3	1	0	N/A	0	0	0	0	0	N/A	0	**12**
Polk CI	6	0	0	0	0	0	2	1	N/A	0	0	1	0	0	N/A	0	**10**
Lowell CI- Main	24	0	1	1	0	5	2	4	2	1	5	1	0	0	N/A	0	**46**
Lowell CI-Annex	26	2	2	1	0	5	6	3	3	1	1	3	1	0	N/A	0	**54**
Liberty CI	6	1	3	0	0	1	3	0	0	0	0	1	0	0	N/A	0	**15**
Charlotte CI	5	1	1	0	0	0	2	0	0	0	0	0	0	0	N/A	0	**9**
Hamilton CI-Main	5	2	1	0	0	N/A	1	0	1	0	1	1	0	0	N/A	0	**12**
Hamilton CI-Annex	5	1	1	0	0	0	0	0	0	0	0	0	0	0	N/A	1	**8**
Holmes CI	3	1	1	0	0	0	0	0	1	0	0	0	1	1	N/A	0	**8**
Baker CI	6	1	0	0	0	0	2	0	0	0	0	0	0	0	N/A	0	**9**
Total Findings	**248**	**30**	**26**	**9**	**0**	**42**	**25**	**14**	**7**	**4**	**7**	**14**	**3**	**3**	**0**	**7**	**439**

Chronic Illness Clinics

Chronic illness refers to diseases and/or conditions that are ongoing or recurring. FDC maintains the following CICs: cardiovascular, endocrine, gastrointestinal, immunity, miscellaneous, neurology, oncology, respiratory, and tuberculosis (TB). Health Services Bulletins (HSB) standards outline detailed clinical protocols that provide guidelines for disease management. Inmates are routinely seen in CICs and may be enrolled in multiple clinics. The minimum frequency of CIC visits are determined by medical grade classification or, more frequently, as determined by the clinician.

Clinical record reviews are completed for all CIC areas to assess compliance with chronic illness clinical protocols as outlined in HSB standards. 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	31 (13%)	14 (70%)
Endocrine	44 (18%)	17 (85%)
Gastrointestinal	32 (13%)	15 (75%)
Immunity	15 (6%)	9 (45%)
Miscellaneous	15 (6%)	10 (50%)
Neurology	28 (11%)	15 (75%)
Oncology	24 (10%)	12 (60%)
Respiratory	18 (7%)	14 (70%)
Tuberculosis	34 (14%)	13 (65%)

Marion CI, Liberty CI, Holmes CI, and Hamilton CI-Main do not have immunity clinics and Hamilton CI-Main does not have a neurology clinic.

In total, 248 CIC findings were identified across all 20 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, missing vaccinations, and missing or incomplete referrals for specialty care.

Below are common CIC findings noted for specific clinics:

- In the endocrine clinic, records reviews indicated that fundoscopic examinations were not completed annually, inmates with uncontrolled blood sugars were not seen at appropriate intervals, and diabetic inmates with cardiovascular risk factors were not placed on appropriate medication therapies.
- In the neurology clinic, seizures were not consistently classified by type.
- In the respiratory clinic, the most common finding was that reactive airway diseases were not classified as mild, moderate, or severe.
- In the TB clinic, record reviews indicated that inmates were not given the correct number of doses medication of latent TB infection (LTBI) medication.

Consultation Requests

When an inmate requires specialized care, a clinician submits a consultation request to utilization management. Consultation requests are either approved and scheduled, or denied. If the request is denied, an alternative treatment plan should be provided.

Findings related to the consultation process were noted for 18 (90 percent) surveys. These findings represented 7 percent of physical health findings, and revealed substantial deficiencies related to the timeliness and follow-up of care. The most common consultation findings across institutions included unnecessary delays in referrals, delayed or incomplete incorporation of consultant's treatment recommendations and/or diagnostic testing, and inadequate documentation of new diagnoses in the medical record.

Dental Review

CMA's dental review encompasses an evaluation of dental care and systems. Dental care refers to the provision of dental care provided by licensed dentists while dental systems refers to the infrastructure for providing dental care. Reviews of dental care records determine if dental care is provided in accordance with HSB standards and guidelines for care. Dental systems are evaluated by conducting physical examinations of dental clinics, specialized equipment, instruments, and supplies.

Dental review findings were noted at 15 (75 percent) institutions. There were 26 (6 percent) findings related to dental care, eight related to clinical care, and 18 system findings. Clinical care findings were related to timeliness of care and referrals. System findings were related to the disrepair, accessibility, and availability of dental equipment.

Emergency Care

Department policy requires that inmates have access to health services outside of regular medical clinic hours. Emergency care may be provided in the event of an acute illness or injury that poses an immediate risk to a person's life or long-term health. On occasion, inmates may request emergency services for non-emergent reasons, these requests must still be triaged and responded to by medical staff.

Emergency care findings were noted for seven (35 percent) surveys, with a total of nine (2 percent) findings. The most common finding was related to inadequate follow-up care after emergency services.

Infection Control

There were no survey findings in the area of infection control.

Infirmary Care

Infirmary care services are provided for inmates requiring higher levels of skilled nursing care but not requiring hospitalization. Inmates may be admitted into the infirmary on either outpatient or inpatient status. Inmates requiring short-term treatment and monitoring for acute illnesses are admitted on outpatient status for up to 23 hours and then evaluated for discharge back to housing units. If additional care is needed, inmates may be admitted to the infirmary on inpatient status or transferred to an outside hospital if a higher level of care is needed.

Infirmary care findings were noted for 11 (61 percent) surveys. Clinical records reviews resulted in 42 (10 percent) findings and represented the second largest number of physical health survey findings. The most common findings across institutions included incomplete or missing physician orders, incomplete or incorrect implementation of physician orders, missing discharge notes for outpatient infirmary admissions, inappropriate use of 23-hour observation status, incomplete clinician rounds for inpatient infirmary admissions, and incomplete discharge summaries for inpatient infirmary admissions.

Institutional Tour

During institutional surveys, clinical facilities are toured to assess compliance with FDC clinic operational and safety policies. CMA surveyors examine several areas of the institutions, including medical and dental exam rooms, inmate housings, and special housing areas. Tour findings were noted for 13 (65 percent) institutions, however, no system-wide trends were identified.

Intra-system Transfers

The intra-system transfer process ensures continuity of care when inmates are transferred between institutions. When an inmate is transferred, a form is generated by sending institutions to document inmate medical information and medications, pending appointments, and other pertinent information. The form is reviewed and completed by staff at the receiving institution upon the inmate's arrival.

Fourteen (3 percent) findings related to intra-system transfers were noted for eight (40 percent) surveys. The most common findings were related to incomplete documentation and the timeliness of clinician reviews of health records.

Medical Inmate Requests

Inmates submit written requests to obtain information or assistance for health care related issues. Medical staff responds to inmate requests by providing written responses, and CMA surveyors evaluate staff responses to medical inmate requests to determine whether replies are appropriate. Also, if responses indicate follow-up action is needed, surveyors determine if follow-up took place.

It is important to note that the CMA began assessing the medical inmate request process in February 2015, therefore, reviews were completed for eight surveys. Of those surveys, four (50 percent) had identified findings. There were seven (2 percent) findings, the most common of which were related to untimely responses to inmate requests.

Medication Administration Record Review and Pill Line Observation

Medication Administration Records (MAR) are reviewed to determine if medication is being distributed in a timely manner, according to clinician orders, and properly documented by nursing staff. CMA surveyors observe nursing staff administer medication to determine compliance with nursing protocols. Clinical record reviews and observations of medication administration indicated four (0.91 percent) findings in four (20 percent) institutions and did not reveal any trends across institutions. Clinical record reviews of pill line observation indicated three (1 percent) findings in three (15 percent) institutions.

Periodic Screenings

Periodic screenings serve as a preventive measure to monitor and document the health status of inmates while they are incarcerated. According to FDC policy, inmates should be scheduled for periodic examinations every five years until age 50 and for yearly exams thereafter. For inmates followed in a CIC, routine periodic screenings are performed at the required interval by clinicians during CIC visits.

Periodic screening findings were noted for eight (40 percent) surveys. The most common findings identified were related incomplete periodic screening documentation, untimely diagnostic tests, and a lack of referrals for higher level clinician assessment.

Pharmacy Services

As part of the institutional tour, pharmacies are toured to evaluate compliance with FDC policies and procedures for medication storage, inventory, and disposal. No system-wide issues were identified related to pharmacy services.

Sick Call

The sick call process allows inmates to make requests to be evaluated for non-emergency health services. To access sick call, inmates submit written requests to nursing staff. During sick call visits, nursing staff provides patient education, evaluates health concerns, and determines if a follow-up appointment with the clinician is necessary.

No system-wide sick call findings were noted. While there were seven (1 percent) findings, none of the findings occurred more than once across institutions.

Reception Process

Reception centers temporarily house inmates waiting to be assigned and transferred to permanent FDC institutions. While at reception facilities, inmates receive initial health services and screening to determine if they have medical issues that will require follow-up and monitoring while incarcerated. Also, inmates receive their initial medical grade during the reception process.

There was only one surveyed institution that provided reception services, and no reception process findings were identified.

Mental Health Survey Findings

Mental health surveys assess inmate access to mental health services, the provision and adequacy of outpatient and inpatient mental health services, and administrative processes and procedures. The following areas are evaluated during mental health surveys: discharge planning, inpatient mental health services, inpatient psychiatric medications, mental health inmate requests, mental health systems, psychiatric restraints, psychological emergencies, outpatient mental health services, outpatient psychiatric medications, reception process, self-injury/suicide prevention, special housing, and use of force. There were 285 mental health findings in FY 2014-15 that represented 40 percent of total survey findings.

Based on an analysis of aggregate survey data, the area of outpatient mental health services had the most (22 percent) findings. There were also a significant number of findings in the areas of outpatient psychiatric medications, self-injury/suicide prevention, inpatient psychiatric medications, and inpatient mental health services.

It is important to note that some mental health assessment areas were not applicable for all institutions. Record reviews for self-injury/suicide prevention, psychiatric restraint, and use of force were completed for institutions that had

applicable episodes for review. Outpatient psychiatric medication and discharge planning record reviews were only applicable for institutions housing inmates who have mental health grades of S3 and above. Additionally, special housing reviews were applicable for institutions with confinement. Lastly, inpatient mental health services were provided at two 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 end of sentence.	14 (5%)	5 (36%)
Inpatient Mental Health Services	Assesses the provision of psychiatric care in inpatient settings.	16 (6%)	2 (100%)*
Inpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in inpatient settings.	19 (7%)	2 (100%)*
Mental Health Inmate Requests	Assesses systems and processes for reviewing, approving, and denying mental health related inmate requests.	10 (4%)	7 (35%)
Mental Health Systems Reviews	Assesses systems and processes related to mental health staff training, clinical supervision, and other administrative functions.	13 (5%)	8 (40%)
Psychiatric Restraints	Assesses compliance with FDC policies and procedures for psychiatric restraints.	10 (4%)	2 (100%)*
Psychological Emergencies	Assesses process for responding to inmate mental health emergencies.	4 (1%)	4 (20%)
Outpatient Mental Health Services	Assesses the provision of mental health services in an outpatient setting.	62 (22%)	18 (90%)
Outpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in outpatient settings.	52 (18%)	9 (60%)*
Reception Process	Assesses compliance with FDC policies and procedures for mental health screenings of new inmates.	2 (1%)	1 (100%)*
Self-Injury/ Suicide Prevention	Assesses compliance with FDC policies and procedures for self-injury and suicide prevention.	52 (18%)	16 (94%)*
Special Housing	Assesses compliance with FDC policies and procedures for providing mental health services to inmates assigned to confinement, protective management, or close management.	11 (4%)	7 (39%)*
Use of Force	Assesses compliance with FDC use of force policies and procedures following episodes for inmates on the mental health caseload.	16 (6%)	5 (50%)*

Inpatient Mental Health services and Inpatient Psychiatric Medication are provided only at Lake CI and Charlotte CI.
****There were only two institutions with applicable Psychiatric Restraint episodes.***
*****Outpatient Psychiatric Medication is provided at institutions with grades of S-3 and higher. Fifteen institutions were assessed.***
******Wakulla CI-Annex, Lowell CI-Main, and Hamilton CI-Main do not house inmates for Self-Injury/Suicide Prevention. Seventeen institutions were assessed.***
*******Discharge Planning is provided at institutions with grades S3 and higher.***
********Lowell CI-Main and Wakulla CI-Main do not have special housing. Eighteen institutions were assessed.***
*********There were only 10 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 Emergencies	Other Administrative Findings	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total Findings
Sumter CI	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	3	0	N/A	**3**
Marion CI	0	N/A	N/A	1	1	N/A	0	0	1	0	N/A	2	0	N/A	**5**
Lake CI	3	9	15	0	1	5	1	1	1	7	N/A	3	2	0	**48**
Tomoka CI	0	N/A	N/A	0	0	N/A	0	1	5	7	N/A	5	0	2	**20**
NWFRC-Main	0	N/A	N/A	0	0	N/A	0	0	1	6	N/A	1	0	0	**8**
NWFRC-Annex	0	N/A	N/A	1	0	N/A	0	0	4	7	2	1	0	0	**15**
Okeechobee CI	N/A	N/A	N/A	0	0	N/A	1	0	1	N/A	N/A	1	0	0	**3**
Moore Haven CF	2	N/A	N/A	0	1	N/A	1	0	5	2	N/A	4	1	2	**18**
Wakulla CI-Main	0	N/A	N/A	0	0	N/A	0	0	4	0	N/A	12	N/A	0	**16**
Wakulla CI-Annex	N/A	N/A	N/A	0	0	N/A	1	0	5	5	N/A	N/A	0	N/A	**11**
Avon Park CI	N/A	N/A	N/A	0	0	N/A	0	0	1	N/A	N/A	1	1	N/A	**3**
Polk CI	N/A	N/A	N/A	2	0	N/A	0	0	8	N/A	N/A	3	0	N/A	**13**
Lowell CI-Main	3	N/A	N/A	3	3	N/A	0	1	6	8	N/A	N/A	N/A	4	**28**
Lowell CI-Annex	1	N/A	N/A	0	3	5	0	1	5	6	N/A	4	3	4	**32**
Liberty CI	0	N/A	N/A	1	3	N/A	0	0	1	0	N/A	3	0	N/A	**8**
Charlotte CI	3	7	4	1	1	N/A	0	0	3	4	N/A	2	2	4	**31**
Hamilton CI-Main	0	N/A	N/A	0	0	N/A	0	0	8	0	N/A	N/A	0	N/A	**8**
Hamilton CI-Annex	0	N/A	N/A	1	1	N/A	0	0	2	0	N/A	4	1	N/A	**9**
Holmes CI	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	0	0	N/A	**0**
Baker CI	0	N/A	N/A	0	2	N/A	0	0	1	0	N/A	3	1	N/A	**7**
Total Findings	**12**	**16**	**19**	**10**	**16**	**10**	**4**	**4**	**62**	**52**	**2**	**52**	**11**	**16**	**286**

Discharge Planning

Discharge planning facilitates the continuity of mental health services for inmates who are expected to need mental health care upon their release from FDC. For eligible inmates classified with a mental health grade of S3 or above, aftercare planning is initiated when inmates are within 180 days of the end of their sentence (EOS).

Record reviews for discharge planning were completed for seven institutions, and of those institutions, five (36 percent) had findings. The most common findings were related to aftercare planning not being included in individualized services plans (ISP), incomplete discharge planning documentation, and the timeliness of applying for Social Security benefits for eligible inmates.

Inpatient Mental Health Services

Inmates requiring higher levels of mental health services receive treatment in inpatient settings. Inpatient mental health units provide three levels of care: crisis stabilization units (CSU), transitional care units (TCU), and corrections mental health treatment facilities (CMHTF). Care is provided in CSU settings for inmates who are experiencing acute and debilitating symptoms of mental impairment and cannot be adequately evaluated and treated in a mental health infirmary or TCU. Care provided in TCU settings is for inmates with chronic or residual mental health disorders who do not require crisis stabilization. However, because of their mental health disorders, they are unable to adapt to general population

settings. Care is provided in CMHTF settings for inmates whose mental health disorders are so incapacitating that it renders them unable to understand the nature and consequences of their mental illness and their need for treatment. CMHTF treatment is mandated by the court system.

Inpatient mental health services were provided at two (100 percent) surveyed institutions, and record reviews for these institutions resulted in 16 (6 percent) findings. Both institutions had findings related to: missing or incomplete risk assessments for violence, missing or untimely ISP documentation, inconsistent and/or non-compliant planned structured therapeutic services, incomplete and/or untimely treatment goal documentation, and missing and/or untimely behavioral level assessments.

Mental Health Inmate Requests

The process for submitting mental health inmate requests is similar to the medical inmate request process. Surveyors evaluate staff responses for appropriateness and to determine if follow-up action occurred, if indicated.

Mental health inmate request findings were noted at seven (35 percent) institutions, and 10 (4 percent) findings were identified. Across institutions, the most common findings were related to follow-up interviews or referrals not taking place as indicated in inmate request responses.

Mental Health Systems Reviews

The review of mental health systems assesses the operational and administrative functions of mental health services. Mental health systems findings were noted at eight (40 percent) institutions, and 13 (5 percent) findings were identified. No system-wide findings were noted in this area.

Psychiatric Medication Practices

Psychotropic medications are prescribed as a treatment method for psychiatric disorders by either psychiatrists or other qualified prescribing clinicians. The use of psychotropic medications is combined with other forms of treatment to alleviate symptoms of mental illness. Psychotropic medications are prescribed for inmates assigned mental health grades S3 or higher. CMA surveyors assess psychiatric medication practices for both inpatient and outpatient mental health settings.

Inpatient Psychiatric Medication Practices Findings (S4, S5, and S6 Inmates)

Inpatient psychiatric medication practice record reviews were completed for two institutions and resulted in 19 (7 percent) findings. The following findings were identified at both institutions: incomplete follow-up labs, medications not given as ordered and/or missing documentation for medication refusal, nursing staff failing to meet with inmates who refused medication for two consecutive days, and untimely Abnormal Involuntary Movement Scale (AIMS) assessments.

Outpatient Psychiatric Medication Practices Findings (S3 Inmates)

Outpatient psychiatric medication practice record reviews were completed for nine institutions and resulted in 52 (18 percent) findings. 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, nursing staff failing to meet with inmates who refused medication for two consecutive days, incomplete documentation for consecutive medication refusals, missing or inaccurate medication consent forms, untimely, incomplete, and/or insufficient documentation of follow-up psychiatric contacts, and untimely AIMS assessments.

Psychiatric Restraints

HSB standards provide very specific guidelines related to the use of psychiatric restraints. Restraints should be used only as a last resort and when there is clinical justification for doing so. Psychiatric restraints can only be used for inmates receiving inpatient care, including infirmary care.

During the fiscal year, psychiatric restraint episodes were available for review at two institutions, and based on those episodes, 10 (4 percent) findings were identified. Both surveys had findings related to incomplete restraint orders, inconsistent and/or missing restraint documentation, and missing restraint discharge orders.

Psychological Emergencies

Psychological emergencies refer to crisis intervention services for inmates experiencing acute distress and/or acute symptoms of mental illness for the purpose of preventing suicide and self-injury. Crisis intervention services address unforeseen incidents that require an immediate response and provide supportive services to decrease mental health distress.

Psychological emergency findings were noted for four (20 percent) institutions and resulted in four (1 percent) findings. However, no system-wide trends were identified.

Outpatient Mental Health Services

Outpatient mental health services are provided to inmates classified with mental health grades of S2 and S3. Services are provided to help alleviate symptoms of mental illness that impact inmates' abilities to adapt to and function in correctional settings. Outpatient mental health services include mental health evaluation, counseling, and case management.

The bulk of mental health survey findings were in the area of outpatient mental health services, with 62 (22 percent) findings. Across the 18 (90 percent) institutions with findings, the most common survey findings were related to missing or incomplete intra-system transfer documentation, untimely mental health screening evaluations, incomplete, inadequate, and untimely initial and follow-up ISP documentation, and failure to provide the services listed on the ISPs.

Reception Process

While at reception facilities, inmates receive mental health evaluations that initiate mental health services for eligible inmates. CMA surveyors assess compliance with mental health screening procedures.

NWFRC-Annex was the only reception center surveyed during the fiscal year, which resulted in two (1 percent) findings. Therefore, system-wide trends related to the reception process cannot be inferred.

Self-injury/Suicide Prevention

Self-Harm Observation Status (SHOS) provides for safe housing and close monitoring of inmates at risk for self-harm and/or suicide. FDC has comprehensive policies and procedures that govern self-injury and suicide prevention activities.

SHOS findings were identified for 16 (94 percent) surveys and resulted in 52 (18 percent) findings. The most commonly identified findings across institutions were related to missing and/or incomplete SHOS emergency evaluations, incomplete and untimely SHOS admission documentation, noncompliance with SHOS management guidelines, noncompliance with clinician orders for SHOS observation frequency, incomplete and/or missing nursing evaluation documentation, incomplete daily rounds by attending clinicians, non-fulfillment of daily counseling by mental health staff, and missing clinician evaluations for discharge from SHOS.

Special Housing

Special housing record reviews evaluate the delivery of mental health services to inmates assigned to confinement, close management, and protective management. HSB standards provide specific guidelines for providing mental health care to inmates assigned to special housing. Special housing was provided at 18 institutions, and seven (39 percent) of these institutions had 11 (4 percent) findings. The most common finding was related to untimely mental status exams.

Use of Force

According to Florida Administrative Code (Rule 33-602.210, F.A.C.), any inmate who is exposed to a chemical agent is to be examined by medical staff. In addition, attending medical staff members shall make a mental health referral for any inmate who is exposed to chemical agents and classified as S2 or S3. The CMA reviews the process of evaluation and referral of inmates who are exposed to chemical agents.

During the fiscal year, 10 institutions had applicable use of force episodes for review, and based on those episodes, 16 (6 percent) findings were identified. The most common findings were related to missing and/or incomplete post use of force exam documentation, incomplete referrals for mental health services, and untimely mental health assessments following use of force episodes.

Summary of System-wide Trends and Recommendations

System-Wide Trends

Tables 8 and 9 below summarize system-wide findings identified during FY 2014-15 physical and mental health surveys. These findings were not noted at all institutions, however, they were noted at three or more institutions, with the exception of inpatient mental health, psychiatric restraint, and reception findings.

Table 8. Physical Health Survey System-Wide Trends

Assessment Area	Physical Health Survey System-Wide Areas of Concern
Chronic Illness Clinics	• CIC baseline information and documentation was missing from records. • No evidence of vaccinations or inmate refusal. • Referrals for specialty care were not made. • Fundoscopic exams were not completed annually. • Inmates with uncontrolled blood sugars were not seen at appropriate intervals. • Diabetic inmates with cardiovascular risk factors were not placed on appropriate medication therapies. • Seizures were not classified by type. • Reactive airway diseases were not classified as mild, moderate, or severe.
Consultation Requests	• Consultations were not performed in a timely manner. • Consultant recommendations were not incorporated into treatment plans. • Follow-up or additional diagnostic and/or laboratory testing was not completed per consultant's recommendations. • New diagnoses were not documented to the problem list.
Dental Review	• Dental care was not provided in a timely manner and/ or referrals for specialty care were not made. • Dental equipment was not in working order and/or not accessible.
Emergency Care	• Follow-up care following emergency services was not completed.
Infirmary Care	• Physician's orders were incomplete or missing. • Physician's orders were not implemented or implemented incorrectly. • Discharge notes for outpatient infirmary admissions were missing. • Outpatient status was not conducted according to FDC policy. • Physicians failed to make rounds for inpatient infirmary admissions. • Physicians failed to complete discharge summaries within 72 hours of discharge.
Intra-System Transfers	• Intra-system transfer documentation was not completed in its entirety. • Clinicians did not review intra-system transfer forms within seven days of arrival.
Medical Inmate Requests	• Inmate requests were not responded to in a timely manner.
Periodic Screenings	• Periodic screening encounter documentation was not completed in its entirety. • Diagnostic tests were not performed within designated timeframes. • Referrals were not made when indicated.

Table 9. Mental Health Survey System-Wide Trends

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

Recommendations

Three common issues emerge when looking at survey finding data across assessment areas: insufficient and/or missing documentation, delays in care and treatment, and inadequate administrative processes. These issues reflect significant areas where system-wide improvements are needed. Based on the system-wide issues identified, the CMA makes the following recommendations:

Insufficient and/or Missing Documentation

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

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

Delays in Care and Treatment

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

- Provide additional training for clinicians and clinical associates regarding timely follow-up of consultations and documentation for new plans of care following consultation denials by utilization management.
- Provide training for clinicians regarding timely supervisory reviews of consultations, past due appointment logs, and or/ emergency and sick call encounters to ensure appropriate follow-up.
- Ensure inmates are evaluated timely and in accordance with their diagnosis and medical and mental health grades.
- Ensure required hours of planned structured therapeutic services, in inpatient units, are provided and documented according to protocol.
- Determine a method to ensure inmate requests are responded to in a timely manner and follow-up is provided, when indicated.
- Provide training to staff to ensure that mental status exams, for inmates in confinement, are completed within the required time frame.
- Ensure inmates who are in SHOS for four or more days are evaluated on the fourth day to determine if a

higher level of care is needed.

- Ensure inmates are included in the planning of their treatment goals to encourage compliance with mental health treatment.
- Provide training to physical health staff regarding post of use of force protocols for inmates on the mental health case load.

Inadequate Administrative Processes

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

- Implement a standardized tracking system to ensure baseline and current mammograms and pap smears are ordered, completed, and documented in the medical record within the appropriate timeframes.
- Improve administrative systems to track the timeliness of diagnostic testing, receipt of laboratory results, and follow-up care.
- Develop a system-wide method to document the distribution of keep-on-person (KOP) medication in the medical record. This would allow a service provider, such as a prescribing professional or case manager, to assess the KOP process and any system barriers to timely distributions of the medication.
- Develop and implement a standardized tracking system to document use of force episodes to ensure inmates on the mental health case load are referred for evaluation to determine if additional mental health interventions are needed.
- Provide training to institutional staff to ensure proper documentation of SHOS observations as ordered by clinicians to ensure the safety of inmates who are at risk for self-harm.

Section 2

2014-2015
Update on the Status of Elderly Offenders in Florida

Introduction

Over the last ten years, the number of elderly offenders housed in Florida's correctional institutions increased by 93 percent. On June 30, 2006, 11,178 inmates age 50 and older were housed in correctional institutions, compared to 21,620 inmates age 50 and older on June 30, 2014. At the end of FY 2014-15, 22 percent of Florida's 100,050 general prison population was age 50 and older.[4]

Despite comprising a small proportion of the state's total inmate population, elderly offenders significantly impact the Florida Department of Correction's (FDC) health care system. FDC does not track inmate health care costs by age, but utilization data from FY 2013-14 revealed that inmates age 50 and older represented 21 percent of the total prison population, yet accounted for 51 percent of all episodes of care and 63 percent of all hospital days.[5] According to a 2014 Florida Tax Watch Report, the average yearly cost of providing health care to elderly offenders is $11,000 per inmate, compared to $2,500 for inmates under the age of 50.[6]

Florida's elderly offender population is expected to continue to increase over the next decade. As the population grows, the demand of caring for inmates age 50 and older will continue to have a significant impact on FDC's health care service delivery system and expenditures. Assessing the health care status of elderly offenders is essential because the information gathered provides 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 prison to meet statutory requirements outlined in § 944.8041 F.S. that mandates the agency submit an annual report on the status of elderly offenders to the Florida Legislature. In this annual update, data obtained from FDC's Bureau of Research and Data Analysis is used to provide a comprehensive profile of Florida's elderly offenders by presenting two sets of data: (1) characteristics of all elderly offenders admitted during Fiscal Year 2014-15, and (2) a snapshot of the elderly offender population on June 30, 2015. The profile includes demographic, sentencing, health utilization, and housing data. Also included in this update are CMA's recommendations for elderly offenders.

[4] Florida Department of Corrections, Bureau of Research and Data Analysis, Sept. 2015.
[5] Florida Department of Corrections Report," *Elderly Inmates, 2013-2014 Agency Annual Report*." Florida Department of Corrections, 2014. Web. 3 Nov. 2015.
[6] 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

In correctional settings, the age threshold for classifying offenders as elderly is lower than the commonly accepted age for elderly persons in the community. Outside of corrections, age 65 is generally considered to be the age at which persons are classified as elderly, however, at least 20 state department of corrections and the National Commission on Correctional Health Care have set the age cutoff for elderly offenders at 50 or 55. [7] Correctional experts share a common view that many incarcerated persons experience accelerated aging as a result of poor health, lifestyle risk factors, and limited health care access prior to incarceration. Many inmates have early-onset chronic medical conditions, untreated mental health issues, and unmet psychosocial needs that make them more medically and socially vulnerable to experience chronic illness and disability approximately 10-15 years earlier than the rest of the population. [8]

In Florida, elderly offenders are defined by § 944.02 F.S. as "prisoners age 50 or older in state correctional institutions or facility operated by the Department of Corrections." [9] Therefore, elderly offenders are defined in this report as inmates age 50 and older.

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

[8] Ibid., 1151.

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

Fiscal Year 2014-2015 Admissions

Demographic Characteristics

In FY 2014-15, elderly offenders accounted for 12 percent (3,739) of 30,985 inmates admitted to FDC institutions. Males represented 90 percent (3,371) of elderly offender admissions while females age 50 and older accounted for 10 percent (368) of admissions. When looking at racial/ethnic demographics for newly admitted inmates age 50 and older, 58 percent (2, 160) were white, 39 percent (1,473) were black, and 3 percent (106) were classified as other. The majority of elderly offenders (81 percent) were between the ages of 50 and 59, with an average age of 55 at time of admission. The oldest male offender admitted in FY 2014-15 was age 88 while the oldest female admitted was age 78. Demographic data is summarized in Table 10 below.

Table 10. Fiscal Year 2014-2015 FDC Elderly Offender Admissions Demographics

2014-2015 Admissions Demographics				
Demographics	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	27,220 (88%)	23,849 (88%)	3,371 (90%)	**12%**
Female	3,765 (12%)	3,397 (12%)	368 (10%)	**10%**
Total	**30,985**	**27,246**	**3,739**	**12%**
Race/Ethnicity				
Black	13,185 (43%)	11,712 (43%)	1,473 (39%)	**11%**
White	16,667 (54%)	14,507 (53%)	2,160 (58%)	**13%**
Other	1,133 (4%)	1,027 (4%)	106 (3%)	**9%**
Total	**30,985**	**27,246**	**3,739**	**12%**
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	3,037 (81%)	**10%**		
60-69	611 (16%)	**2%**		
70+	91 (2%)	**0.29%**		
Total	**3,739**			

Commitments, Primary Offenses, and Sentences

Most (39 percent or 1,419) of the elderly offenders admitted to FDC in FY 2014-15 had no prior commitments, while 16 percent (581) had one, 11 percent (400) had two, 9 percent (320) had three, and 26 percent had four or more prior FDC commitments. The average age of elderly offenders entering FDC in FY 2014-15 was age 56. Among new admissions, 30 percent (1,123) of inmates age 50 and older were incarcerated for violent crimes, 30 percent (1,104) for property crimes, 24 percent (905) for drug offenses, and 15 percent (551) were incarcerated for offenses classified as other. Inmates age 50 and older serving sentences for murder/manslaughter and sexual/lewd behavior were serving sentences of 25 years for murder/manslaughter and 13 years for sexual/lewd behavior, which were longer sentences compared to other offenses. Table 11 below summarizes previous FDC commitments for elderly offenders and their average age at the time of admission by offense type. Table 12 provides a summary of primary offense categories for all ages.

Table 11. Elderly Offenders: Summary of Previous FDC Commitments and Average Age at Time of Admission by Offense Type

2014-15 Admissions Previous FDC Commitments	
Previous Number of Commitments	Total Number Elderly Offender
0	1,419 (39%)
1	581 (16%)
2	400 (11%)
3	320 (9%)
4+	963 (26%)
2014-15 Admissions Average Age at Time of FDC Admission by Offense Type	
Primary Offense Type	Average Age At Admission
Murder/Manslaughter	58
Sexual/Lewd Behavior	56
Robbery	56
Violent, Other	59
Burglary	55
Property Theft/ Fraud/ Damage	55
Drugs	55
Weapons	56
Other	56
All	**56**

Table 12. Summary of Primary Offense Categories by Age

2014-15 Admissions Primary Offenses						
Primary Offense Type	Total Inmates	15-49	50-59	60-69	70+	Total Inmates Age 50+
Murder/Manslaughter	942 (3%)	815 (87%)	89 (9%)	31 (3%)	7 (0.74%)	**127 (13%)**
Sexual/Lewd Behavior	1,770 (6%)	1,387 (78%)	238 (13%)	105 (6%)	40 (2%)	**383 (22%)**
Robbery	2,053 (7%)	1,947 (95%)	91 (4%)	13 (0.63%)	2 (0.10%)	**106 (5%)**
Violent, Other	4,304 (14%)	3,772 (88%)	433 (10%)	87 (2%)	12 (0.28%)	**532 (12%)**
Burglary	5,058 (16%)	4,669 (92%)	348 (7%)	37 (0.73%)	4 (0.08%)	**389 (8%)**
Property Theft/ Fraud/ Damage	5,172 (17%)	4,438 (86%)	618 (12%)	106 (2%)	10 (0.19%)	**734 (14%)**
Drugs	6,961 (22%)	6,056 (87%)	764 (11%)	132 (2%)	9 (0.13%)	**905 (13%)**
Weapons	1,628 (5%)	1,519 (93%)	92 (6%)	16 (1%)	1 (0.06%)	**109 (7%)**
Other	2,424 (8%)	2,026 (84%)	316 (13%)	78 (3%)	4 (0.17%)	**398 (16%)**
Unknown	673 (2%)	617 (92%)	48 (7%)	6 (0.89%)	2 (0.30%)	**56 (8%)**
Total	**30,985**	**27,246**	**3,037**	**611**	**91**	**3,739**

Medical and Mental Health Classifications

Among elderly offenders admitted to FDC in FY 2014-15, 44 percent (1,646), had medical grade classifications of M1, 17 percent (654) were classified as M2, and 34 percent (1,267) were classified as M3. Elderly offenders entering FDC were more likely to be assigned mental health classifications of S1 (72 percent), while 5 percent (175) were classified as S2, and 18 percent (664) as S3. [10] Table 13 below summarizes the medical and mental health classifications of Fiscal Year 2014-15 admissions, comparing elderly offenders with all offenders.

Table 13. Summary of Fiscal Year 2014-2015 Admissions Medical and Mental Health Classifications

2014-15 Admissions Medical Grade Classifications				
Medical Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
M1	21,642 (73%)	19,996 (77%)	1,646 (46%)	**8%**
M2	3,821 (13%)	3,167 (12%)	654 (18%)	**17%**
M3	4,040 (14%)	2,773 (11%)	1,267 (35%)	**31%**
M4	12 (0.04%)	8 (0.03%)	4 (0.11%)	**33%**
M5	3 (0.01%)	2 (0.01%)	1 (0.03%)	**33%**
Total	29,518	25,946	3,572	
2014-15 Admissions Mental Health Classifications				
Mental Health Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
S1	24,518 (83%)	21,821 (84%)	2,697 (76%)	**11%**
S2	1,185 (4%)	1,010 (4%)	175 (5%)	**15%**
S3	3,763 (13%)	3,099 (12%)	664 (19%)	**18%**
S4	18 (0.06%)	16 (0.06%)	2 (0.06%)	**11%**
S5	16 (0.05%)	16 (0.06%)	0 (0%)	**0%**
S6	2 (0.01%)	2 (0.01%)	0 (0%)	**0%**
Total	29,502	25,964	3,538	

Inmate Mortality

It is estimated that two percent (632) of inmates admitted in FY 2014-15 will die while incarcerated, and elderly offenders accounted for 29 percent (184) of these inmates. Among inmates age 50 and older, 57 percent (104) for inmates age 50 to 59, 30 percent for inmates age 60 to 69, and 14 percent for inmates age 70 and older.

[10] Medical and mental health Classifications were unavailable for all inmates.

June 30, 2015, Population

Demographic Characteristics

On June 30, 2015, inmates age 50 and older comprised 22 percent of Florida's reported 100,050 inmate population. Males accounted for 94 percent of the June 30, 2015, elderly offender population while women accounted for 6 percent (1,209). The racial/ethnic demographics for the June 30, 2015, elderly offender population are as follows: 55 percent (11,796) were white, 42 percent (9,049) were black, three percent (684) were Hispanic, and 0.40 percent were classified as other. The greatest majority of elderly offenders, 75 percent (15,478), were in the 50-59 age group while inmates between the ages of 60 and 69 represented 23 percent (4926), and persons age 70 and older represented five percent (1216) of the June 30, 2015, elderly offender population. The average age of elderly offenders housed on June 30, 2015, was 57. Three 93-year-old offenders were the oldest male offenders incarcerated on June 30, 2015. The oldest female offender was age 91. Table 14 below summarizes the demographics of the June 30, 2015, inmate population.

Table 14. June 30, 2015, Population Demographics

June 30, 2015 Demographics				
Demographics	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	93,032 (93%)	72,621 (93%)	20,411 (94%)	22%
Female	7,018 (7%)	5,809 (7%)	1,209 (6%)	17%
Total	100,050	78,430	21,620	22%
Race/Ethnicity				
Black	48,020 (48%)	38,971 (50%)	9,049 (42%)	19%
White	47,539 (48%)	35,743 (46%)	11,796 (55%)	25%
Hispanic	4,061 (4%)	3,377 (4%)	684 (3%)	17%
Other	417 (0.42%)	330 (0.42%)	87 (0.40%)	21%
Unavalible	13 (0.01%)	9 (0.01%)	4 (0.02%)	31%
Total	100,050	78,430	21,620	22%
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	15,478 (72%)	15%		
60-69	4,926 (23%)	5%		
70+	1,216 (6%)	1%		
Total	21,620			

Commitments, Primary Offenses, and Sentences

The majority of elderly offenders, 54 percent (11,633), housed on June 30, 2015, were repeat offenders with one or more previous FDC commitments. However, 46 percent (9,959) had no prior FDC commitments. Among the June 30, 2015, population, the average age at the time of FDC admission for inmates age 50 and older was age 47. On average, the sentence length for inmates age 50 and older was 25 years, across all offense categories. The majority of the June 30, 2015, elderly offender population, 63 percent (13,604), were incarcerated for violent crimes, 17 percent (3,748) for

property crimes, 13 percent (2,712) for drug offenses, and 7 percent (1,553) for crimes classified as other. Table 15 summarizes the previous FDC commitments and average age at time of admission by offense type for the June 30, 2015, Population.

When comparing the average sentence length of elderly offenders to the average sentence length of inmates under the age of 50, elderly inmates were more likely to be serving longer sentences. Additionally, inmates age 50 and older were more likely to be serving longer sentences for murder/manslaughter, sexual/lewd behavior, and robbery. The average sentence for elderly inmates was 43 years for murder/manslaughter, 31 years for sexual/lewd behavior, and 37 years for robbery. Table 16 summarizes the primary offense categories by age of the June 30, 2015, population.

Table 15. June 30, 2015, Population: Previous FDC Commitments and Average Age at Time of Admission by Offense Type

June 30, 2015 Population Previous FDC Commitments	
Previous Number of Commitments	Total Number Elderly Offender
0	9,959 (46%)
1	3,410 (16%)
2	2,280 (11%)
3	1,806 (8%)
4+	4,137 (19%)
June 30, 2015 Population Average Age at Time of FDC Admission by Offense Type	
Primary Offense Type	Average Age At Admission
Murder/Manslaughter	37
Sexual/Lewd Behavior	49
Robbery	53
Violent, Other	47
Burglary	39
Property Theft/ Fraud/ Damage	46
Drugs	53
Weapons	51
Other	50
All	47

Table 16. June 30, 2015, Population: Primary Offense Categories by Age

June 30, 2015 Population Primary Offenses						
Primary Offense Type	Total Inmates	15-49	50-59	60-69	70+	Total Inmates Age 50+
Murder/Manslaughter	14,576 (15%)	10,034 (69%)	2,776 (19%)	1,348 (9%)	418 (3%)	**4,542 (31%)**
Sexual/Lewd Behavior	12,291 (12%)	7,612 (62%)	2833 (23%)	1,342 (11%)	504 (4%)	**4,679 (38%)**
Robbery	12,949 (13%)	10,921 (84%)	1,511 (12%)	428 (3%)	89 (0.69%)	**2,028 (16%)**
Violent, Other	12,025 (12%)	9,932 (83%)	1,601 (13%)	432 (4%)	60 (0.50%)	**2,093 (17%)**
Burglary	16,509 (17%)	13,905 (84%)	2,217 (13%)	364 (2%)	23 (0.14%)	**2,604 (16%)**
Property Theft/ Fraud/ Damage	8,017 (8%)	6,410 (80%)	1,297 (16%)	273 (3%)	37 (0.46%)	**1,607 (20%)**
Drugs	15,479 (15%)	12,767 (82%)	2,159 (14%)	497 (3%)	56 (0.36%)	**2,712 (18%)**
Weapons	3,764 (4%)	3,353 (89%)	336 (9%)	67 (2%)	8 (0.21%)	**411 (11%)**
Other	4,402 (4%)	3,461 (79%)	746 (17%)	175 (4%)	20 (0.45%)	**941 (21%)**
Unknown	38 (0.04%)	35 (92%)	2 (5%)	0 (0%)	1 (2%)	**3 (8%)**
Total	100,050	78,430	15,478	4,926	1,216	21,620

Medical and Mental Health Classifications

Among the June 30, 2015, elderly offender population, 28 percent (5,970) of offenders were classified as M1, 52 percent (11,341) as M2, and 19 percent (4,052) as M3. Inmates age 50 and older represented the majority of all inmates with M4 and M5 classifications. Elderly offenders accounted for 62 percent (57) of M4 inmates and 76 percent (139) of M5 inmates. Among inmates age 50 and older, 81 percent (17,512) were more likely to have mental health classifications of S1, 4 percent (897) were classified as S2, 13 percent (2,893) were classified as S3, and 8 percent (1,774) had mental health classifications of S4-S6. A summary of health classifications is provided in Table 17 below.[11]

Table 17. Medical and Mental Health Classifications

June 30, 2015 Medical Grade Classifications				
Medical Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
M1	60,925 (61%)	54,955 (71%)	5,970 (28%)	**10%**
M2	29,090 (29%)	17,749 (23%)	11,341 (53%)	**39%**
M3	9,221 (9%)	5,169 (7%)	4,052 (19%)	**44%**
M4	92 (0.09%)	35 (0.04%)	57 (0.26%)	**62%**
M5	182 (0.18%)	43 (0.06%)	139 (0.64%)	**76%**
Total	99,510	77,951	21,559	
June 30, 2015 Mental Health Classifications				
Mental Health Grade	Total Population	15-49	50+	Percentage of Total Population Age 50+
S1	82,372 (83%)	64,860 (83%)	17,512 (81%)	**21%**
S2	4,395 (4%)	3,498 (4%)	897 (4%)	**20%**
S3	11,714 (12%)	8,821 (11%)	2,893 (13%)	**25%**
S4	725 (0.73%)	541 (0.69%)	184 (1%)	**25%**
S5	203 (0.20%)	171 (0.22%)	32 (0.15%)	**16%**
S6	73 (0.07%)	61 (0.08%)	12 (0.06%)	**0.07%**
Total	99,482	77,952	21,530	

Inmate Mortality

FDC reported 343 inmate deaths in FY 2014-15, and elderly offenders accounted for 76 percent (261) of those deaths. It is estimated that 14 percent (14,236) of inmates housed on June 30, 2015, will die while incarcerated. Elderly offenders account for 30 percent (6,608) of those expected to die in prison, compared to 10 percent of offenders under age 50.

[11] Medical and mental health Classifications were unavailable for all inmates.

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 condition or disability. 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.[12] To address the complex health needs of elderly offenders, FDC provides comprehensive medical and mental health care that includes special accommodations and programs, medical passes, skilled nursing services for chronic and acute conditions, and palliative care for terminally ill inmates.

Impairments and Assistive Devices

FDC assigns inmate impairment grades based on visual impairments, hearing impairments, physical limitations, and developmental disabilities. In FY 2014-15, there were 2,316 inmates with assigned impairment grades, with 62 percent (1,434) of assigned impairments being among elderly offenders. Inmates age 50 and older comprised 54 percent (195) of inmates with visual impairments, 59 percent (195) with hearing impairments, 65 percent (1,034) with physical impairments, and 49 percent (44) with developmental impairments.

Inmates requiring special assistance or assistive devices are issued special passes to accommodate their needs. FDC issued 21,117 passes for special assistance and/or assistive devices in FY 2014-15, and 43 percent (9,030) of those passes were issued to elderly offenders. Low bunk passes were the most frequently issued pass for inmates age 50 and older.

Table 18.Summary of FDC Impairment Grade Assignments and Assistive Devices/Special Passes Issued in FY 2014-2015

Impairment Grade Assignments				
Impairments	**15-49**	**50+**	**Total Population**	**Percentage of Total Population Age 50+**
Visual	139	161	300	54%
Hearing	137	195	332	59%
Physical	560	1,034	1,594	65%
Developmental	46	44	90	49%
Total	**882**	**1,434**	**2,316**	
Assistive Devices/Special Passes				
Assistive Devices/Special Passes	**15-49**	**50+**	**Total Population**	**Percentage of Total Population Age 50+**
Adaptive Device Assigned	1,360	1,205	2,565	47%
Attendant Assigned	45	91	136	67%
Low Bunk Pass	10,273	7,029	17,302	41%
Guide Assigned	3	6	9	67%
Hearing Aid Assigned	13	32	45	71%
Pusher Assigned	26	64	90	71%
Prescribed Special Shoes	179	132	311	42%
Wheelchair	188	471	659	71%
Total	**12,087**	**9,030**	**21,117**	

[12] Fellner, Jamie, and Patrick Vinck. *Old behind Bars: The Aging Prison Population in the United States*. New York, NY: Human Rights Watch, 2012. Print.

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

Inmates access health care services through visits to chronic illness clinics (CIC), sick call, and emergency care. CICs provide ongoing monitoring and treatment for chronic diseases, and inmates are scheduled for visits according to their medical grade. For non-routine health care services, inmates utilize the sick call process to request services. Inmates are provided access to health services outside of regular medical clinic hours through emergency care. FDC reported 460,259 health services encounters for FY 2014-15. Elderly offenders accounted for 33 percent (149,827) of sick call, emergency care, and CIC encounters while comprising only 22 percent of the FDC total inmate population on June 30, 2015.

Sick Call and Emergency Care Encounters

There were 303,562 reported sick call encounters in FY 2014-15, and elderly offenders accounted for 29 percent (87,424) of these encounters. Sick call encounters represented the greatest proportion of health service encounters for elderly offenders during the fiscal year. Males accounted for 92 percent (80,662) of sick call encounters for inmates age 50 and older while females accounted for eight percent (6,762). When compared to the total inmate population, males age 50 and older represented 27 percent of all sick call encounters, while females represented 2 percent.

Inmates age 50 and older accounted for 22 percent (6,118) of 28,409 emergency care encounters reported during FY 2014-15. Males accounted for 93 percent (5,673) of encounters for inmates age 50 and older, while women accounted for 7 percent (445).

Table 19 summarizes all sick call and emergency care encounters during Fiscal Year 2014-15.

Table 19. Summary of Fiscal Year 2014-2015 Sick Call and Emergency Care Encounters

Sick Call Encounters			
Age Groups	Males	Females	Total Sick Call Encounters
15-49	189,821 (70%)	26,317 (80%)	216,138 (71%)
50+	80,662 (30%)	6,762 (20%)	87,424 (29%)
Total	270,483	33,079	303,562
Emergency Care Encounters			
Age	Male	Female	Total Emergency Care Encounters
15-49	20,323 (78%)	1,968 (81%)	22,291 (78%)
50+	5,673 (22%)	445 (18%)	6,118 (22%)
Total	25,996	2,413	28,409

Chronic Illness Clinic Encounters

As indicated in the profile of elderly offenders housed on June 30, 2015, inmates age 50 and older represented the majority of all inmates with higher medical grade classifications, and at least half required routine care for chronic illness. CIC data for FY 2014-15 highlights greater utilization of CIC services for inmates age 50 and older. In FY 2014-15, 63,289 inmates were enrolled in CICs, and inmates age 50 and older accounted for 46 percent (28,851) of enrolled inmates. Elderly offenders accounted for 50 percent or more of inmates in five clinics and accounted for 55 percent (8,558) of 15,561

inmates assigned to multiple CICs. Inmates age 50 and older comprised the majority of inmates assigned to the oncology, renal, and endocrine clinics. Tables 20 and 21 summarize CIC enrollment.

Table 20. Summary of Fiscal Year 2014-2015 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 Assigned Inmates 50+
Cardiovascular	26,606 (42%)	21 (0.08%)	1,523 (6%)	4,440 (17%)	7,268 (27%)	8,500 (32%)	3,747 (14%)	1,107 (4%)	**13,354 (50%)**
Endocrine	8,513 (13%)	8 (0.09%)	478 (6%)	1,375 (16%)	2,245 (26%)	2,750 (32%)	1,232 (14%)	425 (5%)	**4,407 (52%)**
Gastrointestinal	8,713 (14%)	2 (0.02%)	875 (10%)	1,808 (21%)	1,851 (21%)	2,890 (33%)	1,186 (14%)	101 (1%)	**4,177 (48%)**
Immunity	2,920 (5%)	2 (0.07%)	225 (8%)	561 (19%)	1,001 (34%)	915 (31%)	197 (7%)	19 (0.65%)	**1,131 (39%)**
Renal	67 (0.11%)	0 (0%)	3 (4%)	12 (18%)	14 (21%)	22 (33%)	10 (15%)	6 (9%)	**38 (57%)**
Miscellaneous	2,713 (4%)	2 (0.07%)	217 (8%)	449 (17%)	678 (25%)	788 (29%)	404 (15%)	175 (6%)	**1,367 (50%)**
Neurology	3,185 (5%)	8 (0.25%)	549 (17%)	927 (29%)	890 (28%)	623 (20%)	148 (5%)	40 (1%)	**811 (25%)**
Oncology	757 (1%)	3 (0.40%)	27 (4%)	64 (8%)	119 (16%)	249 (33%)	190 (25%)	105 (14%)	**544)72%)**
Respiratory	7,448 (12%)	80 (1%)	1,386 (19%)	1,789 (24%)	1,629 (22%)	1,569 (21%)	733 (10%)	262 (4%)	**2,564 (34%)**
Tuberculosis	2,367 (4%)	34 (1%)	720 (30%)	670 (28%)	485 (20%)	350 (15%)	88 (4%)	20 (0.84%)	**458 (19%)**
Total	**63,289**	**160**	**6,003**	**12,095**	**16,180**	**18,656**	**7,935**	**2,260**	**63,289**

There were 128,288 reported CIC encounters during the fiscal year, and inmates age 50 and older accounted for 45 percent (58,257) of CIC visits. In six clinics, elderly offenders accounted for 50 percent or more of visits in FY 2014-15. Table 22 provides a breakdown of CIC encounters for elderly offenders by clinic.

Table 21. Summary of Fiscal Year 2014-2015 Chronic Illness Clinic Encounters

Chronic Illness Clinic Encounters					
Chronic Clinic	Total Number of Clinic Visits	50-59	60-69	70+	Total Visits Inmates 50+
Cardiovascular	50,361 (39%)	16,398 (33%)	7,550 (15%)	2,326 (5%)	**26,274 (52%)**
Endocrine	17,106 (13%)	5,589 (33%)	2,632 (155)	929 (5%)	**9,150 (53%)**
Gastrointestinal	15,525 (12%)	5,537 (36%)	2,304 (15%)	211 (1%)	**8,052 (52%)**
Immunity	8,253 (6%)	1,938 (23%)	575 (7%)	49 (0.59%)	**2,562 (31%)**
Renal	125 (0.10%)	45 (36%)	20 (16%)	9 (7%)	**74 (59%)**
Miscellaneous	4,702 (4%)	1,377 (29%)	724 (15%)	351 (7%)	**2,452 (52%)**
Neurology	5,742 (4%)	1,143 (20%)	295 (5%)	76 (1%)	**1,514 (26%)**
Oncology	1,513 (1%)	487 (32%)	382 (25%)	230 (15%)	**1,099 (73%)**
Respiratory	13,629 (11%)	2,984 (22%)	1,450 (11%)	560 (4%)	**4,994 (37%)**
Tuberculosis	11,332 (9%)	1,616 (14%)	389 (3%)	81 (0.71%)	**2,086 (18%)**
Total	**128,288**	**37,114**	**16321**	**4822**	**58,257**

Housing Elderly Offenders

Out of 87 major FDC correctional institutions and facilities, two institutions reported housing no inmates age 50 and older on June 30, 2015. Inmates age 50 and older represented 20 percent or more of the total institution population at 16 institutions, and 25 percent or more of the total population at 12 institutions. Table 22 displays the institutions with the greatest concentration of inmates age 50 and older.

Table 22. FDC Institutions with the Greatest Concentration of Elderly Offenders

Institutions with the Greatest Concentration of Elderly Offenders		
Institutions	Institution Population	Total 50+ Population
Union CI	2,345	**1,483 (63%)**
Zephyrhills CI	1,026	**419 (41%)**
Dade CI	1,557	**576 (37%)**
Hardee CI	1,822	**557 (31%)**
Okeechobee CI	1,603	**480 (30%)**

FDC does not house inmates based solely on age, therefore, elderly offenders are housed in most of the Department's major institutions. All inmates, including elderly offenders, who have significant limitations performing activities of daily living or serious physical conditions, may be housed in institutions that have the capacity to meet their needs. Listed below are FDC institutions that currently have the capacity to provide specialized services to elderly offenders.[13]

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

Among the 2,998 offenders reported to be housed in close management (segregated from the general population) on June 30, 2015, inmates age 50 and older represented 9 percent (268) of those inmates. As age thresholds increased, the number of elderly offenders housed in close management decreased.

[13]Florida Department of Corrections Report

Characteristics of Florida's Elderly Offender

Based on the data present in this report, the following facts summarize the status of elderly offenders housed in FDC institutions during FY 2014-15:

- Elderly offenders represented 22 percent of Florida's 100,050 general prison population.
- Elderly offenders entering FDC in FY 2014-15 were more likely to be white, male, age 56, first-time offenders, incarcerated for a violent crime, and serving average sentences of 8 years.
- Elderly offenders housed in FDC institutions on June 30, 2015, were more likely to be white, male, age 55, repeat offenders with one or more FDC admissions, admitted to FDC at age 47, incarcerated for a violent crime, and serving average sentences of 25 years.
- Most of the inmates age 50 and older entering FDC in FY 2014-15 had M1 classifications, while those housed on June 30, 2015, had higher medical classifications than those admitted during the fiscal year.
- Elderly offenders accounted for the majority of inmates with assigned impairments, and 43 percent of assistive devices and special passes were issued to inmates age 50 and older.
- Inmates age 50 and older consumed a third of FDC health services during the fiscal year, and they accounted for almost half of all inmates enrolled in CICs and CIC encounters.
- Inmates age 50 and older comprised 72 percent of inmates assigned to oncology clinics, 57 percent of inmates assigned to renal clinics, 52 percent of inmates assigned to endocrine clinics.
- Elderly offenders represented 20 percent or more of the total population at 28 FDC institutions and facilities.
- FDC estimates that 30 percent of its June 30, 2015, inmate population expected to die in prison are elderly offenders.

Looking to the Future

If FDC's elderly offender population continues to grow at the same rate it has during the past 10 years, it is projected that over the next five years, inmates age 50 and older will account for 27 percent of Florida's inmate population. [14] It is a generally recognized fact that elderly offenders disproportionately impact correctional health care systems. They have complex needs that often require ongoing and extensive treatment and care. As Florida's elderly offender population continues to grow, FDC will be faced with operational and fiscal challenges as the agency works to meet the demands of caring for this population. To meet those demands, FDC must be proactive and identify fiscal, programmatic, system, and policy solutions that can alleviate the burden of providing care to a growing 50 and over inmate population.

Detailed below are the CMA's recommendations for addressing Florida's elderly offender population:

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

[14] Population projections based on estimates from Florida's Office of Economic Research, Criminal Justice Estimating Conference (CJEC).