State of Florida Correctional Medical Authority

2018-2019 Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons

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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

Vacant
Representative
Florida Medical Association

Ryan D. Beaty
Representative
Florida Hospital Association

Kris-Tena Albers, APRN, MN
Representative
Nursing

Lee B. Chaykin
Representative
Healthcare Administration

Richard Huot, DDS
Representative
Dentistry

Leigh-Ann Cuddy, MS
Representative
Mental Health

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

December 27, 2019

The Honorable Ron DeSantis
Governor of Florida

The Honorable Bill Galvano, President
The Florida Senate

The Honorable Jose R. Oliva, Speaker
Florida House of Representatives

Dear Governor DeSantis, 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) 2018-19 Annual Report. This report summarizes the CMA's activities during the fiscal year and details the work of the CMA's governing board, staff, and Quality Management Committee fulfilling the agency's statutory responsibility to assure adequate standards of physical and mental health care are maintained in Florida's correctional institutions.

This report also summarizes the findings of CMA institutional surveys. During Fiscal Year (FY) 2018-19, the CMA conducted on-site physical and mental health surveys of 16 major correctional institutions, which included one reception center and four institutions with annexes or separate units. Additionally, CMA staff conducted 53 corrective action plan (CAP) assessments based on findings from this and the previous year's surveys.

Pursuant to § 944.8041, F.S., section two of this report includes the CMA's statutorily mandated report on the status and treatment of elderly offenders in Florida's prison system. The Update on the Status of Elderly Offenders in Florida's Prisons report describes the elderly population admitted to Florida's prisons in FY 2018-19 and the elderly population housed in Florida Department of Corrections (FDC) institutions on June 30, 2019. The report also contains information related to the use of health care services by inmates age 50 and older and housing options available for elderly offenders.

The CMA continues to support the State of Florida in its efforts to assure the provision of adequate health care to inmates. Thank you for recognizing the important public health mission at the core of correctional health care and your continued support of the CMA. Please contact me if you have any questions or would like additional information about our work.

Sincerely,

Jane Holmes-Cain LCSW

Jane Holmes-Cain, LCSW
Executive Director

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INTRODUCTION

ABOUT THE CORRECTIONAL MEDICAL AUTHORITY

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

The CMA was created as part of the settlement of the Costello case and continues to serve as an independent monitoring body to provide oversight over the systems in place that provide health care to inmates in Florida Department of Corrections (FDC) institutions. In the final order closing the Costello case, Judge Susan Black noted that the creation of the CMA made it possible for the Federal court to relinquish prison monitoring and oversight functions it had performed for the prior 20 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 healthcare."[2]

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

CORRECTIONAL MEDICAL AUTHORITY STRUCTURE AND RESPONSIBILITIES

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

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

As an independent agency, the CMA's primary role is to provide oversight and monitoring of FDC's health care delivery system to ensure adequate standards of physical and mental health care are maintained in Florida's correctional institutions. Since 2012, FDC has relied on contracted health services providers to provide comprehensive health care services. FDC currently contracts with Centurion of Florida, LLC to provide health care services statewide. Seven private correctional facilities are managed by the Department of Management Services (DMS), and health care is provided in these facilities by providers contracted by DMS.
The CMA advises the Governor and legislature on the status of FDC's health care delivery system. It is important to note that the CMA and all functions set forth by the legislature resulted from federal court findings that Florida's correctional system provided inadequate health care and that an oversight agency with board review powers was needed. Therefore, the CMA's activities serve as an important risk management function for the State of Florida by ensuring constitutionally adequate health care is provided in FDC institutions.

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

- Reviewing and advising the Secretary of Corrections on FDC's health services plan, including standards of care, quality management programs, cost containment measures, continuing education of health care personnel, budget and contract recommendations, and projected medical needs of inmates.

- Reporting to the Governor and legislature on the status of FDC's health care delivery system, including cost containment measures and performance and financial audits.

- Conducting surveys of the physical and mental health services at each correctional institution every three years and reporting findings to the Secretary of Corrections.

- Reporting serious or life-threatening deficiencies to the Secretary of Corrections for immediate action.

- Monitoring corrective actions taken to address survey findings.

- Providing oversight for FDC's quality management program to ensure coordination with the CMA.

- Reviewing amendments to the health care delivery system submitted by FDC prior to implementation.

2018-2019 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 FDC health services updates, highlights CMA's activities, 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.

FLORIDA DEPARTMENT OF CORRECTIONS HEALTH SERVICES UPDATE

FDC currently contracts with Centurion of Florida, LLC to provide medical, mental health, and dental services statewide. These contracts are managed through the Department's Office of Health Services (OHS). OHS ensures that medical, dental, and mental health services provided to inmates through contracts with the comprehensive health care provider are adequate. Additionally, OHS ensures that FDC's healthcare delivery system is multifaceted and driven by access to care requirements, national medical standards, policies and procedures, and internal and external quality improvement.[3]

Detailed below is a brief summary of some major OHS activities during FY 2018-19.

Inpatient Mental Health Unit: The Department received an appropriation of $7 Million in FY 2019-2020 to fund a contract for architectural and engineering services for a new mental health inpatient unit at Lake CI. This project will consist of a 550-bed mental health facility that integrates group and individual therapy rooms, recreational space, medical consultation rooms, nursing stations, and multi-use office/workstation space into the secure inmate housing areas.

Electronic Medical Record System: Through negotiations, the Department's Comprehensive Healthcare Contractor (Centurion) agreed to, as part of their contract renewal, a deliverable of the implementation of an electronic medical record (EMR) system in accordance with Electronic Health Record System Requirements incorporated into contract C2930, and ongoing maintenance and support throughout the term of the 3-year contract.

APA Accredited Residency Program: FDC became the first correctional agency in the nation to have a Psychological Residency Program accredited by the American Psychological Association (APA). The residency program is supervised out of the Department's central office with operations at three facilities serving mentally ill inmate populations (Lake, Lowell and Zephyrhills).

[3] *Florida Department of Corrections Report, "2018 Comprehensive Correctional Master Plan." Tue. Nov. 19, 2019.*

CMA KEY ACTIVITIES FISCAL YEAR 2018-2019

CMA activities during fiscal year (FY) 2018-19 focused on meeting the agency's statutorily required responsibilities. Key agency activities are summarized below.

CMA BOARD MEETINGS

The governing board of the CMA is composed of seven citizen volunteers appointed by the Governor and approved by the Senate. The Board is comprised of health care professionals from various administrative and clinical disciplines including nurses, hospital administrators, dentists, and mental and physical health care experts. At the end of the fiscal year, all board seats were filled.

The CMA Board held five public meetings during FY 2018-19. One meeting was hosted by the FDC Office of Health Services (OHS) staff and the staff of Florida Women's Reception Center (FWRC) in Ocala, FL. In addition to conducting regular business, board members were provided a tour of FWRC, which included an in-depth overview of the reception process and health care services provided at the institution.

During the board meetings, members received updates regarding institutional surveys and corrective action plan (CAP) assessments, and reports from FDC's 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

According to § 945.6034, F.S., the CMA is required to review FDC policies pertinent to health care and to provide qualified professional advice regarding that care. During the fiscal year, the CMA reviewed and made recommendations, when necessary, for 28 Health Services Bulletins (HSB) and eight FDC policies and procedures.

INMATE CORRESPONDENCE

CMA staff responded to 97 inmate letters during FY 2018-19. Responding to inmate correspondence is a valuable risk management function of the CMA. Because the CMA is not authorized to direct staff in FDC institutions or require that specific actions be taken by the Department, inmate letters are forwarded to OHS for investigation and response. In cases relating to security or other issues, letters are referred to the Department's Inspector General or General Counsel. CMA staff tracks the outcome of these letters and subsequently reviews health care issues identified in inmate letters during on-site surveys.

QUALITY MANAGEMENT

CMA's quality management program requirements are outlined in § 945.6032, F.S. As required by statute, the CMA appoints a medical review committee to provide oversight for FDC's inmate health care quality management program. CMA's Quality Management Committee (QMC) functions 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 QMC's mission is to provide feedback to the Department regarding its quality management process and ensure that corrective actions and policy changes identified throughout the process are effective. The QMC's primary method for accessing quality of care issues is through the review of OHS's mortality review process.

All in-custody deaths, except executions, require a mortality review. QMC mortality reviews assess whether the mortality review process effectively identified any deficiencies in health care that may have contributed to death and determine whether appropriate action was taken to prevent deficiencies from happening in the future. The administrative systems involved in providing care are also reviewed during this process.

It is important to note that the QMC's review of mortality cases is based on a non-random sample, and the intent of the review is not to generalize review findings to all mortality cases. The QMC's mortality review process is intended to function as an educational tool when areas of deficiency are identified whether they are clinical or administrative in nature. Education may be limited to the health care professional that provided the care or extended to a group of health care professionals where a systems deficiency existed, or the deficiency can potentially happen across institutions. The purpose of mortality reviews is to improve the quality of service across FDC's system of care while providing for professional growth and development.

The QMC met twice during the fiscal year and reviewed 12 mortality cases. One meeting was hosted by OHS staff and the staff of Reception Medical Center (RMC) in Lake Butler, FL.

MOORE HAVEN CORRECTIONAL FACILITY EMERGENCY NOTIFICATION

On February 20-21, 2019, CMA staff and licensed professional surveyors conducted a survey of the physical and mental health care services provided at Moore Haven Correctional Facility (MHCF). A thorough review of MHCF's health care delivery system, which encompassed chart reviews and interviews with staff and inmates, revealed inadequate medical and mental health care systems. In accordance with s. 945.6031 (3), F.S., these findings were considered to be very serious and required emergency notification and the Department's immediate attention.

The totality of findings, in conjunction with a lack of credible systems in place to address deficiencies, resulted in significant impediments to basic standards of care for the inmates at MHCF. CMA clinical surveyors identified deficiencies in almost all areas of the physical and mental health care reviewed. The findings themselves were not related to just one component of a dysfunctional health care delivery system, rather they were related to many areas including barriers to accessing care, delays in treatment, inadequate laboratory and diagnostic testing follow-up, and inadequate medication administration. Also, there was a significant lapse in medical record keeping which resulted in the CMA surveyors being unable to fully assess the care provided.

Due to the pervasive and persistent pattern of inadequate health care, it was evident that institutional quality management processes were inadequate and failed to identify systemic issues affecting quality of care. There were serious concerns that deficiencies could be adequately addressed through the CMA's standard corrective action process, as outlined in s. 945.6031 (3), (4) F.S., without addressing the larger systemic issues that were placing inmates at risk for adverse health outcomes.

On March 2, 2019, FDC provided the CMA an extensive corrective action plan (CAP) which outlined plans to address the findings identified in the emergency notification. CMA staff conducted a site visit on April 29, 2019, to ensure the actions described in the emergency CAP were being implemented. This was not a formal CAP assessment, rather a visit to verify emergency findings were being addressed appropriately and monitoring efforts were conducted accurately. A formal CAP assessment of Moore Haven CF was conducted on November 2, 2019. The results of the assessment can be located at http://www.flgov.com/correctional-medical-authority-cma/.

DISABILITY RIGHTS OF FLORIDA SETTLEMENT AGREEMENT MONITORING

On January 31, 2018, FDC and Disability Rights Florida, Inc. (DRF), signed and submitted to the courts a Settlement Agreement regarding the provision of mental health services in FDC inpatient mental health units. Included in the agreement was a provision for compliance monitoring by the CMA.

The CMA is responsible for conducting two rounds of compliance monitoring for each FDC inpatient unit. A team of contracted compliance monitors with appropriate experience and education/training related to the subject areas being assessed is utilized to monitor the terms of the Settlement Agreement. The CMA began the first round of inpatient monitoring in February 2019 and completed the monitoring in October 2019. Eight inpatient units were monitored (Reception and Medical Center, Zephyrhills CI, Dade CI, Lake CI, Florida Women's Reception Center, Wakulla CI, Suwannee CI, and Santa Rosa CI). The results of the monitoring were formally reported to DRF and FDC.

EXECUTIVE OFFICE OF THE GOVERNOR, CHIEF INSPECTOR GENERAL AUDIT CORRECTIVE ACTION PLAN

In FY 2017-18, the CMA was audited by the Executive Office of the Governor (EOG), Chief Inspector General (CIG). The audit examined whether the CMA met its statutory responsibilities as detailed in § 945.601, F.S., through 945.6036, F.S., and § 944.8041, F.S. CIG auditors reviewed the CMA's internal controls and accountability for statutory activities conducted in FY 2016-17. The CIG's final audit report indicated that "the CMA generally complied with § 945.601, F.S., through 945.6036, F.S., and fulfilled its statutory responsibilities to monitor and promote the maintenance of adequate standards of physical and mental health in Florida's correctional facilities."[4] The requirement of § 944.8041, F.S., was also met. However, one area of non-compliance, related to § 945.6031(2), F.S. was noted. The CIG found that the CMA did not conduct surveys of all correctional institutions triennially.

CIG's corrective action recommendation was that CMA's executive director seek assistance with policy and budget issues that impacted the agency's ability to conduct surveys on a triennial cycle. The CMA concurred with the recommendation, and in response, the CMA's executive director met with EOG Administration leadership staff to discuss the audit finding and identify steps to be taken to address this finding.

Six months after the CMA submitted its initial management response to the audit finding, the CIG requested a follow-up management response as a part of their office's corrective action process. CMA's response indicated that the agency had plans to submit a funding request to EOG's Office of Policy and Budget (OPB) requesting additional funding for travel, contractual expenses, and to hire additional staff persons.

[4] Office of the Chief Inspector General. (2018). *Audit of the Correctional Medical Authority* (Audit Report Number A-17/18-001)

INSTITUTIONAL SURVEYS

The CMA is required, per § 945.6031(2), F.S., to conduct triennial surveys of the physical and mental health care systems at each correctional institution and report survey findings to the Secretary of Corrections. The process is designed to assess whether inmates in FDC's correctional institutions can access medical, dental, and mental health care and to evaluate the clinical adequacy of the resulting care. To determine the adequacy of care, the CMA conducts clinical record reviews that assess the timeliness and appropriateness of both routine and emergency physical and mental health services. Additionally, administrative processes, institutional systems for informing inmates of their ability to request and receive timely care, and operational aspects of health care services are examined. The CMA contracts with a variety of licensed community and public health care practitioners including physicians, psychiatrists, dentists, nurses, psychologists, and other licensed mental health professionals to conduct surveys.

In FY 2018-19, 16 institutions were surveyed. All institutions had previously been surveyed as a result of the CMA's triennial survey schedule. Four institutions (Charlotte CI, Holmes CI, Madison CI, and South Bay CF) were surveyed in FY 2013-14, eight institutions (Avon Park CI, Baker CI, Columbia CI, Liberty CI, Lowell CI, Moore Haven CF, Okeechobee CI, and Polk CI) were surveyed in FY 2014-15, and four institutions (Dade CI, Hamilton CI, Jackson CI, and RMC) were surveyed in FY 2015-16. Of the institutions surveyed, one has reception services (RMC); four institutions have main and annex units (Columbia CI, Lowell CI, RMC, and Hamilton CI), with each unit being surveyed separately; and two have inpatient mental health units (Dade CI and RMC). Two surveyed institutions (South Bay CF and Moore Haven CF) are private facilities managed by the Department of Management Services.

In total, 595 institutional survey findings were identified in FY 2018-19. Of reportable findings, 326 (55 percent) were physical health findings and 269 (45 percent) were mental health findings. The results of CMA surveys were formally reported to the Secretary of Corrections. Detailed reports for each institutional survey can be accessed on the CMA website at http://www.flgov.com/correctional-medical-authority-cma. A summary of medical and mental health grades,[5] the number of inmates housed, and survey findings identified are provided in Table 1 below. A detailed summary of findings from institutional surveys will be presented later in this report.

[5] Medical grades reflect the level of care inmates require. Grades range from M1, requiring the least level of medical care, to M5, requiring the highest level of care. Pregnant offenders are assigned to grade M9. Medical grades are as follows: M1, inmate requires routine care; M2, inmate is followed in a chronic illness clinic (CIC) but is stable and requires care every six to twelve months; M3, inmate is followed in a CIC every three months; M4, inmate is followed in a CIC every three months and requires on-going visits to the physician more often than every three months; M5, inmate requires long-term care (longer than 30 days) in inpatient, infirmary, or other designated housing. Mental health grades reflect the level of psychological treatment inmates require. Grades range from S1, requiring the least level of psychological treatment, to S6, requiring the highest level of treatment. Mental health grades are as follows: S1, inmate requires routine care; S2, inmate requires ongoing services of outpatient psychology (intermittent or continuous); S3, inmate requires ongoing services of outpatient psychiatry; S4, inmates are assigned to a transitional care unit (TCU); S5, inmates are assigned to a crisis stabilization unit (CSU); and S6, inmates are assigned to a corrections mental health treatment facility (CMHTF).

Table 1. Summary of Fiscal Year 2018-2019 Institutional Surveys

Summary of Fiscal Year 2018-2019 Institutional Surveys									
Institution	Grades Served		Maximum Capacity	Census at Time of Survey	Infirmary Care	Inpatient Mental Health	Special Housing	Findings	
	Medical	Mental Health						Physical Health	Mental Health
Columbia CI-Main	M1-M5	S1-S3	1427	1153	Yes	No	Yes	25	23
Columbia CI-Annex	M1-M3	S1-S3	1566	1462	No	No	Yes	29	21
Liberty CI	M1-M3	S1-S2	1330	1357	Yes	No	Yes	4	1
Baker CI	M1-M3	S1-S2	1047	1098	Yes	No	Yes	8	5
Lowell CI-Main	M1-M9	S1-S3	1221	838	Yes	No	Yes	30	8
Lowell CI-Annex	M1-M5	S1-S3	1579	1306	Yes	No	Yes	12	20
South Bay CF	M1-M4	S1-S3	1948	1942	Yes	No	Yes	23	20
Reception and Medical Center-Main	M1-M5	S1-S5	1504	1459	Yes	Yes	Yes	8	15
Reception and Medical Center-West	M1-M3	S1-S3	1290	1003	No	No	Yes	5	3
Holmes CI	M1-M3	S1-S2	1185	1229	Yes	No	Yes	2	2
Jackson CI	M1-M5	S1-S2	1346	1298	Yes	No	Yes	17	6
Dade CI	M1-M5	S1-S5	1521	1582	Yes	Yes	Yes	31	36
Okeechobee CI	M1-M3	S1-S2	1356	1719	Yes	No	Yes	26	18
Moore Haven CF	M1-M3	S1-S3	985	897	Yes	No	Yes	55	24
Avon Park CI	M1-M3	S1-S2	842	1065	Yes	No	Yes	9	6
Polk CI	M1-M3	S1-S2	1200	1217	Yes	No	Yes	11	7
Charlotte CI	M1-M3	S1-S3	1078	802	Yes	No	Yes	10	7
Hamilton CI-Main	M1-M3	S1-S2	981	1007	No	No	Yes	9	12
Hamilton CI-Annex	M1-M3	S1-S3	1239	1207	Yes	No	Yes	8	5
Madison CI	M1-M3	S1-S3	1351	1288	Yes	No	Yes	4	30
								326	269

CORRECTIVE ACTION PLAN (CAP) ASSESSMENTS

Within 30 days of receiving the final copy of the CMA's survey report, institutional staff must develop and submit a CAP that addresses the deficiencies outlined in the report. The CAP is submitted to OHS for approval before it is reviewed and approved by CMA staff. Once approved, institutional staff implement and monitor the CAP. Usually, four to five months after a CAP is implemented (but no less than three months) CMA staff evaluates the effectiveness of the corrective actions taken. Findings deemed corrected are closed and monitoring is no longer required. Conversely, findings not corrected remain open. Institutional staff monitor 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 53 CAP assessments in FY 2018-19. This included four CAP assessments for institutions surveyed in FY 2015-16, 10 CAP assessments for institutions surveyed in FY 2016-17, 32 CAP assessments for institutions surveyed in FY 2017-18, and seven CAP assessments for institutions surveyed in FY 2018-19.

At the end of the fiscal year, three of four remaining open CAPs from FY 2016-17 were closed, six of 15 open CAPs from FY 2017-18 were closed, and four of 20 CAPs from FY 2018-19 were closed. The results of CAP assessments are summarized in Tables 2a-2c.

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

Fiscal Year 2016-2017 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Suwannee CI-Main	20	39	0	4	4	Open
Suwannee CI-Annex	17	9	0	0	4	Closed (5/24/19)
Lancaster CI	12	3	0	0	4	Closed (12/14/18)
Zephyrhills CI	17	26	0	0	4	Closed (8/14/19)*

Indicates institutions with CAP assessments completed after June 30, 2019.

Table 2b. Fiscal Year 2017-2018 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2017-2018 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Gadsden CF	12	20	0	2	3	Closed (3/14/19)
Lake City CF	5	15	0	0	3	Closed (2/4/19)
Taylor CI-Main	19	14	0	3	4	Open
Taylor CI-Annex	17	15	0	3	4	Open
Sumter CI	29	29	2	0	4	Open
Marion CI	12	16	0	1	4	Open
Tomoka CI	17	6	0	0	2	Closed (12/4/18)
Lake CI	30	31	0	6	3	Open
Wakulla CI-Main	27	6	0	1	3	Open
Wakulla CI-Annex	13	20	0	3	3	Open
Central Florida Reception Center-Main	18	17	0	0	2	Closed (3/15/19)
Central Florida Reception Center-East	15	2	0	0	2	Closed (3/15/19)
Central Florida Reception Center-South	6	8	0	0	2	Closed (3/15/19)
Northwest Florida Reception Center-Main	23	16	7	2	2	Open
Northwest Florida Reception Center-Annex	10	14	0	2	2	Open

Table 2c. Fiscal Year 2018-2019 Surveyed Institutions CAP Assessment Summary

Fiscal Year 2018-2019 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Columbia CI-Main	25	23	1	7	3	Open
Columbia CI-Annex	29	21	3	1	3	Open
Liberty CI	4	1	0	0	1	Closed (1/30/19)
Baker CI	8	5	0	0	3	Closed (7/25/19)*
Lowell CI-Main	30	8	5	3	2	Open
Lowell CI-Annex	12	20	1	10	2	Open
South Bay CF	23	20	0	0	3	Closed (12/2/19)*
Reception and Medical Center-Main	8	15	0	8	2	Open
Reception and Medical Center-West	5	3	1	0	2	Open
Holmes CI	2	2	0	0	2	Closed (12/3/19)*
Jackson CI	17	6	0	2	2	Open
Dade CI	31	36	16	26	1	Open
Okeechobee CI	26	18	16	7	1	Open
Moore Haven CF	55	24	19	12	1	Open
Avon Park CI	9	6	3	3	1	Open
Polk CI	11	7	0	2	1	Open
Charlotte CI	10	7	3	2	1	Open
Hamilton CI-Main	9	12	N/A	N/A	0	Open
Hamilton CI-Annex	8	5	N/A	N/A	0	Open
Madison CI	4	30	N/A	N/A	0	Open

Indicates institutions with CAP assessments completed after June 30, 2019.

SUMMARY OF FISCAL YEAR 2018-2019 INSTITUTIONAL SURVEY FINDINGS

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

Institutional survey reports provide detailed information that 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 except for findings for inpatient mental health services and reception because only two inpatient units and one reception center were surveyed during the fiscal year.

PHYSICAL HEALTH SURVEY FINDINGS

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

In FY 2018-19, there were 326 physical health findings which represented 55 percent of total survey findings. CIC findings represent the majority of physical health findings (45 percent). Findings in the areas of infirmary care and consultations also account for a significant number of physical health findings.

Table 3 provides a description of each physical health assessment area, the total number of findings by area, and the total number of institutions with findings in each area. Table 4 provides a summary of findings by institution.

Table 3. Description of Physical Health Survey Assessment Areas

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Chronic Illness Clinics	Assesses care provided to inmates with specific chronic care issues. Clinical records reviews are completed for the following chronic illness clinics: cardiovascular, endocrine, gastrointestinal, immunity, miscellaneous, neurology, oncology, respiratory, and tuberculosis	147 (45%)	20 (100%)
Consultation Requests	Assesses processes for approving, denying, scheduling services, and follow-up for specialty care services	29 (9%)	11 (55%)
Dental Care	Assesses the provision of dental care	7 (2%)	5 (25%)
Dental Systems	Assesses compliance with FDC's policies and procedures for dental services	7 (2%)	6 (30%)
Emergency Care	Assesses emergency care processes for addressing urgent/emergent medical complaints	16 (5%)	9 (45%)
Infection Control	Assesses compliance with infection control policies and procedures	1 (0.31%)	1 (5%)
Infirmary Care	Assesses the provision of skilled nursing services in infirmary settings	32 (10%)	10 (59%)*
Institutional Tour	Tour of medical, dental, and housing facilities	25 (8%)	14 (70%)
Intra-System Transfers	Assesses systems and processes for ensuring continuity of care for inmates transferred between institutions	7 (2%)	5 (25%)
Medical Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying physical health related inmate requests	9 (3%)	6 (30%)
Medication Administration	Assesses the administration of medication and clinical documentation related to medication practices	11 (3%)	8 (40%)
Periodic Screenings	Assesses the provision of periodic physical examinations and health screenings	8 (2%)	6 (30%)
Pharmacy Services	Assesses compliance with FDC's policies and procedures for medication storage, inventory, and disposal	2 (0.61%)	2 (10%)
Pill Line Administration	Assesses medication dispensing practices to ensure proper nursing practices and policies are followed	1 (0.31%)	1 (5%)
Reception Process	Assesses compliance with FDC's policies and procedures for physical health screenings of new inmates	0	0**
Sick Call	Assesses sick call processes to address acute and non-emergency medical complaints and inmate access to sick call	16 (5%)	8 (40%)

Infirmary services were not provided at Columbia CI-Annex, RMC-West, and Hamilton CI-Main.

****Reception services were provided at RMC-Main***

Table 4. Summary of Physical Health Survey Findings by Institution

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Care	Dental Systems	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Additional Administrative Issues	Total
Columbia CI-Main	4	2	2	1	2	0	3	4	1	1	1	0	0	1	N/A	2	1	**25**
Columbia CI-Annex	10	8	2	1	1	1	N/A	1	0	1	0	1	0	0	N/A	1	2	**29**
Liberty CI	3	0	0	0	0	0	0	1	0	0	0	0	0	0	N/A	0	0	**4**
Baker CI	4	1	1	0	0	0	0	0	0	0	0	0	0	0	N/A	1	1	**8**
Lowell CI-Main	13	4	0	0	1	0	5	0	0	2	0	2	0	0	N/A	2	1	**30**
Lowell CI-Annex	5	0	0	0	0	0	4	1	2	0	0	0	0	0	N/A	0	0	**12**
South Bay CF	6	3	0	0	0	0	5	2	0	2	1	1	1	0	N/A	2	N/A	**23**
Reception and Medical Center-Main	6	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	N/A	**8**
Reception and Medical Center-West	3	0	0	0	0	0	N/A	2	0	0	0	0	0	0	N/A	0	N/A	**5**
Holmes CI	1	0	0	0	0	0	0	1	0	0	0	0	0	0	N/A	0	N/A	**2**
Jackson CI	8	1	0	2	1	0	0	3	2	0	0	0	0	0	N/A	0	N/A	**17**
Dade CI	18	2	0	1	0	0	2	2	1	0	2	1	0	0	N/A	2	N/A	**31**
Okeechobee CI	16	2	0	1	3	0	1	1	1	0	1	0	0	0	N/A	0	N/A	**26**
Moore Haven CF	25	2	0	1	3	0	7	4	0	2	2	2	0	0	N/A	4	3	**55**
Avon Park CI	5	1	0	0	0	0	1	0	0	0	1	0	1	0	N/A	0	N/A	**9**
Polk CI	5	3	0	0	0	0	0	1	0	0	2	0	0	0	N/A	0	N/A	**11**
Charlotte CI	5	0	0	0	2	0	2	0	0	1	0	0	0	0	N/A	0	0	**10**
Hamilton CI-Main	5	0	1	0	1	0	N/A	1	0	0	0	1	0	0	N/A	0	N/A	**9**
Hamilton CI-Annex	2	0	0	0	2	0	2	0	0	0	0	0	0	0	N/A	2	N/A	**8**
Madison CI	3	0	1	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	**4**
	147	**29**	**7**	**7**	**16**	**1**	**32**	**25**	**7**	**9**	**11**	**8**	**2**	**1**	**0**	**16**	**2**	**326**

CHRONIC ILLNESS CLINICS

As in previous years, an analysis of aggregated survey data revealed that the majority (45 percent) of physical health survey findings were related to CICs. CIC findings were noted at all surveyed institutions.

In total, 147 CIC findings were identified across all 20 surveys. While there were findings noted in CICs 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 inmates not being seen at the required intervals according to M-grade status, missing vaccinations, abnormal labs not being addressed timely, and patient education not being completed.

Common CIC findings for specific clinics are detailed below:

- Endocrine Clinic: fundoscopic examinations were not completed annually, inmates with uncontrolled blood sugar levels were not seen at required intervals, and diabetic inmates with cardiovascular risk factors were not placed on appropriate medication therapies.
- Miscellaneous Clinic: the control of the disease was not evaluated at each clinic visit.
- Neurology Clinic: seizures were not consistently classified by type.
- Oncology Clinic: missing or incomplete referrals to specialists for more in-depth treatment.
- Respiratory Clinic: reactive airway diseases were not classified.

CONSULTATION REQUESTS

Consultation findings represented nine percent of physical health findings. Findings were noted for 11 (55 percent) surveys. The most common consultation findings across institutions were inadequate documentation of consultant's treatment recommendations in the medical record, incomplete or missing documentation of new diagnoses on problem lists, delayed or incomplete incorporation of consultant's treatment recommendations and/or diagnostic testing, incomplete or missing documentation of consultation appointments, missing or incomplete documentation of alternative treatment plans (ATP), and delayed or incomplete implementation of ATPs.

DENTAL REVIEW

Dental care findings were noted at 11 (55 percent) institutions and dental systems findings were noted at 5 (25 percent) institutions. Seven findings were related to clinical care and seven findings were related to dental systems. Across institutions, the most common clinical care findings were related to incomplete or inaccurate charting of dental findings and inaccurate diagnosis and inappropriate treatment plans. The most common systems finding was related to the disrepair, accessibility, and availability of dental equipment.

EMERGENCY CARE

Emergency care findings were noted for nine (45 percent) surveys with 16 (5 percent) findings. No system-wide trends were identified.

INFECTION CONTROL

One (0.31 percent) finding related to infection control was noted for one (five percent) survey. There were no system-wide trends.

INFIRMARY CARE

Infirmary care findings were noted at 10 (59 percent) institutions where infirmary care services were provided. Clinical records reviews resulted in 32 (10 percent) findings. The most common findings across institutions included: clinician orders not implemented or implemented incorrectly, missing outpatient discharge notes, incomplete clinician daily rounds, incomplete clinician weekend telephone rounds, and incomplete clinician discharge summaries.

INSTITUTIONAL TOUR

Institutional tour findings were noted for 14 (70 percent) surveys and resulted in 25 (eight percent) findings. No system-wide trends were identified.

INTRA-SYSTEM TRANSFERS

Seven (two percent) findings related to intra-system transfers were noted for five (25 percent) surveys. One system-wide trend was noted across institutions: incomplete clinician review of intra-system transfer documentation.

MEDICAL INMATE REQUESTS

Six (30 percent) institutions surveyed had findings related to medical inmate requests. In total, nine (3 percent) findings were identified. The most common findings noted were related to missing inmate request documentation, untimely responses to requests, request responses that were not direct, specific and/or did not

address stated needs, missing or incomplete incidental notes, and incomplete or missing follow-up for appointments/interviews.

MEDICATION ADMINISTRATION RECORD REVIEW AND PILL LINE OBSERVATIONS

Clinical record reviews related to medication administration resulted in 11 (3 percent) findings across eight (40 percent) institutions surveyed. There was one (five percent) finding resulting from pill line observations of medication administration.

There were no system-wide issues related to pill line observation. Two system-wide trends related to medication administration were noted across institutions: medication orders were not signed, dated, and timed and were missing corresponding clinician notes in the medical record.

PERIODIC SCREENING

Eight (two percent) periodic screening findings were noted at six (30 percent) institutions. The most common findings were incomplete periodic screening documentation and untimely or incomplete diagnostic testing.

PHARMACY SERVICES

One institution had two (0.61 percent) findings related to pharmacy services. There were no system-wide findings.

RECEPTION PROCESS

Reception services were provided at one institution. No findings were noted.

SICK CALL

There were 16 (five percent) findings related to the sick call process. Eight (40 percent) institutions had reportable findings. Inadequate and/or untimely follow-up visits were the only system-wide issues identified across institutions.

MENTAL HEALTH SURVEY FINDINGS

Mental health surveys assess inmates' access to mental health services, the provision and adequacy of outpatient and inpatient mental health services, and administrative processes and procedures. The following areas are evaluated during mental health surveys: discharge planning, inpatient mental health services, inpatient psychiatric medication practices, mental health inmate requests, mental health systems, psychiatric restraints, psychological emergencies, outpatient mental health services, outpatient psychiatric medication practices, the reception process, self-injury/suicide prevention, access to care in special housing, and use of force.

It is important to note that some mental health assessment areas were not applicable for all institutions. Record reviews for self-injury/suicide prevention, psychiatric restraint, and use of force were completed for institutions that had available episodes for review. Psychiatric medication practices and discharge planning record reviews were only applicable for institutions housing inmates who had mental health grades of S3 and above. Additionally, special housing was reviewed only at institutions where confinement was provided. Reception and inpatient mental health were assessed at specific institutions that provide these services.

There were 269 mental health findings in FY 2018-19 that represented 45 percent of total survey findings. Findings in the areas of self-injury/suicide prevention, outpatient mental health services, and outpatient psychiatric medication practices account for the majority of mental health findings. There were no findings related to psychiatric restraints.

Table 5 b provides a description of each mental health survey assessment area, the total number of findings by area, and the total number of institutions with findings in each area. Table 6 summarizes mental health survey findings across institutions.

Table 5. Description of Mental Health Survey Assessment Area

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Discharge Planning	Assesses processes for ensuring the continuity of mental health care for inmates within 180 days of end of sentence	16 (6%)	9 (82%)*
Inpatient Mental Health Services	Assesses the provision of mental health care in inpatient settings	14 (5%)	2 (100%)**
Inpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in inpatient settings	11 (4%)	2 (100%)**
Mental Health Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying mental health related inmate requests	13 (5%)	9 (45%)
Mental Health Systems Reviews	Assesses systems and processes related to mental health staff training, clinical supervision, and other administrative functions	21 (8%)	15 (75%)
Psychiatric Restraints	Assesses compliance with FDC's policies and procedures for psychiatric restraints	N/A	***
Psychological Emergencies	Assesses the process for responding to inmate mental health emergencies	14 (5%)	8 (40%)
Outpatient Mental Health Services	Assesses the provision of mental health services in an outpatient setting	53 (20%)	14 (70%)
Outpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in outpatient settings	37 (10%)	12 (100%)****
Reception Process	Assesses compliance with FDC's policies and procedures for mental health screenings of new inmates	0	0
Self-Injury/ Suicide Prevention	Assesses compliance with FDC's policies and procedures for self-injury and suicide prevention	58 (22%)	15 (94%)*****
Special Housing	Assesses compliance with FDC's policies and procedures for providing mental health services to inmates assigned to confinement, protective management, or close management	17 (6%)	10 (53%)******
Use of Force	Assesses compliance with FDC's use of force policies and procedures following use of force episodes for inmates on the mental health caseload	13 (5%)	7 (47%)*******

Discharge Planning was provided at institutions housing inmates with grades S-3 and higher.
****Inpatient Mental Health Services and Inpatient Psychiatric Medications were provided at RMC and Dade CI.***
*****There were no institutions with Psychiatric Restraint episodes.***
******Outpatient Psychiatric Medication was provided at institutions housing inmates with a grade of S-3. Twelve institutions were assessed.***
*******Reception Services were only provided at RMC***
********There were no episodes of Self-Injury/Suicide Prevention (SHOS) for review at Liberty CI. Inmates were not housed for SHOS at Lowell CI-Main, RMC-West, and Hamilton-Main.***
*********Special housing was not provided at RMC-West***
**********There were 15 institutions with applicable use of force episodes.***

Table 6. Summary of Mental Health Survey Findings by Institution

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Columbia CI-Main	1	N/A	N/A	2	1	N/A	0	7	7	N/A	2	2	1	**23**
Columbia CI-Annex	2	N/A	N/A	0	2	N/A	0	5	1	N/A	7	3	1	**21**
Liberty CI	N/A	N/A	N/A	0	0	N/A	0	1	N/A	N/A	N/A	0	N/A	**1**
Baker CI	N/A	N/A	N/A	0	0	N/A	2	0	N/A	N/A	3	0	0	**5**
Lowell CI-Main	1	N/A	N/A	1	1	N/A	1	0	4	N/A	N/A	0	N/A	**8**
Lowell CI-Annex	1	N/A	N/A	0	2	N/A	3	7	4	N/A	2	1	0	**20**
South Bay CF	1	N/A	N/A	1	2	N/A	1	1	2	N/A	5	3	4	**20**
Reception and Medical Center-Main	0	1	2	0	0	N/A	0	7	4	0	0	1	0	**15**
Reception and Medical Center-West	1	N/A	N/A	0	0	N/A	0	0	2	N/A	N/A	N/A	0	**3**
Holmes CI	N/A	N/A	N/A	0	1	N/A	0	0	N/A	N/A	1	0	0	**2**
Jackson CI	N/A	N/A	N/A	0	1	N/A	0	0	N/A	N/A	3	0	2	**6**
Dade CI	2	13	9	2	2	N/A	0	0	1	N/A	5	2	N/A	**36**
Okeechobee CI	N/A	N/A	N/A	2	1	N/A	4	2	N/A	N/A	7	1	1	**18**
Moore Haven CF	4	N/A	N/A	1	1	N/A	1	8	5	N/A	3	0	1	**24**
Avon Park CI	N/A	N/A	N/A	1	1	N/A	0	1	N/A	N/A	3	0	0	**6**
Polk CI	N/A	N/A	N/A	0	1	N/A	0	1	N/A	N/A	5	0	N/A	**7**
Charlotte CI	0	N/A	N/A	0	0	N/A	1	1	2	N/A	2	1	0	**7**
Hamilton CI-Main	N/A	N/A	N/A	2	2	N/A	0	7	N/A	N/A	N/A	1	N/A	**12**
Hamilton CI-Annex	N/A	N/A	N/A	0	1	N/A	0	2	1	N/A	1	0	0	**5**
Madison CI	3	N/A	N/A	1	2	N/A	1	3	6	N/A	9	2	3	**30**
Total Findings	**16**	**14**	**11**	**13**	**21**	**0**	**14**	**53**	**39**	**0**	**58**	**17**	**13**	**269**

DISCHARGE PLANNING

Record reviews for discharge planning were completed at 11 institutions, and of those institutions, nine (82 percent) had findings. The most common findings were related to aftercare planning not being included in individualized services plans (ISP), inadequate or incomplete aftercare planning documentation, and the timeliness of applying for social security benefits for eligible inmates.

MENTAL HEALTH INMATE REQUESTS

Nine institutions (45 percent) had mental health inmate request findings, with 13 (5 percent) reportable findings. The most common findings were requests not being present in the medical record and incomplete or missing follow-up for referrals/interviews.

MENTAL HEALTH SERVICES

INPATIENT MENTAL HEALTH SERVICES

Inpatient mental health services were provided at two surveyed institutions. Fourteen (5 percent) findings were noted. No system-wide trends were identified.

OUTPATIENT MENTAL HEALTH SERVICES

Findings related to outpatient mental health services accounted for 20 percent (53) of mental health survey findings. Fourteen (70 percent) institutions had reportable findings. Across institutions with findings, the most common were related to: inaccurate mental health grade documentation, discontinuation of psychotropic medication upon arrival to receiving institutions, incomplete ISP documentation, untimely follow-up ISP documentation, failure to provide the services listed on the ISP, incomplete problem list documentation, and missing, inadequate, or untimely counseling services.

PSYCHIATRIC RESTRAINTS

During the fiscal year, no psychiatric restraint episodes were available for review at any surveyed institution.

PSYCHOLOGICAL EMERGENCIES

Psychological emergency findings were noted for eight (40 percent) institutions and resulted in 14 (5 percent) findings. The most common findings across institutions were incomplete and/or missing documentation regarding consideration of the inmate's prior mental health history and incomplete or missing follow-up in response to psychological emergencies.

RECEPTION PROCESS

One reception center was surveyed during the fiscal year. No findings were identified.

SELF-INJURY/SUICIDE PREVENTION

Self-harm observation status (SHOS) findings were identified for 15 (94 percent) surveys with SHOS episodes for review, resulting in 58 (22 percent) findings. The most commonly identified findings across institutions were related to missing and/or incomplete emergency evaluations, incomplete and/or missing clinician orders, untimely admission documentation, non-compliance with SHOS management guidelines, non-compliance with clinician orders for SHOS observation frequency, incomplete and/or missing nursing evaluations, missing daily rounds by attending clinicians, missing clinician evaluations for discharge, missing post-discharge follow-up, and incomplete SHOS documentation.

SPECIAL HOUSING

Special housing findings were noted at 10 (53 percent) surveyed institutions. There were 17 (6 percent) reportable findings. The most common findings were related to incomplete special housing health appraisals, untimely mental status exams, and interruptions in psychotropic medications and outpatient treatment while the inmate was held in confinement.

USE OF FORCE

There were applicable use of force episodes for review at 15 institutions surveyed during the fiscal year. Findings were noted at seven (47 percent) of those institutions, which resulted in 13 (5 percent) findings. The most common findings were related to incomplete referrals to mental health services from nursing staff and untimely mental health assessments following use of force episodes.

SUMMARY OF SYSTEM-WIDE TRENDS

Tables 7 and 8 below summarize system-wide findings identified during FY 2018-19 physical and mental health surveys. These findings were not noted at all institutions; however, they were noted at three or more institutions.

Table 7. Physical Health Survey: System-Wide Trends

Assessment Area	Physical Health Survey System-Wide Areas of Concern
Chronic Illness Clinics	• Baseline information (history, physical examination, labs, etc.) was incomplete or missing (Chronic Illness) • Patient education was incomplete or missing (Chronic Illness) • Inmates were not seen timely according to M-grade status (Chronic Illness) • No evidence of vaccinations or refusals (Cardiovascular, Gastrointestinal, Immunity, and Miscellaneous Clinics) • Abnormal labs were not addressed in a timely manner (Endocrine and Miscellaneous Clinics) • There was no evidence of fundoscopic examinations (Endocrine Clinic) • There was no evidence that inmates with HgbA1c over 8.0 were seen at least every three months (Endocrine Clinic) • There was no evidence that aspirin therapy was initiated for inmates with vascular disease or risk for vascular disease (Endocrine Clinic) • There was no evidence that the control of the disease was documented at each clinic visit (Miscellaneous Clinic) • Seizures were not classified by nomenclature (Neurology Clinic) • There was no evidence of referrals to a specialist for more in-depth treatment, when indicated (Oncology Clinic) • There was no evidence reactive airway diseases were classified as mild, moderate, or severe (Respiratory Clinic)
Consultation Requests	• There was no evidence of an incidental note which addressed consultant's treatment recommendations • New diagnoses were not reflected on problem lists • There was no evidence consultant's recommendations were incorporated into treatment plans • The Consultation Appointment Log was incomplete • There was no evidence that ATPs were documented in the medical record • There was no evidence that ATPs were implemented
Dental Review	• Dental equipment was not in working order or not accessible • There was no evidence of complete and accurate charting of dental findings • There was no evidence of accurate diagnoses and appropriate treatment plans
Emergency Care	• No trends identified
Infection Control	• No trends identified
Infirmary Care	• Physician's orders were not implemented or implemented incorrectly • Discharge notes for outpatient infirmary admissions were missing • There was no evidence of clinician daily rounds • There was no evidence of clinician weekend telephone rounds • Clinician discharge summaries were not completed within 72 hours of discharge
Institutional Tour	• No trends identified
Intra-system Transfers	• Clinicians did not review intra-system transfer forms within seven days of arrival
Medical Inmate Requests	• Copies of the inmate request were not present in medical records • Request responses were untimely • Request responses were not direct, specific, and/or did not address stated needs • Incidental notes regarding responses were incomplete or missing • There was no evidence that interviews/appointments indicated in the response occurred as intended
Medication Administration	• There was no evidence of corresponding notes for medication orders in the medical record from an advanced level provider • Medication orders were not signed, dated, and/or timed
Periodic Screenings	• Periodic screening documentation was incomplete • Referrals were not made when indicated
Pill Line Observation	• No trends identified
Pharmacy Services	• No trends identified
Reception Process	• No trends identified
Sick Call	• No trends identified

Table 8. Mental Health Survey: System-Wide Trends

Assessment Area	Mental Health Survey System-Wide Areas of Concern
Discharge Planning	• Aftercare planning was not addressed on the Individualized Service Plan (ISP) within 180 days of expiration of sentence (EOS) • 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	• No trends identified
Inpatient Psychiatric Medication Practices	• Follow-up labs were not completed
Mental Health Inmate Requests	• A copy of the inmate request form was not present in the medical record • Interview or referral indicated in request response did not occur
Psychiatric Restraints	• No findings noted
Psychological Emergencies	• Incomplete documentation of inmate's prior mental health history • Following psychological emergency, there was no evidence of follow-up
Outpatient Mental Health Services	• Inaccurate mental health grade documentation • Psychotropic medications discontinued upon arrival to receiving institution • ISPs were not signed by all members of the MDST and/or inmate, or inmate refusal was not documented • ISPs were not reviewed or revised at the 180-day interval • Mental health problems were not recorded on the problem list • There was no evidence that inmates received mental health interventions and services described on the ISP •There was no evidence that counseling (individual or group) was offered and provided at least once every 90 days • There was no evidence that counseling was provided at required intervals for inmates with a diagnosis of Schizophrenia or other psychotic disorders
Outpatient Psychiatric Medication Practices	• Initial laboratory tests were not ordered • 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 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 • Follow-up psychiatric contacts were not conducted at appropriate intervals • AIMS were not administered within the appropriate time frame
Reception Process	• No findings noted
Self-Injury/ Suicide Prevention	• Emergency evaluations were not completed by mental health or nursing staff prior to admissions • There was no evidence clinician's orders were written or verbal orders given at the time of admission• Guidelines for SHOS management were not observed • There was no evidence that inmates were observed at the frequency ordered by clinicians • "Mental Health Daily Nursing Evaluations" were not completed once per shift, as required • Daily counseling by mental health staff did not occur • There was no evidence of a face-to-face evaluation by a clinician prior to discharge from SHOS • There was no evidence that mental health staff provided post-discharge follow-up within seven days
Special Housing	• "Special Housing Health Appraisals" were not completed • Mental status exams were not completed within the required timeframe • There were interruptions in outpatient treatment and psychotropic medications for inmates held in special housing
Use of Force	• Following use of force episodes, there was no evidence of a referral to mental health from physical health staff •Untimely mental health assessments following use of force episodes

THREE-YEAR INSTITUTIONAL SURVEY COMPARISON

During FY 2018-19, 16 institutions were resurveyed as a part of the CMA's triennial survey schedule. These institutions were initially surveyed in FY 2013-14, 2014-15, and 2015-16. The tables below provide a comparison of survey findings from the first survey cycle and FY 2018-19.

While a side-by-side comparison is provided, it is important to note that new survey tools have been implemented since the first round of CMA triennial surveys beginning in 2013. The CMA routinely updates survey tools as FDC policies and procedures are written, revised, and implemented. Additionally, CMA creates or revises tools to increase the efficiency and accuracy of the survey process. The number of findings related to chronic illness clinics and medical inmate requests was impacted by these changes. Additionally, mission changes at Charlotte CI, Madison CI, and Hamilton CI impacted the number of findings.

PHYSICAL HEALTH SURVEY FINDINGS

Table 9a. Fiscal Years 2013-2014, 2014-2015, and 2015-2016 Surveyed Institutions Physical Health Findings

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Care	Dental Systems	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Additional Administrative Issue	Total
Columbia CI-Main	17	4	0	0	0	0	9	1	2	1	1	4	0	0	N/A	1	N/A	**40**
Columbia CI-Annex	8	5	1	4	0	0	N/A	4	0	0	0	0	0	2	N/A	1	N/A	**25**
Liberty CI	6	1	2	1	0	0	1	3	0	0	0	1	0	0	N/A	0	N/A	**15**
Baker CI	6	1	0	0	0	0	0	2	0	0	0	0	0	0	N/A	0	N/A	**9**
Lowell CI-Main	24	0	0	1	1	0	5	2	4	2	1	1	0	0	N/A	0	5	**46**
Lowell CI-Annex	26	2	1	1	1	0	5	6	3	3	1	3	1	0	N/A	0	2	**55**
South Bay CF	9	0	0	0	0	0	0	0	1	N/A	0	0	0	0	N/A	0	N/A	**10**
Reception and Medical Center-Main	8	1	0	2	0	0	0	3	0	0	0	0	0	3	2	0	N/A	**19**
Reception and Medical Center-West	14	0	0	0	0	0	N/A	2	0	1	0	1	2	2	N/A	0	N/A	**22**
Holmes CI	3	1	1	0	0	0	0	0	0	1	0	0	1	1	N/A	0	N/A	**8**
Jackson CI	8	2	0	1	0	0	0	2	0	0	1	0	0	0	N/A	0	N/A	**14**
Dade CI	9	2	0	0	0	0	1	0	0	1	1	1	0	0	N/A	0	N/A	**15**
Okeechobee CI	5	2	0	1	0	0	2	0	0	N/A	0	0	0	0	N/A	0	N/A	**10**
Moore Haven CF	7	2	0	0	1	0	0	0	1	N/A	0	0	0	0	N/A	1	N/A	**12**
Avon Park CI	4	1	0	3	0	0	3	1	0	N/A	0	0	0	0	N/A	0	N/A	**12**
Polk CI	6	0	0	0	0	0	0	2	1	N/A	0	1	0	0	N/A	0	N/A	**10**
Charlotte CI	5	1	0	1	0	0	0	2	0	0	0	0	0	0	N/A	0	N/A	**9**
Hamilton CI-Main	5	2	0	1	0	0	N/A	1	0	1	0	1	0	0	N/A	0	1	**12**
Hamilton CI-Annex	5	1	0	1	0	0	0	0	0	0	0	0	0	0	N/A	1	N/A	**8**
Madison CI	3	1	2	0	0	0	0	0	0	1	0	0	0	0	N/A	0	N/A	**7**
Total Findings	**178**	**29**	**7**	**17**	**3**	**0**	**26**	**31**	**12**	**9**	**5**	**13**	**4**	**8**	**2**	**4**	**8**	**358**

Table 9b. Fiscal Year 2018-2019 Surveyed Institutions Physical Health Findings

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Care	Dental Systems	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Additional Administrative Issues	Total
Columbia CI-Main	4	2	2	1	2	0	3	4	1	1	1	0	0	1	N/A	2	1	**25**
Columbia CI-Annex	10	8	2	1	1	1	N/A	1	0	1	0	1	0	0	N/A	1	2	**29**
Liberty CI	3	0	0	0	0	0	0	1	0	0	0	0	0	0	N/A	0	0	**4**
Baker CI	4	1	1	0	0	0	0	0	0	0	0	0	0	0	N/A	1	1	**8**
Lowell CI-Main	13	4	0	0	1	0	5	0	0	2	0	2	0	0	N/A	2	1	**30**
Lowell CI-Annex	5	0	0	0	0	0	4	1	2	0	0	0	0	0	N/A	0	0	**12**
South Bay CF	6	3	0	0	0	0	5	2	0	2	1	1	1	0	N/A	2	N/A	**23**
Reception and Medical Center-Main	6	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	N/A	**8**
Reception and Medical Center-West	3	0	0	0	0	0	N/A	2	0	0	0	0	0	0	N/A	0	N/A	**5**
Holmes CI	1	0	0	0	0	0	0	1	0	0	0	0	0	0	N/A	0	N/A	**2**
Jackson CI	8	1	0	2	1	0	0	3	2	0	0	0	0	0	N/A	0	N/A	**17**
Dade CI	18	2	0	1	0	0	2	2	1	0	2	1	0	0	N/A	2	N/A	**31**
Okeechobee CI	16	2	0	1	3	0	1	1	1	0	1	0	0	0	N/A	0	N/A	**26**
Moore Haven CF	25	2	0	1	3	0	7	4	0	2	2	2	0	0	N/A	4	3	**55**
Avon Park CI	5	1	0	0	0	0	1	0	0	0	1	0	1	0	N/A	0	N/A	**9**
Polk CI	5	3	0	0	0	0	0	1	0	0	2	0	0	0	N/A	0	N/A	**11**
Charlotte CI	5	0	0	0	2	0	2	0	0	1	0	0	0	0	N/A	0	0	**10**
Hamilton CI-Main	5	0	1	0	1	0	N/A	1	0	0	0	1	0	0	N/A	0	N/A	**9**
Hamilton CI-Annex	2	0	0	0	2	0	2	0	0	0	0	0	0	0	N/A	2	N/A	**8**
Madison CI	3	0	1	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0	**4**
	147	**29**	**7**	**7**	**16**	**1**	**32**	**25**	**7**	**9**	**11**	**8**	**2**	**1**	**0**	**16**	**2**	**326**

MENTAL HEALTH SURVEY FINDINGS

Table 9c. 2013-2014, 2014-2015, and 2015-2016 Surveyed Institutions Mental Health Findings

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Columbia CI-Main	0	N/A	N/A	1	3	N/A	0	3	7	N/A	7	1	0	22
Columbia CI-Annex	2	N/A	N/A	0	2	N/A	0	7	7	N/A	8	2	1	29
Liberty CI	N/A	N/A	N/A	1	2	N/A	0	1	N/A	N/A	3	0	N/A	7
Baker CI	N/A	N/A	N/A	0	2	N/A	0	1	N/A	N/A	3	1	N/A	7
Lowell CI-Main	3	N/A	N/A	3	4	N/A	0	6	8	N/A	N/A	0	4	28
Lowell CI-Annex	1	N/A	N/A	0	4	5	0	5	6	N/A	4	3	4	32
South Bay CF	1	N/A	N/A	1	0	N/A	0	2	0	N/A	0	0	0	4
Reception and Medical	3	7	6	1	1	N/A	1	8	9	4	3	3	1	47
Reception and Medical	3	N/A	N/A	1	0	N/A	N/A	0	6	N/A	N/A	N/A	N/A	10
Holmes CI	N/A	N/A	N/A	0	0	N/A	0	0	N/A	N/A	0	0	N/A	0
Jackson CI	N/A	N/A	N/A	1	2	N/A	0	3	N/A	N/A	1	1	2	10
Dade CI	0	3	3	0	1	3	4	1	1	N/A	3	1	1	21
Okeechobee CI	N/A	N/A	N/A	0	0	N/A	1	1	N/A	N/A	1	0	0	3
Moore Haven CF	2	N/A	N/A	0	1	N/A	1	5	2	N/A	4	1	2	18
Avon Park CI	N/A	N/A	N/A	0	0	N/A	0	1	N/A	N/A	1	1	N/A	3
Polk CI	N/A	N/A	N/A	2	0	N/A	0	8	N/A	N/A	3	0	N/A	13
Charlotte CI	3	7	4	1	1	N/A	0	3	4	N/A	2	2	4	31
Hamilton CI-Main	N/A	N/A	N/A	0	0	N/A	N/A	8	N/A	N/A	N/A	0	N/A	8
Hamilton CI-Annex	N/A	N/A	N/A	1	1	N/A	0	2	N/A	N/A	4	1	N/A	9
Madison CI	N/A	N/A	N/A	0	0	N/A	0	1	N/A	N/A	3	1	N/A	5
Total Findings	**18**	**17**	**13**	**13**	**24**	**8**	**7**	**66**	**50**	**4**	**43**	**18**	**19**	**307**

Table 9d. Fiscal Year 2018-2019 Surveyed Institutions Mental Health Findings

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Columbia CI-Main	1	N/A	N/A	2	1	N/A	0	7	7	N/A	2	2	1	**23**
Columbia CI-Annex	2	N/A	N/A	0	2	N/A	0	5	1	N/A	7	3	1	**21**
Liberty CI	N/A	N/A	N/A	0	0	N/A	0	1	N/A	N/A	N/A	0	N/A	**1**
Baker CI	N/A	N/A	N/A	0	0	N/A	2	0	N/A	N/A	3	0	0	**5**
Lowell CI-Main	1	N/A	N/A	1	1	N/A	1	0	4	N/A	N/A	0	N/A	**8**
Lowell CI-Annex	1	N/A	N/A	0	2	N/A	3	7	4	N/A	2	1	0	**20**
South Bay CF	1	N/A	N/A	1	2	N/A	1	1	2	N/A	5	3	4	**20**
Reception and Medical Center-Main	0	1	2	0	0	N/A	0	7	4	0	0	1	0	**15**
Reception and Medical Center-West	1	N/A	N/A	0	0	N/A	0	0	2	N/A	N/A	N/A	0	**3**
Holmes CI	N/A	N/A	N/A	0	1	N/A	0	0	N/A	N/A	1	0	0	**2**
Jackson CI	N/A	N/A	N/A	0	1	N/A	0	0	N/A	N/A	3	0	2	**6**
Dade CI	2	13	9	2	2	N/A	0	0	1	N/A	5	2	N/A	**36**
Okeechobee CI	N/A	N/A	N/A	2	1	N/A	4	2	N/A	N/A	7	1	1	**18**
Moore Haven CF	4	N/A	N/A	1	1	N/A	1	8	5	N/A	3	0	1	**24**
Avon Park CI	N/A	N/A	N/A	1	1	N/A	0	1	N/A	N/A	3	0	0	**6**
Polk CI	N/A	N/A	N/A	0	1	N/A	0	1	N/A	N/A	5	0	N/A	**7**
Charlotte CI	0	N/A	N/A	0	0	N/A	1	1	2	N/A	2	1	0	**7**
Hamilton CI-Main	N/A	N/A	N/A	2	2	N/A	0	7	N/A	N/A	N/A	1	N/A	**12**
Hamilton CI-Annex	N/A	N/A	N/A	0	1	N/A	0	2	1	N/A	1	0	0	**5**
Madison CI	3	N/A	N/A	1	2	N/A	1	3	6	N/A	9	2	3	**30**
Total Findings	**16**	**14**	**11**	**13**	**21**	**0**	**14**	**53**	**39**	**0**	**58**	**17**	**13**	**269**

RECOMMENDATIONS

As in previous years, institutional surveys for FY 2018-19 continued to reveal FDC generally has an overall adequate structure for the delivery of health care services. However, deficiencies were noted at all institutions, and a wide variability of care exists at the institutional level. This year's report reiterates some concerns highlighted in previous annual reports. Detailed below are the CMA's recommendations to address these areas of concern.

Insufficient and/or Missing Clinical Documentation

Incomplete or missing documentation continued to be a system-wide issue noted in several assessment areas. Complete and accurate clinical documentation is a critical component for the delivery of health care services. Additionally, clinical documentation ensures that continuity of care is maintained. To improve issues related to clinical documentation, the following strategies are recommended:

- Create and implement a medical record face sheet to capture pertinent clinical information such as vital signs, weights, mammograms, pap smears, etc.

- Provide routine and on-going training on medical records management practices and clinical documentation requirements to all health services staff. Training should reinforce the importance of avoiding risk management issues associated with inadequate and missing clinical documentation.

- FDC should continue to explore information technology solutions for an electronic medical record and determine the fiscal impact of implementing an electronic system. The implementation of an electronic medical record, in a system as large as FDC, could improve administrative and clinical efficiencies.

- Re-educate nursing staff on transcribing orders and use of the medication administration record (MAR).

- Create a tracking mechanism for medication errors and delays.

- Develop a medication administration face sheet to track keep-on-person (KOP) medications to monitor when medications are ordered, received, and dispersed.

Diagnostic Delays

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

- Provide training for clinicians regarding timely supervisory reviews of consultations, past due appointment logs, abnormal labs, and/or emergency and sick call encounters to ensure appropriate follow-up.

- Streamline RMC consultation process to decrease wait times and transportation problems.

- Review staffing levels for physical health staff, including physicians, mid-level practitioners, and nursing staff.

Periodic Screenings

The purpose of the periodic screening is to determine the past and present health status of the inmate patient and provide a means of preventive health maintenance. For many inmates with M1 or S1 status, this is the only contact with medical services other than an occasional sick call or emergency situation. As such, the periodic screening serves as an important tool for determining if any changes or problems have occurred that may indicate risk of disease or new diagnosis. This may indicate additional tests or diagnostic services are needed, and as a way for the provider to educate regarding healthy behavior. To improve issues related to periodic screenings, the following strategies are recommended:

- Consider changing the periodic screening guidelines from every five years for those under age 50 and yearly thereafter to: every five years for those under age 40, every three years for those 40-49 years of age, and every year for those age 50 and above.

- Identify a system or process to provide clinicians with notification reminders to order periodic screening diagnostic tests within the required time frame.

- Revise the DC4-541 "Periodic Screening Encounter" form to include a check box to indicate last pap smear and mammogram and to serve as a prompt to ensure timely follow-up.

- Revise the DC4-541 "Periodic Screening Encounter" form to include a mechanism to indicate if vaccinations are up to date. A check box could be added to indicate date of last influenza vaccination and one for last pneumococcal vaccination. To ensure timely follow-up, a box: If not current, date scheduled.

- Revise the DC4-541 "Periodic Screening Encounter" form to include questions to assess mental health risks and suicidal ideation.

Mental Health Treatment Delays

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

- Ensure inmates on the mental health caseload are evaluated in a timely manner and provided the services listed on their ISPs, including inmates housed in confinement.

- Establish a system to provide consistent delivery of medications to inmates regardless of institution or housing status.

- Review staffing levels for psychiatry, mental health professionals, and mental health nursing.

- Revise the DC4-541 “Periodic Screening Encounter” form to include questions to assess mental health risks and suicidal ideation.

Self-Harm Observation Status Assessment and Treatment

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

- Provide training to medical and security staff to ensure proper procedures are followed and subsequent documentation of the psychological emergency is complete and accurate.

- Develop a tracking mechanism to ensure inmates in need of referral to a higher level of care are evaluated.

SECTION II

2018-2019
UPDATE ON THE STATUS OF ELDERLY OFFENDERS IN FLORIDA

INTRODUCTION

Since 2001, the CMA has reported annually on the status of elderly offenders in Florida's prisons to meet statutory requirements outlined in § 944.8041, Florida Statutes (F.S.), that requires the agency to submit, each year to the Florida Legislature, an annual report on the status of elderly offenders. Utilizing data from FDC's Bureau of Research and Data Analysis, a comprehensive profile of Florida's elderly offenders will be detailed in this report. This update for FY 2018-19 will include demographics, sentencing, health utilization, and housing data for elderly offenders. Also included is a discussion regarding national and state policies related to elderly offenders and CMA's recommendations related to Florida's elderly prison population.

DEFINING ELDERLY OFFENDERS

Correctional experts share a common view that many incarcerated persons experience accelerated aging because of poor health, lifestyle risk factors, and limited health care access prior to incarceration. Many inmates have early-onset chronic medical conditions, untreated mental health issues, and unmet psychosocial needs that make them more medically and socially vulnerable to experience chronic illness and disability approximately 10-15 years earlier than the rest of the population.[6]

Outside of correctional settings, age 65 is generally considered to be the age at which persons are classified as elderly. However, at least 20 state departments of corrections and the National Commission on Correctional Health Care have set the age cutoff for elderly offenders at 50 or 55.[7] In Florida, elderly offenders are defined as "prisoners age 50 or older in a state correctional institution or facility operated by the Department of Corrections."[8] Therefore, elderly offenders are defined in this report as inmates age 50 and older.

[6] Williams, Brie A., et al. "Addressing the Aging Crisis in U.S. Criminal Justice Health Care." Journal of the American Geriatrics Society, vol. 60, no. 6, 2012, pp. 1150–1156.
[7] Ibid.
[8] Florida Department of Corrections Report, "Elderly Inmates, 2017-2018 Agency Annual Report." Tue. Nov. 19, 2019.

PROFILE OF FLORIDA'S ELDERLY OFFENDERS

FISCAL YEAR 2018-2019 ADMISSIONS

DEMOGRAPHIC CHARACTERISTICS

In FY 2018-19, elderly offenders accounted for 14 percent (3,956) of 28,782 inmates admitted to FDC institutions. Males represented 91 percent (3,601) of elderly offender admissions, while females age 50 and older accounted for 9 percent (355) of admissions. When looking at racial/ethnic demographics for newly admitted inmates age 50 and older, 37 percent (1,447) were black, 10 percent (381) were Hispanic, 53 percent (2,111) were white, and 0.43 percent (17) were classified as other. Table 11 further details racial/ethnic demographics by gender.

Seventy-six percent (3,007) of newly admitted elderly offenders were between the ages of 50 and 59. The average age at the time of admission for males was age 56 and age 55 for females. The oldest male offender admitted in FY 2018-19 was age 84, while the oldest female admitted was age 72. Demographic data is summarized in Table 10 below:

Table 10. Fiscal Year 2018-2019 FDC Elderly Offender Admissions Demographics

Fiscal Year 2018-2019 Admissions: Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	25,191	21,590	3,601	**13%**
Female	3,591	3,236	355	**1%**
Total	**28,782**	**24,826**	**3,956**	**14%**
Race/Ethnicity				
Black Female	761	681	80	**0.28%**
Black Male	10,900	9,533	1,367	**5%**
Hispanic Female	205	189	16	**0.06%**
Hispanic Male	3,053	2,688	365	**1%**
White Female	2,596	2,340	256	**1%**
White Male	11,124	9,269	1,855	**6%**
Other Female	29	26	3	**0.01%**
Other Male	114	100	14	**0.05%**
Total	**28,782**	**24,826**	**3,956**	**14%**
Age Range of 50+ Population				
Age Range	**Total**	**Percentage of Total Population**		
50-59	3,007	**10%**		
60-69	830	**3%**		
70+	119	**0.41%**		
Total	**3,956**	**14%**		

COMMITMENTS AND PRIMARY OFFENSES

Most (34 percent or 1,360) of the elderly offenders admitted to FDC in FY 2018-19 had no prior commitments, while 17 percent (675) had one, 11 percent (446) had two, 9 percent (369) had three, and 28 percent (1,104) had four or more prior FDC commitments. Among new admissions, 30 percent (1,170) of inmates age 50 and older were incarcerated for violent crimes, 28 percent (1,004) for property crimes, 24 percent (935) for drug offenses, and 19 percent (743) were incarcerated for offenses classified as other. Table 11 summarizes previous FDC commitments for elderly offenders. Table 12 summarizes primary offense types.

Table 11. Fiscal Year 2018-19 Admissions: Summary of Previous FDC Commitments

Fiscal Year 2018-2019 Admissions: Previous FDC Commitments For Inmates Age 50 and Older		
Previous Number of Commitments	Total Number of Elderly Offenders	Percentage of Total Population Age 50+
0	1,360	34%
1	675	17%
2	446	11%
3	369	9%
4+	1,104	28%

Table 12. Fiscal Year 2018-19 Admissions: Summary of Primary Offense Categories

Fiscal Year 2018-2019 Admissions: Primary Offense Types For Inmates Age 50 and Older					
Primary Offense Type	50-59	60-69	70+	Total Inmates Age 50+	Percentage of Total Population Age 50+
Violent	845	261	64	**1,170**	**30%**
Property	898	197	11	**1,106**	**28%**
Drugs	720	200	15	**935**	**24%**
Other	543	171	29	**743**	**19%**

INMATE MORTALITY

It is estimated that 2 percent (521) of inmates admitted in FY 2018-19 will die while incarcerated and elderly offenders will account for 72 percent (373) of these inmates.

JUNE 30, 2019 POPULATION

DEMOGRAPHIC CHARACTERISTICS

At the end of FY 2018-19, 25 percent (23,946) of Florida's 95,626 general prison population was age 50 and older. Males accounted for 95 percent (22,729) of the June 30, 2019, elderly offender population and represented 26 percent of the total male inmate population. Female elderly offenders accounted for 5 percent (1,217) of inmates age 50 and over on June 30, 2019 and represented 18 percent (6,618) of the total female inmate population. The racial/ethnic demographics for the June 30, 2019, elderly offender population are as follows: 41 percent (9,881) were black, 47 percent (11,278) were white, 11 percent (2,671) were Hispanic, and 0.48 percent (116) were classified as other.

Elderly offenders between the ages of 50-59 represented 65 percent (15,628) of inmates age 50 and older. The average age of elderly offenders housed on June 30, 2019, was 58. The oldest male offender incarcerated on June 30, 2019, was age 91. The oldest female offender was age 78.

Table 13 summarizes the demographics of the June 30, 2019, inmate population.

Table 13. FDC Elderly Offender June 30, 2019, Demographics

June 30, 2019 Population, Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	89,008	66,279	22,729	**26%**
Female	6,618	5,401	1,217	**18%**
Total	**95,626**	**71,680**	**23,946**	**25%**
Race/Ethnicity				
Black Female	1,810	1,490	320	**0.33%**
Black Male	43,016	33,455	9,561	**10%**
Hispanic Female	448	374	74	**0.08%**
Hispanic Male	11,510	8,913	2,597	**3%**
White Female	4,319	3,505	814	**1%**
White Male	34,100	23,636	10,464	**11%**
Other Female	41	32	9	**0.01%**
Other Male	382	275	107	**0.11%**
Total	**95,626**	**71,680**	**23,946**	**25%**
Age Range of 50+ Population				
Age Range	**Total**	**Percentage of Total Population**		
50-59	15,628	**16%**		
60-69	6,517	**7%**		
70+	1,801	**2%**		
Total	**23,946**	**25%**		

COMMITMENTS AND PRIMARY OFFENSES

Forty-four percent (10,631) of elderly offenders housed on June 30, 2019, had no prior FDC commitments. The remaining 56 percent (13,315) of elderly offenders were repeat offenders with one or more previous FDC commitments. The majority of the June 30, 2019, elderly offender population, 65 percent (15,566) was incarcerated for violent crimes, 16 percent (3,834) for property crimes, 11 percent (2,691) for drug offenses, and 8 percent (1,855) for crimes classified as other.

Table 14. June 30, 2019, Population: Summary of Previous FDC Commitments

June 30, 2019, Population: Previous FDC Commitments For Inmates Age 50 and Older		
Previous Number of Commitments	Total Number of Elderly Offenders	Percentage of Total Population Age 50+
0	10,631	44%
1	3,772	16%
2	2,674	11%
3	2,137	9%
4+	4,732	20%

Table 15. June 30, 2019, Population: Summary of Primary Offense Categories

June 30, 2019 Primary Offense Types For Inmates Age 50 and Older					
Primary Offense Type	50-59	60-69	70+	Total Inmates Age 50+	Percentage of Total Population Age 50+
Violent	9,410	4,592	1,564	**15,566**	**65%**
Property	2,922	846	66	**3,834**	**16%**
Drugs	1,977	636	78	**2,691**	**11%**
Other	1,319	443	93	**1,855**	**8%**

INMATE MORTALITY

It is estimated that 16 percent (14,829) of inmates housed on June 30, 2019, will die while incarcerated. Elderly offenders account for 48 percent (7,109) of those expected to die in prison.

HEALTH SERVICES UTILIZATION

To address the complex health needs of elderly offenders, FDC provides comprehensive medical and mental health care. This includes special accommodations and programs, medical passes, skilled nursing services for chronic and acute conditions, and palliative care for terminally ill inmates. In addition to routine care, inmates age 50 and over receive annual periodic screenings and dental periodic oral examinations. Elderly offenders are also screened for signs of dementia and other cognitive impairments as a part of FDC's health care screening process.[9]

SICK CALL AND EMERGENCY CARE ENCOUNTERS

There were 406,098 sick call and emergency encounters in FY 2018-19. Elderly offenders accounted for 30 percent (121,401) of those encounters. Sick call represented the greatest proportion of those encounters. There were 95,770 (34 percent) sick call encounters for inmates age 50 and older.

Table 16 summarizes all sick call and emergency care encounters during FY 2018-19.

Table 16. Summary of Fiscal Year 2018-2019 Sick Call and Emergency Care Encounters

Sick Call and Emergency Care Encounters							
Encounter Type	Total Encounters	Females		Males		Total Encounters	Percentage of Total
		15-49	50+	15-49	50+		
Sick Call	284,831	22,338	6,962	166,723	88,808	**95,770**	**34%**
Emergency	121,267	9,732	2,091	85,904	23,540	**25,631**	**21%**
Total	406,098	32,070	9,053	252,627	112,348	121,401	30%

CHRONIC ILLNESS CLINICS

In FY 2018-19, 65,494 inmates were enrolled in chronic illness clinics (CIC), and inmates age 50 and older accounted for 49 percent (32,271) of enrolled inmates. Elderly offenders accounted for 50 percent or more of inmates in five clinics: cardiovascular, endocrine, renal, miscellaneous, and oncology clinics. Table 17 summarizes CIC enrollment.

[9] *Florida Department of Corrections Report, "Elderly Inmates, 2017-2018 Agency Annual Report." Tue. Nov. 19, 2019.*

Table 17. Summary of Fiscal Year 2018-2019 Chronic Illness Clinic Enrollment

Chronic Illness Clinic Enrollment					
Chronic Clinic	Total Assigned Inmates	Females 50+	Males 50+	Total Number of Inmates 50+	Percentage of Total Assigned Inmates Age 50+
Cardiovascular	27,521	870	14,291	**15,161**	**55%**
Endocrine	9,038	401	4,887	**5,288**	**59%**
Gastrointestinal	11,375	261	4,003	**4,264**	**37%**
Immunity	2,699	63	1,167	**1,230**	**46%**
Renal	6	0	5	**5**	**83%**
Miscellaneous	2,727	93	1,557	**1,650**	**61%**
Neurology	3,057	49	828	**877**	**29%**
Oncology	919	38	658	**696**	**76%**
Respiratory	6,949	236	2,602	**2,838**	**41%**
Tuberculosis	1,203	7	255	**262**	**22%**
Total	65,494	2,018	30,253	32,271	49%

There were 126,131 reported CIC encounters during the fiscal year, and inmates age 50 and older accounted for 51 percent (64,553) of CIC visits. In five clinics, elderly offenders accounted for 50 percent or more of visits in FY 2018-19. Table 18 provides a breakdown of CIC encounters for elderly offenders by clinic.

Table 18. Summary of Fiscal Year 2018-2019 Chronic Illness Clinic Encounters

Chronic Illness Clinic Enrollment					
Chronic Illness Clinic	Total Number of Clinic Visits	Females 50+	Males 50+	Total Encounters 50+	Percentage of Total Encounters Population Age 50+
Cardiovascular	49,791	1,566	27,134	**28,700**	**58%**
Endocrine	17,722	725	9,926	**10,651**	**60%**
Gastrointestinal	19,735	443	7,964	**8,407**	**43%**
Immunity	8,524	224	3,776	**4,000**	**47%**
Renal	12	0	10	**10**	**83%**
Miscellaneous	4,724	144	2,858	**3,002**	**64%**
Neurology	5,348	72	1,549	**1,621**	**30%**
Oncology	1,786	63	1,330	**1,393**	**78%**
Respiratory	12,168	397	4,984	**5,381**	**44%**
Tuberculosis	6,321	23	1,365	**1,388**	**22%**
Total	126,131	3,657	60,896	64,553	51%

IMPAIRMENTS AND ASSISTIVE DEVICES

FDC assigns inmate impairment grades based on visual impairments, hearing impairments, physical limitations, and developmental disabilities. All FDC institutions have impaired inmate committees that develop, implement, and monitor individualized service plans for all impaired inmates.[10]

In FY 2018-19, there were 12,747 inmates with assigned impairment grades, with 49 percent (6,275) of assigned impairments being among elderly offenders. Inmates age 50 and older comprised 40 percent (9,098) of inmates with visual impairments, 73 percent (642) with hearing impairments, 74 percent (1,950) with physical impairments, and 52 percent (65) with developmental impairments.

Inmates requiring special assistance or assistive devices are issued special passes to accommodate their needs. FDC issued 21,925 passes for special assistance and/or assistive devices in FY 2018-19, and 52 percent (11,406) of those passes were issued to elderly offenders.

A summary of impairments and assistive devices is provided in Tables 19 and 20.

Table 19. Summary of Fiscal Year 2018-2019 FDC Impairment Grade Assignments

Impairment Grade Assignments				
Impairments	15-49	50+	Total Population	Percentage of Total Population Age 50+
Visual	5,480	3618	9,098	40%
Hearing	243	642	885	73%
Physical	690	1,950	2,640	74%
Developmental	59	65	124	52%
Total	6,472	6,275	12,747	49%

Table 20. Summary of Fiscal Year 2018-2019 Issued Assistive Devices/Special Passes

Assistive Devices/Special Passes				
Assistive Devices/Special Passes	15-49	50+	Total Population	Percentage of Total Population Age 50+
Adaptive Device Assigned	932	1,251	2,183	57%
Attendant Assigned	39	141	180	78%
Low Bunk Pass Assigned	9,121	8,890	18,011	49%
Guide Assigned	1	0	1	0%
Hearing Aid Assigned	75	209	284	74%
Pusher Assigned	28	126	154	82%
Prescribed Special Shoes Assigned	154	229	383	60%
Permanent Wheelchair Assigned	169	560	729	77%
Total	10,519	11,406	21,925	52%

[10] *Florida Department of Corrections Report, "Elderly Inmates, 2017-2018 Agency Annual Report." Tue. Nov. 19, 2019.*

ELDERLY OFFENDER POLICY REVIEW

In previous CMA reports regarding the status of elderly offenders in Florida's prisons, several challenges related to meeting the health care needs of this population have been discussed. However, despite known challenges associated with caring for this population, there are currently limited evidence-based programs and public policies in place nationwide that target aging offenders. Inadequate funding, limited institutional understanding of the needs of elderly offenders, and state sentencing and parole practices have been cited factors related to limited programming and policies.[11] When reviewing scholarly articles, reports, and publications that have examined nationwide programs and policies specifically targeting elderly offenders, the following types of programs and public policy approaches are often discussed: designated/segregated housing units, medical/compassionate release, and specialty nursing and palliative care facilities. Detailed below is a summary of how these programs and policies are being implemented nationwide and in Florida.

DESIGNATED/SEGREGATED HOUSING UNITS

In a 2005 article in the *Journal of Contemporary Criminal Justice*, the term "institutional thoughtlessness" was used to describe examples of how prison environments are poorly adapted to meet the needs of elderly offenders and how corrections staff, consciously or otherwise, fail to mitigate the effects of this when it would be within their power to do so.[12] Several examples of "institutional thoughtlessness" were cited in the article and included the following examples of elderly offenders not being allowed sufficient time to complete activities or to get to and from specific locations; being denied additional clothing or bedding in cold weather; and having showers that are tiled and unequipped with grab rails or anti-slip mats. The article presents the argument that prison environments are designed without consideration of the specific needs of elderly offenders and that correctional staff fails to acknowledge age-related problems in correctional settings.

Prisons are generally "designed for the young and able-bodied and not for individuals requiring special services and devices, such as walkers, wheelchairs, or breathing aids" and were not designed to accommodate the physical needs of elderly offenders[13]. State departments of corrections do not typically make housing assignments for inmates solely based on age and often support "mainstreaming," which keeps elderly offenders in the "general population" as long as possible, consistent with their particular physical and mental health needs.[14] As offenders age and begin to experience declines in physical and cognitive functioning, correctional settings can present unique challenges for inmates and correctional staff. These challenges can include a lack of handicap accessible spaces and accommodations; fall risks associated with top bunk assignments; and an increased risk of elderly offenders being preyed upon by younger offenders.

Many state departments of corrections have established designated housing units specifically for elderly offenders or persons requiring assistance with activities of daily living that provide for higher levels of care than offered in general population housing but do not offer the level of care of assisted living or skilled nursing care.[15] The creation of these housing units requires significant investments up front; however, long term benefits

[11] "The High Cost of Low Risk: The Crisis of America's Aging Prison Population." The Osborne Association, *http://www.osborneny.org/*.
[12] Crawley, E. (2005). Institutional Thoughtlessness in Prisons and Its Impacts on the Day-to-Day Prison Lives of Elderly Men. *Journal of Contemporary Criminal Justice*, 21(4), pp. 350–363.
[13] "Old Behind Bars: The Aging Prison Population in the United States." Human Rights Watch, www.hrw.org.
[14] Ibid.
[15] Ibid.

outweigh initial investments. These housing units offer a "more age-sensitive, safer, and healthier environment for the elderly that can help avoid further deterioration and encourage preventive self-care."[16]

Detailed below are examples of segregated housing units for elderly offenders across the nation:

- **Virginia's Deerfield Correctional Center:** This is a medium-security prison designed to serve the elderly and handicapped. Assisted living services and programming such as peer tutoring, horticulture, and library services are provided.[17]

- **New York State's Ulster Correctional Facility Senior Living Dorm:** Established in 2017, this facility for men aged 55 and older, has age-appropriate services and programs for elderly offenders. [18]

- **Mississippi State Penitentiary Unit 31:** This special housing unit houses men who, whether due to age or other reasons, need more support and assistance than is available in general population units. Those housed in this unit remain there until they are unable to care for themselves, even with the assistance of other inmates.[19]

- **Central California Women's Facility Senior Living Unit:** This housing unit is for women age 55 and over. The unit is located in an existing facility and is designed to address the emotional and physical needs of elderly inmates. Women housed in this unit have privileges not otherwise offered to the general population. This includes additional mattresses upon request, unlimited phone access, designated dayroom space for small plants, and the ability to purchase fans without it being counted towards the maximum number of permitted appliances. Additionally, age-specific programs and support groups are offered.[20]

- **Texas Department of Criminal Justice:** Across Texas, several prisons have special geriatric units for offenders who are 60 years old or older and who have specific difficulties with activities of daily living. These units allow elderly offenders longer time periods for dressing, eating, showering, and moving from place to place around the prison.

In Florida, inmates are not housed solely based on age, therefore, elderly offenders are housed in most of the Department's major institutions. All inmates, including elderly offenders, who have significant limitations performing activities of daily living or serious physical conditions may be housed in institutions that have the capacity to meet their needs. Inmates who have visual or hearing impairments, require walkers or wheelchairs, or who have more specialized needs are assigned to institutions designated for assistive devices for ambulating. Currently, the facilities listed below serve relatively large populations of elderly inmates.[21]

[16] 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* 60.6 (2012): pp. 1150-156. Web. 3 Nov. 2015

[17] "The High Cost of Low Risk: The Crisis of America's Aging Prison Population." The Osborne Association, http://www.osborneny.org/.

[18] Ibid.

[19] "Old Behind Bars: The Aging Prison Population in the United States." Human Rights Watch, www.hrw.org.

[20] Ibid.

[21] *Florida Department of Corrections Report, "Elderly Inmates, 2017-2018 Agency Annual Report." Tue. Nov. 19, 2019.*

- **Central Florida Reception Center- South Unit:** This unit is specifically designated for special needs inmates including the elderly as well as palliative care inmates.

- **Zephyrhills Correctional Institution:** Two dorms are specifically designed for elderly inmates as well as inmates with complex medical needs.

- **Lowell Correctional Institution**: There is a dorm specifically designated for female inmates with complex medical needs, including the elderly.

- **South Florida Reception Center-South Unit**: There are 487 beds for inmates age 50 and older.

- **South Florida Reception Center- F-Dorm:** There are 84 beds designated for long-term and palliative 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.

- **Union Correctional Institution:** There are 156 beds for inmates age 50 and older.

- **Inpatient Mental Health Units:** FDC has eight Transitional Care Units (TCU) where elderly inmates with impairment in mental and cognitive functioning receive necessary care in a safe and protective environment.

MEDICAL/COMPASSIONATE RELEASE

CMA's last three reports on elderly offenders have included the recommendation of expanding the use of conditional medical release in Florida. In 1992, the Florida Legislature created the Conditional Medical Release Program as a mechanism to release terminally ill or permanently incapacitated inmates from prison under supervision. According to § 947.149, F.S., an inmate is deemed to be permanently incapacitated if they have a condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, renders the inmate permanently and irreversibly physically incapacitated to the extent that the inmate does not pose a threat to themselves or others. FDC worked in conjunction with the Florida Commission on Offender Review (FCOR) to establish the program, and § 947.149, F.S. gives the Commission the sole authority to approve or deny release.

Despite there being a mechanism to release terminally ill or permanently incapacitated inmates, very few offenders are recommended for release in Florida. FCOR's FY 2019-20 Long Range Program plan indicates that in the previous three fiscal years, FDC recommended 124 inmates for conditional medical release, and the commission approved 66 (53%) inmates for release.[22] In FY 2018-19, 39 inmates were recommended for release and 21 were approved (54%).[23]

It is unclear why conditional medical release is not more widely used in Florida. However, policy papers exploring medical or compassionate release programs and policies, offer insight into why these types of programs are often underutilized. While medical or compassionate release policies vary by state in detail "most have one important thing in common: they provide narrowly circumscribed opportunities for release and have not had a

[22] *"2017-2018 Annual Report - Florida Commission on Offender Review."* ***Https://www.fcor.state.fl.us/.***
[23] Ibid.

significant impact on reducing the number of older and infirm people in prison. In most states, the polices are not widely used and, when the provisions are invoked, people are infrequently released." [24]

In 2010, the Vera Institute of Justice conducted a statutory review of geriatric release policies in correctional systems. It was reported that 15 states and the District of Columbia have some type of compassionate, medical, or geriatric release policy.[25] A 2017 follow-up report by the Vera Institute detailed efforts by the Justice Reinvestment Initiative (JRI) which is a partnership between the Bureau of Justice Assistance of the U.S. Department of Justice's Office of Justice Programs and the Pew Charitable Trusts.[26] The initiative serves as a "data-driven approach to improve public safety, curb corrections costs, and reinvest the savings in evidence-based public safety strategies."[27] Since 2010, 29 states have worked in partnership with the JRI to "collect and analyze data on drivers of corrections costs and prison population growth, identify and implement changes to increase efficiencies, and measure both the fiscal and public safety impacts of those changes."[28] For several of these states, reducing the number of elderly offenders through conditional medical or compassionate release programs has been identified as a solution to reducing state prison populations and increase overall cost savings. Eight states, Alabama, Alaska, Arkansas, Louisiana, Maryland, Mississippi, North Dakota, and South Carolina, have worked with the JRI to introduce legislation to either create or expand release programs.[29]

On the federal level, a federal criminal justice reform bill was signed into law in 2018 and included provisions to address elderly offenders in federal prisons. Under the First Step Act (FSA), compassionate release policies were updated to expand eligibility requirements, allow inmates to appeal Bureau of Prison's (BOP) release decisions in court, and to implement policies that support terminally ill inmates who are physical or mentally unable to submit compassionate medical release requests on their own. The FSA also expands the use of home confinement for elderly offenders and the terminally ill through the reauthorized Second Chance Act of 2007. The act modifies the eligibility criteria for elderly inmates enabling those who are at least 60 years old and have served two-thirds of their sentences can be placed on home confinement. It also expands the program so that terminally ill offenders can be placed on home confinement.[30] The BOP will operate this pilot program at multiple facilities from FY 2019 to FY 2023.

During Florida's 2019 Legislative Session, legislation was introduced to expand the eligibility for conditional medical release. House Bill 607 and Senate Bill 346 would expand conditional medical release to include inmates with debilitating illnesses. Both bills were indefinitely postponed, withdrawn from consideration, and died in committee.

[24] "It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release." Vera Institute of Justice, Center on Sentencing and Corrections, www.vera.org/publications.
[25] Ibid.
[26] "Aging Out: Using Compassionate Release to Address the Growth of Aging and Infirm Prison Population." Vera Institute of Justice, Center on Sentencing and Corrections, www.vera.org/publications.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] "The First Step Act of 2018: An Overview." Congressional Research Services, https://crsreports.congress.gov.

SPECIALTY NURSING AND PALLIATIVE CARE FACILITIES

Elderly offenders tend to suffer from illnesses that are often chronic in nature and progressive, requiring extended treatment and recovery time. As in the community, many elderly offenders will "eventually develop a diminished capacity for self-care and require assistance with daily living activities as well as increased medical care."[31] To meet these needs, state departments of corrections often utilize specialized assistive living, skilled nursing care, and palliative care units. Detailed below are examples of these types of units.

- **New York State's Fishkill Correctional Facility Unit for the Cognitively Impaired:** This unit provides long-term care to men with dementia or progressive cognitive impairments in an infirmary setting.[32]

- **Texas Department of Criminal Justice, Estelle Unit:** This is a higher-level geriatric facility for males, housed next to the Estelle Regional Medical Facility to ensure accessibility to clinical staff. Multiple special medical services such as physical, occupational, and respiratory therapy; special wheelchair accommodations; temperature-adjusted environments; dialysis; and services for inmates with hearing and vision impairments are provided.[33]

- **Connecticut Department of Corrections:** In 2017, the Connecticut Department of Corrections received the first-ever certification by the Centers for Medicare and Medicaid Services (CMS) for a nursing home that houses older people who have been paroled because of physical or mental illness. This certification allows the state to receive federal Medicaid and Medicare matching funds and resources. [34]

- **Bostick Nursing Center:** This is a 100,000 square foot nursing center that was privately developed and managed by CorrectHealth LLP. The 280-bed facility is located in Milledgeville, GA, and housed on the grounds of a former prison. The Center houses formerly incarcerated elderly offenders who are medically frail and have no family or place to go after their release.[35]

- **California Men's Colony:** The California Men's Colony has a special unit for inmates with moderate to severe dementia and persons with developmental disabilities.

Specialized assistive living, skilled nursing and palliative care is provided at the following correctional institution in Florida:

- **Reception and Medical Center, F-Dorm:** FDC's 120-bed licensed hospital located at Reception and Medical Center provides care to elderly inmates in different dorms on campus including F dorm, where nursing care is provided chiefly to the infirmed elderly and others.

[31] "Old Behind Bars: The Aging Prison Population in the United States." Human Rights Watch, www.hrw.org.
[32] Ibid.
[33] Ibid.
[34] "The High Cost of Low Risk: The Crisis of America's Aging Prison Population." The Osborne Association, http://www.osborneny.org/.
[35] Ibid.

RECOMMENDATIONS

Within the resources available, FDC has taken steps to develop programs that address the needs of older inmates such as consolidation of older inmates at certain institutions and palliative care units. While FDC has taken steps to better meet the needs of Florida's elderly offender population, additional system, policy, and programmatic changes are needed. As in previous years, the CMA makes the following recommendations for addressing Florida's elderly offender population:

- Continue efforts to expand FDC's housing and facilities to accommodate elderly offender populations.

- Policymakers and FDC should review conditional medical release policies to identify and address procedural barriers that impact the release of elderly offenders.

- 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.

- 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 the detection of cognitive impairment among elderly offenders should be offered to staff.