STATE OF FLORIDA CORRECTIONAL MEDICAL AUTHORITY

2017-2018 Annual Report and Update on the Status of Elderly Offenders in Florida's Prisons

STATE OF FLORIDA CORRECTIONAL MEDICAL AUTHORITY

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

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

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

Katherine E. Langston, MD
Representative
Florida Medical Association

Ryan D. Beaty
Representative
Florida Hospital Association

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

Peter C. Debelius-Enemark, M.D., Chair
Katherine E. Langston, M.D.
Kris-Tena Albers, APRN, MN
Richard Huot, DDS

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

Leigh-Ann Cuddy, MS
Lee B. Chaykin
Ryan D. Beaty

December 27, 2018

The Honorable Rick Scott
Governor of Florida

The Honorable Bill Galvano, President
The Florida Senate

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

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

In accordance with § 945.6031, Florida Statutes (F.S.), I am pleased to submit the Correctional Medical Authority's (CMA) 2017-18 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) 2017-18, the CMA conducted on-site physical and mental health surveys of 17 major correctional institutions, which included two reception centers and five institutions with annexes or separate units. Additionally, CMA staff conducted 50 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 2017-18 and the elderly population housed in Florida Department of Corrections (FDC) institutions on June 30, 2018. 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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SECTION ONE

2017-2018 Correctional Medical Authority Annual Report

INTRODUCTION

ABOUT THE CORRECTIONAL MEDICAL AUTHORITY

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

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

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

CMA STRUCTURE AND RESPONSIBILITIES

The CMA is composed of a seven-member, volunteer board 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.

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.

2017-2018 ANNUAL REPORT

The CMA is required by § 945.6031, F.S., to provide an annual report detailing the current status of FDC's health care delivery system. This report details CMA's activities during fiscal year (FY) 2017-18, summarizes findings of institutional surveys, provides an update regarding CMA's corrective action plan process, and provides CMA's overall assessment and recommendations regarding FDC's health care delivery system.

KEY CMA ACTIVITIES IN FISCAL YEAR 2017-2018

CMA activities during FY 2017-18 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 2017-18. One meeting was hosted by FDC Office of Health Services (OHS) staff and the staff of Reception and Medical Center (RMC) in Lake Butler, FL. In addition to conducting regular business, board members were provided a tour of RMC, 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 Office of Health Services (OHS) staff and FDC contracted providers regarding health services. CMA board meetings provided an opportunity for members to voice concerns related to FDC's health care delivery system and/or offer recommendations.

HEALTH CARE STANDARDS REVIEW

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 FDC policies and procedures.

INMATE CORRESPONDENCE

Monitoring inmate correspondence is an important risk management function for the CMA. As part of the CMA's mission of ensuring adequate standards of physical and mental health care are maintained at all correctional institutions, CMA staff reviews, triages, and responds to inmate correspondence. The CMA is not authorized to direct staff in FDC institutions, nor does it require that specific actions be taken by the Department; therefore, 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.

There was an increase in the number of inmate letters received by the CMA in FY 2017-18. The CMA responded to 104 inmate letters regarding inmates at 22 correctional institutions, compared to 69 letters in FY 2016-17. Many of these letters were related to complaints of inadequate medical care.

QUALITY MANAGEMENT COMMITTEE

Through its Quality Management Committee (QMC), the CMA operates as an oversight body of FDC's quality management program. The QMC is comprised of a licensed physician committee chair and three volunteer health care professionals, including a representative from the CMA board. The 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. FDC's quality management program is designed to detect statewide trends in health care treatment and track issues that require corrective action.

During FY 2017-18, the QMC primarily focused their efforts on evaluating the effectiveness of FDC's mortality review process. All in-custody deaths, except executions, require a mortality review. Contracted health care providers conduct self-reviews of inmate mortalities to determine the appropriateness of care. The review is submitted to OHS, which determines if there were any quality of care issues not identified by the contractor. The QMC then evaluates this review of mortality cases to facilitate improvements in inmate health care.

QMC mortality reviews assessed whether the mortality review process effectively identified deficiencies in health care that may have contributed to death, and determined whether appropriate action was taken to prevent deficiencies from happening in the future. The QMC's review of mortality cases is based on a non-random sample, and the intent of the review is not to generalize review findings to mortality cases as a whole. The review process is intended to function as an educational tool when areas of deficiency are identified, whether they are clinical or administrative in nature. Education may be limited to the health care professional that provided the care or extended to a group of health care professionals where a systems deficiency existed or the deficiency can potentially happen across institutions. The purpose of mortality review is to improve the quality of service across FDC's system of care, while providing professional growth and development.

The QMC met three times during the fiscal year and reviewed 12 mortality cases. One meeting was hosted by FDC OHS staff and the staff of RMC in Lake Butler, FL. During this meeting, QMC members received a presentation related to Utilization Management. QMC members requested the presentation following a review of mortality cases where delayed consultations were noted as a mortality review finding. Committee members wanted to have a better understanding of how the consultation process worked. After the presentation, QMC members commented that the presentation was informative and provided them with a better understanding of the consultation process.

EXECUTIVE OFFICE OF THE GOVERNOR, CHIEF INSPECTOR GENERAL AUDIT

During FY 2017-18, the CMA was audited by the Executive Office of the Governor (EOG), Chief Inspector General (CIG). The CMA was included in the CIG's 2017-18 audit plan, and the audit was conducted in accordance to Florida Statutes 14.32. 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."[3] The requirement of § 944.8041, F.S., was also met. Only one area of non-compliance, related to § 945.6031(2), was noted. The CIG found that the CMA did not conduct surveys of all correctional institutions triennially.

CIG staff reviewed CMA survey schedules for FY 2016-17 and FY 2017-18 and determined:

> "During fiscal year 2016-17, the CMA conducted on-site surveys of the physical and mental health care systems at 17 correctional institutions; however, seven correctional institutions that were surveyed during fiscal year 2013-2014 were not surveyed again within the required triennial period. For fiscal year 2017-2018, the CMA has scheduled 17 correctional institutions for on-site surveys of their physical and mental health care systems; thirteen correctional institutions that were surveyed during fiscal year 2014-2015 were not included in this schedule and were not scheduled to be surveyed again within the required triennial period."[4]

Budgetary constraints and reduced staffing was cited as contributing factors for triennial survey non-compliance. The CIG indicated that:

> "Since 1995, the CMA's funding has been reduced from $1,399,031 to $735,729 and staffing has been reduced from 15 to 6 full-time employees. However, since 1995, the number of correctional institutions has not significantly changed, and the resources required to conduct surveys of correctional institutions has increased. These reductions in resources have had a substantial impact on the CMA's ability to conduct surveys of the correctional institutions on a triennial cycle."[5]

Based on the audit findings, the CIG auditors recommended that the CMA's executive director seek assistance with policy and budget issues that impacted the agency's ability to conduct surveys on a triennial cycle. Specifically, CIG auditors recommended:

> "The Executive Director of the CMA request additional funding and staff to conduct surveys and/or assistance in effecting change to the statutory language in section 945.6031(2), F.S., that would adjust the cycle for conducting surveys to a period longer than three years, to better accommodate the CMA's funding and staffing levels."[6]

The CMA concurred with the finding of the audit. In response to the CIG auditor's recommendations, the CMA's executive director met with EOG Administration leadership staff to discuss audit findings and identify steps to be taken to address audit findings. CMA staff will continue to work with incoming EOG staff as well as legislative staff during the next legislative session to address CIG audit findings.

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[3] Office of the Chief Inspector General. (2018). *Audit of the Correctional Medical Authority* (Audit Report Number A-17/18-001), pp. 1.
[4] Ibid., 4.
[5] Ibid.,4.
[6] Ibid., 5.

DISABILITY RIGHTS FLORIDA SETTLEMENT AGREEMENT

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's monitoring of the agreement will include the processes and authority of the CMA as provided in § 945.601, F.S. The CMA monitoring team will evaluate the level of compliance for each relevant provision of the agreement beginning February 2019 and conduct two rounds of monitoring.

INSTITUTIONAL SURVEYS

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

In FY 2017-18, 17 institutions were surveyed. This included 13 institutions previously surveyed as a result of the CMA's triennial survey schedule. Seven institutions (Hernando CI, Homestead CI, Taylor CI, Florida State Prison (FSP), Gadsden CF, Central Florida Reception Center (CFRC), and Cross City CI) were surveyed in FY 2013-14 and six institutions (Marion CI, Sumter CI, Tomoka CI, Wakulla CI, North West Florida Reception Center (NWFRC), and Lake CI) were surveyed in FY 2014-15; two reception centers (NWFRC and CFRC); five institutions with main and annex units (FSP, Taylor CI, Wakulla CI, CFRC, and NWFRC), with each unit being surveyed separately; and one institution with inpatient mental health units (Lake CI). Two surveyed institutions (Gadsden CF and Lake CF) were private facilities managed by DMS.

A total of 612 institutional survey findings were identified, which represents a 24 percent increase in findings from FY 2016-17. Of reportable findings, 332 (54 percent) were physical health findings and 280 (46 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[7],

[7] 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).

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

Table 1. Summary of Fiscal Year 2017-2018 Institutional Surveys

Summary of Fiscal Year 2017-2018 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
Hernando CI	M1-M3	S1-S3	797	722	No	No	Yes	11	10
Gadsden CF	M1-M3	S1-S3	1544	1529	Yes	No	No	12	20
Cross City CI	M1-M3	S1-S2	1734	1708	Yes	No	Yes	14	20
Lake City CF	M1-M3	S1-S3	894	875	Yes	No	Yes	5	15
Lawtey CI	M1-M3	S1-S2	879	827	Yes	No	No	9	0
Florida State Prison	M1-M4	S1-S3	1460	1259	No	No	Yes	12	5
Florida State Prison-West	M1-M4	S1-S2	802	813	Yes	No	Yes	20	12
Taylor CI-Main	M1-M5	S1-S2	1198	932	Yes	No	Yes	19	14
Taylor CI-Annex	M1-M4	S1-S2	1027	847	No	No	Yes	17	15
Sumter CI	M1-M3	S1-S2	2380	2551	Yes	No	Yes	29	29
Marion CI	M1-M4	S1-S3	1161	1764	Yes	No	Yes	12	16
Baker Re-Entry Center	M1-M3	S1-S2	432	391	No	No	No	3	0
Tomoka CI	M1-M4	S1-S3	1812	1726	Yes	No	Yes	17	6
Gadsden Re-Entry Center	M1-M2	S1-S2	432	429	No	No	No	3	0
Lake CI	M1-M5	S1-S6	1093	1078	Yes	Yes	Yes	30	31
Homestead CI	M1-M5	S1-S3	929	874	Yes	No	Yes	7	4
Wakulla CI-Main	M1-M5	S1-S2	1280	1442	Yes	No	Yes	27	6
Wakulla CI-Annex	M1-M3	S1-S3	756	560	No	No	Yes	13	20
Central Florida Reception Center-Main	M1-M5	S1-S3	1473	927	Yes	No	Yes	18	17
Central Florida Reception Center-East	M1-M3	S1-S2	1407	894	Yes	No	Yes	15	2
Central Florida Reception Center-South	M1-M5	S1-S3	140	86	Yes	No	No	6	8
Northwest Florida Reception Center-Main	M1-M5	S1-S3	1303	940	Yes	No	Yes	23	16
Northwest Florida Reception Center-Annex	M1-M5	S1-S3	1615	1135	Yes	No	Yes	10	14
								332	280

CORRECTIVE ACTION PLAN ASSESSMENTS

Within 30 days of receiving the final copy of the CMA's survey report, institutional staff must develop and submit a CAP that addresses the deficiencies outlined in the report. The CAP is submitted to OHS for approval before it is reviewed and approved by CMA staff. Once approved, institutional staff implement and monitor the CAP. Usually four to five months after a CAP is implemented (but no less than three months) CMA staff evaluates the effectiveness of the corrective actions taken. Findings deemed corrected are closed and monitoring is no longer required. Conversely, findings not corrected remain open. Institutional staff continue to monitor the open findings until the next assessment is conducted, typically within three to four months. This process continues until all findings are closed.

CMA staff completed 50 CAP assessments in FY 2017-18. This included three CAP assessments for institutions surveyed in FY 2014-15, 18 CAP assessments for institutions surveyed in FY 2015-16, 20 CAP assessments for institutions surveyed in FY 2016-17, and nine CAP assessments for institutions surveyed in FY 2017-18.

At the end of the fiscal year, all CAPs from FY 2012-13 were closed, 12 of 13 CAPs from FY 2013-14 were closed, 14 of 16 CAPs from FY 2014-15 were closed, 10 of 15 CAPs from FY 2015-16 were closed, 8 of 13 CAPs from FY 2016-17, and 2 of 18 CAPs from FY 2017-18 were closed. The results of CAP assessments for the last five years are summarized below in Tables 2a-2d.

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

Fiscal Year 2014-2015 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Lake CI*	24	48	0	3	8	Open
Lowell CI-Annex*	54	32	1	0	9	Open

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

Fiscal Year 2015-2016 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Columbia CI-Annex*	25	29	0	1	6	Open
FWRC*	52	59	0	0	8	Closed 10/30/18
RMC-Main*	19	47	0	0	7	Closed 2/22/18
Dade CI*	15	21	0	5	6	Open
Everglades CI**	9	4	0	0	0	Closed 8/24/18
Apalachee CI-East**	19	23	0	0	0	Closed 10/17/18

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

Fiscal Year 2016-2017 Surveyed Institutions						
Institution	Total Number of Physical Health Findings	Total Number of Mental Health Findings	Total Number of Open Physical Health CAP Findings	Total Number of Open Mental Health CAP Findings	Number of CAP Assessments	Open or Closed
Martin CI	7	19	0	0	4	Closed 2/6/18
Desoto Annex	9	7	0	0	3	Closed 2/19/18
Santa Rosa CI-Main	8	28	0	6	4	Open
Santa Rosa CI-Annex	13	24	0	2	4	Open
Jefferson CI**	12	13	0	0	5	Closed 8/14/18
Union CI	19	48	0	0	2	Closed 2/19/18
Suwannee CI-Main	20	39	1	6	3	Open
Suwannee CI-Annex	17	9	1	1	3	Open
Mayo CI	16	11	0	0	3	Closed
SFRC-Main	19	20	0	2	3	Open
SFRC-South Unit	17	0	0	0	2	Closed 3/29/18
Putnam CI	2	2	0	0	1	Closed 12/8/17
Lancaster CI	12	3	0	1	3	Open
Zephyrhills CI	17	26	7	3	2	Open

Table 2d. 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
Hernando CI	11	10	0	0	2	Closed 5/17/18
Gadsden CF	12	20	0	2	2	Open
Cross City CI**	14	20	0	0	2	Closed 9/25/18
Lake City CF	5	15	0	5	2	Open
Lawtey CI**	9	0	0	0	2	Closed 8/15/18
Florida State Prison**	12	5	0	0	2	Closed 11/21/18
Florida State Prison-West **	20	12	0	0	2	Closed 11/21/18
Taylor CI-Main	19	14	7	9	1	Open
Taylor CI-Annex	17	15	2	10	1	Open
Sumter CI	29	29	15	23	1	Open
Marion CI	12	16	12	16	1	Open
Baker Re-Entry Center	3	0	0	0	1	Closed 4/26/18
Tomoka CI	17	6	3	1	1	Open
Gadsden Re-Entry Center**	3	0	0	0	1	Closed 9/17/18
Lake CI	30	31	6	11	1	Open
Homestead CI**	7	4	0	0	1	Closed 10/19/18
Wakulla CI-Main	27	6	27	6	0	Open
Wakulla CI-Annex	13	20	13	20	0	Open
Central Florida Reception Center-Main	18	17	18	17	0	Open
Central Florida Reception Center-East	15	2	15	2	0	Open
Central Florida Reception Center-South	6	8	6	8	0	Open
Northwest Florida Reception Center-Main	23	16	23	16	0	Open
Northwest Florida Reception Center-Annex	10	14	10	14	0	Open

Institutions will be re-surveyed in FY 2018-19.

****Indicates institutions with CAP assessments completed after June 30, 2018.***

Summary of Fiscal Year 2017-2018 Institutional Survey Findings

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

Institutional survey reports provide detailed information that include descriptions of findings and discussion points. In contrast to individual reports, the information presented in this section does not attempt to provide a detailed summary of all identified survey findings, nor does it attempt to compare institutions based on individual performance. The information presented summarizes overall performance and identifies significant findings from each service delivery area evaluated during physical and mental health surveys. These findings required corrective action and include only findings noted at three or more institutions, except for findings for inpatient mental health services and reception because only one inpatient unit and two reception centers 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 2017-18, there were 332 physical health findings, which represented 54 percent of total survey findings. When compared to FY 2016-17, there was a 47 percent increase in the number of physical health findings. Table 3 provides a description of each physical health assessment area, the total number of findings by area, and the total number of institutions with findings in each area. Table 4 provides a summary of findings by institution.

Table 3. Description of Physical Health Survey Assessment Areas

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Chronic Illness Clinics	Assesses care provided to inmates with specific chronic care issues. Clinical records reviews are completed for the following chronic illness clinics: cardiovascular, endocrine, gastrointestinal, immunity, miscellaneous, neurology, oncology, respiratory, and tuberculosis	111 (33%)	22 (96%)
Consultation Requests	Assesses processes for approving, denying, scheduling services, and follow-up for specialty care services	29 (9%)	19 (83%)
Dental Care	Assesses the provision of dental care	19 (6%)	10 (50%)*
Dental Systems	Assesses compliance with FDC's policies and procedures for dental services	20 (6%)	13 (65%)*
Emergency Care	Assesses emergency care processes for addressing urgent/emergent medical complaints	12 (4%)	10 (43%)
Infection Control	Assesses compliance with infection control policies and procedures	1 (0.30%)	1 (4%)
Infirmary Care	Assesses the provision of skilled nursing services in infirmary settings	33 (10%)	12 (75%)***
Institutional Tour	Tour of medical, dental, and housing facilities	40 (12%)	20 (87%)
Intra-System Transfers	Assesses systems and processes for ensuring continuity of care for inmates transferred between institutions	12 (4%)	10 (43%)
Medical Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying physical health related inmate requests	9 (3%)	7 (30%)
Medication Administration	Assesses the administration of medication and clinical documentation related to medication practices	11 (3%)	7 (30%)
Periodic Screenings	Assesses the provision of periodic physical examinations and health screenings	11 (3%)	8 (35%)
Pharmacy Services	Assesses compliance with FDC's policies and procedures for medication storage, inventory, and disposal	5 (2%)	3 (13%)
Pill Line Administration	Assesses medication dispensing practices to ensure proper nursing practices and policies are followed	5 (2%)	2 (9%)
Reception Process	Assesses compliance with FDC's policies and procedures for physical health screenings of new inmates	1 (0.30%)	1 (50%)****
Sick Call	Assesses sick call processes to address acute and non-emergency medical complaints and inmate access to sick call	10 (3%)	9 (39%)

****Dental services were not provided at Baker Re-Entry and Gadsden Re-Entry.***

******Infirmary services were not provided at Hernando CI, FSP, Taylor CI-Annex, Baker Re-Entry, Gadsden Re-Entry, and Wakulla CI-Annex.***

********Reception services were provided at CFRC-Main and NWFRC-Annex.***

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
Hernando CI	3	2	0	2	0	1	N/A	1	1	0	0	0	1	0	N/A	0	N/A	**11**
Gadsden CF	5	0	1	1	0	0	0	1	0	0	3	1	0	0	N/A	0	N/A	**12**
Cross City CI	7	4	0	1	1	0	0	0	0	1	0	0	0	0	N/A	0	N/A	**14**
Lake City CF	3	1	0	0	0	0	1	0	0	0	0	0	0	0	N/A	0	N/A	**5**
Lawtey CI	3	1	0	0	0	0	2	1	0	0	0	0	0	0	N/A	1	1	**9**
Florida State Prison	1	3	0	1	0	0	N/A	1	0	1	1	3	0	0	N/A	0	1	**12**
Florida State Prison-West	7	1	2	1	1	0	3	5	0	0	0	0	0	0	N/A	0	N/A	**20**
Taylor CI-Main	6	0	0	2	0	0	5	0	3	0	1	1	1	0	N/A	0	N/A	**19**
Taylor CI-Annex	1	2	3	2	1	0	N/A	5	0	2	1	0	0	0	N/A	0	N/A	**17**
Sumter CI	14	1	1	2	2	0	3	3	1	1	0	0	0	0	N/A	1	N/A	**29**
Marion CI	4	1	0	1	0	0	2	2	0	0	2	0	0	0	N/A	0	N/A	**12**
Baker Re-Entry Center	1	0	N/A	N/A	0	0	N/A	1	1	0	0	0	0	0	N/A	0	N/A	**3**
Tomoka CI	5	1	0	0	1	0	2	1	0	0	2	0	0	3	N/A	2	N/A	**17**
Gadsden Re-Entry Center	0	0	N/A	N/A	0	0	N/A	1	1	0	0	1	0	0	N/A	0	N/A	**3**
Lake CI	9	1	3	1	2	0	7	2	1	0	0	0	3	0	N/A	1	N/A	**30**
Homestead CI	1	1	1	1	0	0	0	1	0	0	0	0	0	2	N/A	0	N/A	**7**
Wakulla CI-Main	9	1	3	3	0	0	4	2	0	2	1	0	0	0	N/A	1	1	**27**
Wakulla CI-Annex	3	2	2	2	1	0	N/A	1	1	0	0	1	0	0	N/A	0	N/A	**13**
Central Florida Reception Center-Main	7	2	2	0	1	0	1	2	1	0	0	1	0	0	1	0	N/A	**18**
Central Florida Reception Center-East	4	1	0	0	0	0	N/A	5	1	1	0	2	0	0	N/A	1	N/A	**15**
Central Florida Reception Center-South	1	2	N/A	N/A	1	0	0	1	0	0	0	0	0	0	N/A	1	N/A	**6**
Northwest Florida Reception Center-Main	14	1	0	0	1	0	2	2	0	1	0	1	0	0	N/A	1	N/A	**23**
Northwest Florida Reception Center-Annex	3	1	1	0	0	0	1	2	1	0	0	0	0	0	0	1	N/A	**10**
	111	29	19	20	12	1	33	40	12	9	11	11	5	5	1	10	2	332

CHRONIC ILLNESS CLINICS

As in previous years, an analysis of aggregate survey data revealed that the majority (33 percent) of physical health survey findings were related to CICs. CIC findings were noted at 22 of 23 surveyed institutions. Table 5 summarizes CIC findings.

Table 5. Summary of Chronic Illness Clinic Findings

Chronic Illness Clinics	Total Findings	Institutions with Findings
Cardiovascular	4 (4%)	4 (17%)
Endocrine	19 (17%)	15 (65%)
Gastrointestinal	11 (10%)	8 (35%)
Immunity	9 (8%)	7 (30%)
Miscellaneous	15 (14%)	9 (39%)
Neurology	17 (15%)	13 (57%)
Oncology	8 (7%)	4 (17%)
Respiratory	8 (7%)	6 (26%)
Tuberculosis	13 (12%)	5 (22%)

In total, 111 CIC findings were identified across all 23 institutions. While CICs had findings specifically related to the delivery of care for that clinic, several common findings were identified across clinics. The most commonly reported findings across all clinics were related to: inmates not being seen at the required intervals according to M-grade status, missing vaccinations, and abnormal labs not being addressed timely.

Common CIC findings for specific clinics are detailed below:

- Endocrine Clinic: record reviews indicated that fundoscopic examinations were not completed annually and inmates with uncontrolled blood sugar levels were not seen at required intervals
- Miscellaneous Clinic: examinations were not appropriate and sufficient to assess conditions, the control of the disease was not evaluated at each clinic visit, and referrals to specialty services were not made when indicated
- Neurology Clinic: seizures were not consistently classified by type
- Respiratory Clinic: reactive airway diseases were not classified
- Tuberculosis Clinic: missing monthly nursing follow-up therapy and incorrect doses of tuberculosis medications administered

CONSULTATION REQUESTS

Consultation findings represented nine percent of physical health findings. Findings were noted for 19 (83 percent) surveys. The most common consultation findings across institutions were untimely follow-up consultation appointments or diagnostic/laboratory testing, incomplete or missing documentation of consultation appointments, and incomplete or missing documentation of new diagnoses on problem lists.

DENTAL REVIEW

Dental care findings were noted at 10 (50 percent) institutions and dental system findings were noted at 13 (65 percent) institutions. Nineteen findings were related to clinical care and 20 findings were related to dental systems. Across institutions, the most common clinical care findings were related to incomplete or inaccurate charting of dental findings, inaccurate diagnosis and inappropriate treatment plans, and incomplete and untimely referrals for higher levels of care. The most common systems findings were related to dental assistants working outside Florida Board of Dentistry (64B5-16, F.A.C.) guidelines and the disrepair, accessibility, and availability of dental equipment.

EMERGENCY CARE

Emergency care findings were noted for 10 (43 percent) surveys, with 12 (4 percent) findings. Incomplete and untimely referrals for higher levels of care were identified as the most common emergency care finding across institutions.

INFECTION CONTROL

One (0.30 percent) finding related to infection control was noted for one (four percent) survey. There were no system-wide trends.

INFIRMARY CARE

Infirmary care findings were noted at 12 (75 percent) institutions where infirmary care services were provided. Clinical records reviews resulted in 33 (10 percent) findings. The most common findings across institutions included: clinician orders not implemented or implemented incorrectly, missing outpatient discharge notes, incomplete nursing evaluations, incomplete clinician weekend telephone rounds, and incomplete clinician discharge summaries.

INSTITUTIONAL TOUR

Institutional tour findings were noted for 20 (87 percent) surveys, and resulted in 40 (12 percent) findings. No system-wide trends were identified.

INTRA-SYSTEM TRANSFERS

Twelve (4 percent) findings related to intra-system transfers were noted for 10 (43 percent) surveys. One system-wide trend was noted across institutions: incomplete clinician review of intra-system transfers documentation.

MEDICAL INMATE REQUESTS

Seven (30 percent) institutions surveyed had findings related to medical inmate requests. In total, 9 (3 percent) findings were identified. There were no system-wide trends.

MEDICATION ADMINISTRATION RECORD REVIEW AND PILL LINE OBSERVATION

Clinical record reviews related to medication administration resulted in 11 (3 percent) findings across seven (30 percent) institutions surveyed. There were five (2 percent) findings 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: missing clinician corresponding notes in the medical record and medication administration records (MAR) not matching clinician's orders.

PERIODIC SCREENINGS

Eleven (3 percent) periodic screening findings were noted at 8 (35 percent) institutions. The most common findings were untimely or incomplete diagnostic testing and incomplete and untimely referrals for higher levels of care.

PHARMACY SERVICES

There were five (2 percent) findings related to pharmacy services at three (13 percent) institutions. No system-wide trends were noted.

SICK CALL

There were 10 (3 percent) findings related to the sick call process. Nine (39 percent) institutions had reportable findings. Inadequate and untimely follow-up visits were the only system-wide issue identified across institutions.

RECEPTION PROCESS

Reception services were provided at two institutions and one (0.30 percent) finding was noted. No system-wide trends were noted.

Mental Health Survey Findings

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

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

There were 280 mental health findings in FY 2017-18 that represented 46 percent of total survey findings. As in previous fiscal years, outpatient mental health services findings represented the majority (29 percent) of reported mental health findings. Findings in the areas of outpatient psychiatric medication practices and self-injury/suicide prevention also continued to represent a significant portion of mental health findings. There were no findings related to psychiatric restraints. There were no mental health findings at three institutions (Lawtey CI, Baker Re-entry, and Gadsden Re-entry).

Table 6 below 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 7 summarizes mental health survey findings across institutions.

Table 6. Description of Mental Health Survey Assessment Area

Assessment Area	Description of Assessment Area	Total Findings	Institutions with Findings
Discharge Planning	Assesses processes for ensuring the continuity of mental health care for inmates within 180 days of end of sentence	9 (3%)	13 (57%)*
Inpatient Mental Health Services	Assesses the provision of mental health care in inpatient settings	3 (1%)	1 (100%)**
Inpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in inpatient settings	4 (1%)	1 (100%)**
Mental Health Inmate Requests	Assesses systems and processes for reviewing, approving, and/or denying mental health related inmate requests	11 (4%)	9 (41%)
Mental Health Systems Reviews	Assesses systems and processes related to mental health staff training, clinical supervision, and other administrative functions	11 (4%)	7 (30%)
Psychiatric Restraints	Assesses compliance with FDC's policies and procedures for psychiatric restraints	0 (0%)	0 (0%)***
Psychological Emergencies	Assesses the process for responding to inmate mental health emergencies	13 (5%)	8 (36%)****
Outpatient Mental Health Services	Assesses the provision of mental health services in an outpatient setting	82 (29%)	18 (78%)
Outpatient Psychiatric Medication Practices	Assesses medication administration and documentation of psychiatric assessment in outpatient settings	50 (18%)	11 (79%)*****
Reception Process	Assesses compliance with FDC's policies and procedures for mental health screenings of new inmates	3 (1%)	2 (100%)******
Self-Injury/ Suicide Prevention	Assesses compliance with FDC's policies and procedures for self-injury and suicide prevention	58 (21%)	16 (100%)*******
Special Housing	Assesses compliance with FDC's policies and procedures for providing mental health services to inmates assigned to confinement, protective management, or close management	13 (5%)	7 (39%)********
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	23 (8%)	10 (77%)*********

****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 Lake CI.***
******There were two institutions with Psychiatric Restraint episodes.***
*******There were no Psychological Emergencies for review at CFRC-South.***
********Outpatient Psychiatric Medication was provided at institutions housing inmates with a grade of S-3. Fourteen institutions were assessed.***
*********Reception Services were only provided at CFRC-Main and NWFRC-Annex.***
**********Inmates were not housed for Self-Injury/Suicide Prevention at Hernando CI, Lawtey CI, Baker Re-entry, Gadsden Re-Entry, Wakulla CI-Annex, CFRC-East, and CFRC-South.***
***********Special housing was not provided at Lawtey CI, Baker Re-entry, Gadsden Re-entry, CFRC-East, and CFRC-South.***
************There were 13 institutions with applicable use of force episodes.***

Table 7. Summary of Mental Health Survey Findings by Institution

Institutions	Discharge Planning	Inpatient Mental Health Services	Inpatient Psychiatric Medication Practices	Mental Health Inmate Requests	Mental Health Systems Reviews	Psychiatric Restraints	Psychological Emergency	Outpatient Mental Health Services	Outpatient Psychiatric Medication Practices	Reception Process	Self-Injury/ Suicide Prevention	Special Housing	Use of Force	Total
Hernando CI	1	N/A	N/A	0	2	N/A	0	5	1	N/A	N/A	1	N/A	**10**
Gadsden CF	2	N/A	N/A	1	1	N/A	1	5	5	N/A	5	0	N/A	**20**
Cross City CI	N/A	N/A	N/A	0	1	N/A	3	8	N/A	N/A	6	2	N/A	**20**
Lake City CF	2	N/A	N/A	0	1	N/A	0	0	7	N/A	3	0	2	**15**
Lawtey CI	N/A	N/A	N/A	0	0	N/A	0	0	0	N/A	N/A	N/A	N/A	**0**
Florida State Prison	0	N/A	N/A	0	0	0	1	3	0	N/A	1	0	0	**5**
Florida State Prison-West	N/A	N/A	N/A	0	2	N/A	0	5	N/A	N/A	5	0	N/A	**12**
Taylor CI-Main	N/A	N/A	N/A	0	0	N/A	2	6	N/A	N/A	4	0	2	**14**
Taylor CI-Annex	N/A	N/A	N/A	1	0	N/A	2	5	N/A	N/A	5	0	2	**15**
Sumter CI	N/A	N/A	N/A	2	3	N/A	2	8	N/A	N/A	9	3	2	**29**
Marion CI	0	N/A	N/A	0	0	N/A	0	9	2	N/A	3	0	2	**16**
Baker Re-Entry Center	N/A	N/A	N/A	0	0	N/A	0	0	N/A	N/A	N/A	N/A	N/A	**0**
Tomoka CI	1	N/A	N/A	0	0	N/A	1	2	1	N/A	1	0	0	**6**
Gadsden Re-Entry Center	N/A	N/A	N/A	0	0	N/A	0	0	N/A	N/A	N/A	N/A	N/A	**0**
Lake CI	2	3	4	0	1	0	1	7	6	N/A	3	2	2	**31**
Homestead CI	0	N/A	N/A	0	0	N/A	0	0	0	N/A	1	0	3	**4**
Wakulla CI-Main	N/A	N/A	N/A	1	0	N/A	0	2	N/A	N/A	3	0	N/A	**6**
Wakulla CI-Annex	1	N/A	N/A	1	0	N/A	0	6	7	N/A	N/A	1	4	**20**
Central Florida Reception Center-Main	0	N/A	N/A	1	0	N/A	0	4	2	2	4	1	3	**17**
Central Florida Reception Center-East	N/A	N/A	N/A	1	0	N/A	0	1	N/A	N/A	N/A	N/A	N/A	**2**
Central Florida Reception Center-South	0	N/A	N/A	N/A	0	N/A	N/A	1	7	N/A	N/A	N/A	N/A	**8**
Northwest Florida Reception Center-Main	0	N/A	N/A	2	0	N/A	0	2	8	N/A	3	0	1	**16**
Northwest Florida Reception Center-Annex	0	N/A	N/A	1	0	N/A	0	3	4	1	2	3	0	**14**
Total Findings	**9**	**3**	**4**	**11**	**11**	**0**	**13**	**82**	**50**	**3**	**58**	**13**	**23**	**280**

DISCHARGE PLANNING

Record reviews for discharge planning were completed at 13 institutions, and of those institutions, 6 (46 percent) had findings. Nine (3 percent) findings were identified and the most common findings were related to: inadequate or incomplete aftercare planning documentation and missing or incomplete consent for release of confidential information.

MENTAL HEALTH INMATE REQUESTS

Nine institutions (41 percent) had mental health inmate request findings, with 11 (4 percent) reportable findings. The most common finding was incomplete or missing follow-up for referrals/interviews.

MENTAL HEALTH SERVICES

INPATIENT MENTAL HEALTH SERVICES

Inpatient mental health services were provided at one surveyed institution. Three (1 percent) findings were noted. No system-wide trends can be determined.

OUTPATIENT MENTAL HEALTH SERVICES

Findings related to outpatient mental health services accounted for 29 percent (82) of mental health survey findings. Eighteen (78 percent) institutions had reportable findings. The most common findings were related to: untimely mental health screening evaluations, incomplete, inadequate, and/or untimely ISP documentation, incomplete problem list documentation, missing, inadequate, and/or untimely counseling and case management services.

MENTAL HEALTH SYSTEMS REVIEWS

Mental health systems findings were noted at 7 (30 percent) institutions, and 11 (4 percent) findings were identified. The lack of psychiatric restraint equipment was a common finding across institutions.

PSYCHIATRIC MEDICATION PRACTICES

INPATIENT PSYCHIATRIC MEDICATION PRACTICES

Inpatient psychiatric medication practice record reviews were completed for one institution and resulted in 4 (1 percent) findings. No system-wide trends can be determined.

OUTPATIENT PSYCHIATRIC MEDICATION PRACTICES

Eleven (79 percent) institutions had outpatient psychiatric medication practice findings and 50 (18 percent) findings were identified. Across institutions, the most common findings were related to incomplete initial laboratory testing, incomplete follow-up treatment and/or referrals for abnormal labs, incomplete follow-up labs, medications not given as ordered and/or missing documentation for medication refusals, and untimely Abnormal Involuntary Movement Scale (AIMS) assessments.

PSYCHIATRIC RESTRAINTS

During the fiscal year, psychiatric restraint episodes were available for review at two institutions and, based on those episodes, no findings were identified.

PSYCHOLOGICAL EMERGENCIES

Psychological emergency findings were noted for eight (36 percent) institutions and resulted in 13 (5 percent) findings. The most common finding across institutions was incomplete or missing follow-up in response to psychological emergencies.

RECEPTION PROCESS

Two reception centers were surveyed during the fiscal year, resulting in three (1 percent) reception process findings. Incomplete or missing intelligence testing was noted as a finding for both reception centers.

SELF-INJURY/SUICIDE PREVENTION

Self-harm observation status (SHOS) findings were identified for 16 (100 percent) surveys with SHOS episodes for review, resulting in 58 (21 percent) findings. The most commonly identified findings across institutions were related to missing and/or incomplete emergency evaluations, noncompliance with SHOS management guidelines, noncompliance with clinician orders for observation frequency, incomplete and/or missing nursing evaluations, missing daily counseling by mental health staff, and missing post-discharge follow-up.

SPECIAL HOUSING

Special housing findings were noted at seven (39 percent) surveyed institutions. There were 13 (5 percent) reportable findings. The most common findings were related to incomplete special housing health appraisals and untimely mental status exams.

USE OF FORCE

There were applicable use of force episodes for review at 13 institutions surveyed during the fiscal year. Findings were noted at 10 (77 percent) of those institutions, which resulted in 23 (8 percent) findings. The most common findings were related to incomplete post use of force examinations, incomplete referrals to mental health from nursing staff, and untimely interviews by mental health staff to determine whether a higher level of care was needed.

SUMMARY OF SYSTEM-WIDE TRENDS AND RECOMMENDATIONS

Tables 8 and 9 below summarize system-wide findings identified during FY 2017-18 physical and mental health surveys. These findings were not noted at all institutions; however, they were noted at three or more institutions.

Table 8. Physical Health Survey: System-Wide Trends

Assessment Area	Physical Health Survey System-Wide Areas of Concern
Chronic Illness Clinics	• Inmates were not seen timely according to M-grade status (Chronic Illness Clinic) • There was no evidence of vaccinations or refusals (Gastroenterology and Immunity 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 the control of the disease was documented at each clinic visit (Miscellaneous Clinic) • There was no evidence of referrals to a specialist for more in-depth treatment, when indicated (Miscellaneous Clinic) • There was no evidence examinations were appropriate to the diagnosis and sufficient to assess patients' current status (Miscellaneous Clinic) • Seizures were not classified by nomenclature (Neurology Clinic) • Abnormal labs were not addressed in a timely manner (Neurology Clinic) • There was no evidence reactive airway diseases were classified as mild, moderate, or severe (Respiratory Clinic) • There was no evidence nursing staff provided monthly follow-up therapy in the Tuberculosis Clinic (Tuberculosis Clinic) • Inmates were not given the correct doses of tuberculosis medication (Tuberculosis Clinic)
Consultation Requests	• 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
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 • There was no evidence that consultation or specialty services were requested in a reasonable timeframe
Emergency Care	• There was no evidence follow-up appointments with higher level clinicians were made in a timely manner
Infirmary Care	• Physician's orders were not implemented or implemented incorrectly • Discharge notes for outpatient infirmary admissions were missing • There was no evidence nursing evaluations were completed at least once every eight hours • There was no evidence of clinician weekend telephone rounds • Clinician discharge summaries were not completed within 72 hours of discharge
Intra-system Transfers	• Clinicians did not review intra-system transfer forms within seven days of arrival
Medication Administration	• There was no evidence of corresponding notes for medication orders in the medical record from an advanced level provider • MARS did not match the medication order
Periodic Screenings	• There was no evidence that all required diagnostic tests were performed prior to screening • Referrals were not made when indicated
Sick Call	• There was no evidence that follow-up visits occurred as indicated in a timely manner

Table 9. Mental Health Survey: System-Wide Trends

Assessment Area	Mental Health Survey System-Wide Areas of Concern
Discharge Planning	• Aftercare planning was not addressed on the Individualized Service Plan (ISP) within 180 days of expiration of sentence (EOS) • Consent to release information for continuity of care was missing or incomplete
Inpatient Mental Health Services	• No trends identified
Inpatient Psychiatric Medication Practices	• No trends identified
Mental Health Inmate Requests	• Interview or referral indicated in request response did not occur
Psychiatric Restraints	• No findings noted
Psychological Emergencies	• Following psychological emergency, there was no evidence of follow-up
Outpatient Mental Health Services	• Mental health screening evaluations were incomplete • Bio-psychosocial Assessments (BPSA) were not approved by all members of the multidisciplinary services team (MDST) within 30 days of initiating treatment • Mental health services were not initiated within 30 days of receiving an S2 or S3 mental health grade • ISPs did not specify the types of interventions, frequency of interventions, and/or the staff responsible for providing interventions • 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 case management was provided at least every 90 days
Outpatient Psychiatric Medication Practices	• Initial laboratory tests were not ordered • Abnormal labs were not followed-up with appropriate treatment and/or referral in a timely manner • Follow-up labs were not completed • Inmates did not receive medications as prescribed and/or there was no documentation of refusal • There was no evidence 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	• Intelligence testing was not completed
Self-Injury/ Suicide Prevention	• Emergency evaluations were not completed by mental health or nursing staff prior to admissions • Guidelines for SHOS management were not observed • There was no 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 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
Use of Force	• There was no evidence that post use of force evaluations were conducted as required • 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 COMPARISION

During FY 2017-18, 13 institutions were resurveyed as a part of the CMA's triennial survey schedule. These institutions were initially surveyed in FY 2013-14 and 2014-15. The tables below provide a comparison of survey findings from the first survey cycle and FY 2017-18.

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 efficiency and accuracy of the survey process. The number of findings related to chronic illness clinics and medical inmate requests were impacted by these changes.

PHYSICAL HEALTH FINDINGS

Table 10a. Fiscal Years 2013-2014 and 2014-2015 Surveyed Institutions Physical Health Findings

Institutions	Chronic Illness Clinics	Consultation Requests	Dental Review	Emergency Care	Infection Control	Infirmary Care	Institutional Tour	Intra-System Transfers	Medical Inmate Requests	Medication Administration	Periodic Screenings	Pharmacy	Pill Line Administration	Reception Process	Sick Call	Additional Administrative Issues	Total
Hernando CI	15	3	6	1	0	N/A	2	2	N/A	1	1	0	2	N/A	0	N/A	**33**
Gadsden CF	29	2	0	0	0	3	1	0	N/A	1	2	0	0	N/A	0	N/A	**38**
Cross City CI	6	1	0	0	0	0	0	2	N/A	2	0	0	0	N/A	0	N/A	**11**
Florida State Prison	10	1	1	0	0	N/A	1	1	N/A	1	0	1	0	N/A	0	N/A	**16**
Florida State Prison-West	21	1	0	0	0	1	2	0	N/A	0	0	0	1	N/A	0	N/A	**26**
Taylor CI-Main	30	2	0	0	0	4	1	1	N/A	1	5	1	0	N/A	5	N/A	**50**
Taylor CI-Annex	35	4	0	1	0	N/A	4	0	N/A	0	0	0	0	N/A	1	N/A	**45**
Sumter CI	6	1	0	0	0	5	0	0	N/A	0	0	0	1	N/A	1	N/A	**14**
Marion CI	21	3	1	1	0	3	1	1	N/A	0	0	0	0	N/A	0	N/A	**31**
Tomoka CI	14	1	2	1	0	6	1	1	N/A	0	2	0	1	N/A	1	N/A	**30**
Lake CI	14	1	3	0	0	2	1	0	N/A	0	3	0	0	N/A	0	N/A	**24**
Homestead CI	14	3	0	0	0	0	0	0	N/A	1	0	2	0	N/A	0	N/A	**20**
Wakulla CI-Main	22	1	1	0	0	2	1	0	N/A	0	0	0	0	N/A	0	N/A	**27**
Wakulla CI-Annex	19	1	1	3	0	N/A	0	1	N/A	1	2	1	0	N/A	1	N/A	**30**
Central Florida Reception Center-Main	5	1	2	2	0	2	2	3	N/A	1	3	1	0	4	0	N/A	**26**
Central Florida Reception Center-East	22	0	2	0	0	N/A	3	0	N/A	0	0	0	0	N/A	0	N/A	**27**
Northwest Florida Reception Center-Main	24	2	3	1	0	8	2	2	N/A	0	0	0	0	N/A	1	N/A	**43**
Northwest Florida Reception Center-Annex	25	6	1	0	0	0	0	0	N/A	1	0	0	0	0	1	N/A	**34**
	332	34	23	10	0	36	22	14	N/A	10	18	6	5	4	11	N/A	525

Table 10b. Fiscal Year 2017-2018 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
Hernando CI	3	2	0	2	0	1	N/A	1	1	0	0	0	1	0	N/A	0	N/A	**11**
Gadsden CF	5	0	1	1	0	0	0	1	0	0	3	1	0	0	N/A	0	N/A	**12**
Cross City CI	7	4	0	1	1	0	0	0	0	1	0	0	0	0	N/A	0	N/A	**14**
Florida State Prison	1	3	0	1	0	0	N/A	1	0	1	1	3	0	0	N/A	0	1	**12**
Florida State Prison-West	7	1	2	1	1	0	3	5	0	0	0	0	0	0	N/A	0	N/A	**20**
Taylor CI-Main	6	0	0	2	0	0	5	0	3	0	1	1	1	0	N/A	0	N/A	**19**
Taylor CI-Annex	1	2	3	2	1	0	N/A	5	0	2	1	0	0	0	N/A	0	N/A	**17**
Sumter CI	14	1	1	2	2	0	3	3	1	1	0	0	0	0	N/A	1	N/A	**29**
Marion CI	4	1	0	1	0	0	2	2	0	0	2	0	0	0	N/A	0	N/A	**12**
Tomoka CI	5	1	0	0	1	0	2	1	0	0	2	0	0	3	N/A	2	N/A	**17**
Lake CI	9	1	3	1	2	0	7	2	1	0	0	0	3	0	N/A	1	N/A	**30**
Homestead CI	1	1	1	1	0	0	0	1	0	0	0	0	0	2	N/A	0	N/A	**7**
Wakulla CI-Main	9	1	3	3	0	0	4	2	0	2	1	0	0	0	N/A	1	1	**27**
Wakulla CI-Annex	3	2	2	2	1	0	N/A	1	1	0	0	1	0	0	N/A	0	N/A	**13**
Central Florida Reception Center-Main	7	2	2	0	1	0	1	2	1	0	0	1	0	0	1	0	N/A	**18**
Central Florida Reception Center-East	4	1	0	0	0	0	N/A	5	1	1	0	2	0	0	N/A	1	N/A	**15**
Northwest Florida Reception Center-Main	14	1	0	0	1	0	2	2	0	1	0	1	0	0	N/A	1	N/A	**23**
Northwest Florida Reception Center-Annex	3	1	1	0	0	0	1	2	1	0	0	0	0	0	0	1	N/A	**10**
	103	25	19	20	11	1	30	36	10	9	11	10	5	5	1	8	2	306

MENTAL HEALTH FINDINGS

Table 10c. Fiscal Years 2013-2014 and 2014-2015 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
Hernando CI	3	N/A	N/A	0	0	N/A	0	4	6	N/A	N/A	0	N/A	**13**
Gadsden CF	1	N/A	N/A	0	2	N/A	1	6	2	N/A	3	1	3	**19**
Cross City CI	N/A	N/A	N/A	0	0	N/A	0	1	N/A	N/A	4	0	0	**5**
Florida State Prison	0	N/A	N/A	0	2	N/A	0	1	3	N/A	2	0	0	**8**
Florida State Prison-West	N/A	N/A	N/A	0	2	N/A	0	1	N/A	N/A	N/A	0	N/A	**3**
Taylor CI-Main	N/A	N/A	N/A	1	4	N/A	2	12	N/A	N/A	5	3	0	**27**
Taylor CI-Annex	N/A	N/A	N/A	1	4	N/A	3	12	N/A	N/A	N/A	2	N/A	**22**
Sumter CI	N/A	N/A	N/A	0	0	N/A	0	0	N/A	N/A	3	0	N/A	**3**
Marion CI	N/A	N/A	N/A	1	1	N/A	0	1	N/A	N/A	2	0	N/A	**5**
Tomoka CI	0	N/A	N/A	0	1	N/A	0	5	7	N/A	5	0	2	**20**
Lake CI	3	9	15	1	1	5	1	1	7	N/A	3	2	0	**48**
Homestead CI	0	N/A	N/A	0	0	N/A	1	1	0	N/A	0	0	0	**2**
Wakulla CI-Main	N/A	N/A	N/A	0	0	N/A	0	4	N/A	N/A	12	N/A	N/A	**16**
Wakulla CI-Annex	N/A	N/A	N/A	0	0	N/A	1	5	5	N/A	N/A	0	N/A	**11**
Central Florida Reception Center-Main	0	N/A	N/A	2	1	N/A	0	6	7	2	3	2	2	**25**
Central Florida Reception Center-East	N/A	N/A	N/A	1	1	N/A	N/A	6	N/A	N/A	N/A	N/A	N/A	**8**
Northwest Florida Reception Center-Main	0	N/A	N/A	0	0	N/A	0	1	6	N/A	1	0	0	**8**
Northwest Florida Reception Center-Annex	0	N/A	N/A	1	0	N/A	0	4	7	2	1	0	0	**15**
Total Findings	7	9	15	8	19	5	9	71	50	4	44	10	7	258

Table 10d. Fiscal Year 2017-2018 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
Hernando CI	1	N/A	N/A	0	2	N/A	0	5	1	N/A	N/A	1	N/A	**10**
Gadsden CF	2	N/A	N/A	1	1	N/A	1	5	5	N/A	5	0	N/A	**20**
Cross City CI	N/A	N/A	N/A	0	1	N/A	3	8	N/A	N/A	6	2	N/A	**20**
Florida State Prison	0	N/A	N/A	0	0	0	1	3	0	N/A	1	0	0	**5**
Florida State Prison-West	N/A	N/A	N/A	0	2	N/A	0	5	N/A	N/A	5	0	N/A	**12**
Taylor CI-Main	N/A	N/A	N/A	0	0	N/A	2	6	N/A	N/A	4	0	2	**14**
Taylor CI-Annex	N/A	N/A	N/A	1	0	N/A	2	5	N/A	N/A	5	0	2	**15**
Sumter CI	N/A	N/A	N/A	2	3	N/A	2	8	N/A	N/A	9	3	2	**29**
Marion CI	0	N/A	N/A	0	0	N/A	0	9	2	N/A	3	0	2	**16**
Tomoka CI	1	N/A	N/A	0	0	N/A	1	2	1	N/A	1	0	0	**6**
Lake CI	2	3	4	0	1	0	1	7	6	N/A	3	2	2	**31**
Homestead CI	0	N/A	N/A	0	0	N/A	0	0	0	N/A	1	0	3	**4**
Wakulla CI-Main	N/A	N/A	N/A	1	0	N/A	0	2	N/A	N/A	3	0	N/A	**6**
Wakulla CI-Annex	1	N/A	N/A	1	0	N/A	0	6	7	N/A	N/A	1	4	**20**
Central Florida Reception Center-Main	0	N/A	N/A	1	0	N/A	0	4	2	2	4	1	3	**17**
Central Florida Reception Center-East	N/A	N/A	N/A	1	0	N/A	0	1	N/A	N/A	N/A	N/A	N/A	**2**
Northwest Florida Reception Center-Main	0	N/A	N/A	2	0	N/A	0	2	8	N/A	3	0	1	**16**
Northwest Florida Reception Center-Annex	0	N/A	N/A	1	0	N/A	0	3	4	1	2	3	0	**14**
Total Findings	**7**	**3**	**4**	**11**	**10**	**0**	**13**	**81**	**36**	**3**	**55**	**13**	**21**	**257**

CMA Recommendations

As in previous years, institutional surveys for FY 2017-18 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 concerns highlighted in previous annual reports. Detailed below are the CMA's recommendations to address 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.
- Review infirmary documentation and forms to reduce duplication and streamline clinical documentation.
- Provide routine and on-going training on medical records management practices and clinical documentation requirements to all health services staff. Training should reinforce the importance of avoiding risk management issues associated with inadequate and missing clinical documentation.
- FDC should continue to explore information technology solutions for an electronic medical record and determine the fiscal impact of implementing an electronic system. The implementation of an electronic medical record, in a system as large as FDC, could improve administrative and clinical efficiencies.
- Determine a method to guarantee problem lists are current and complete so they can be used as an ongoing guide for reviewing physical and mental status and for planning care.
- 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 was noted as a system-wide trend for multiple assessment areas. Diagnostic testing serves as a useful tool to identify issues early in the disease process. Failure to provide or interpret diagnostic testing can put inmates at risk for adverse health outcomes due to delayed diagnosis and treatment. To improve issues related to diagnostic delays, the following strategies are recommended:

- 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.
- Develop a standard mechanism to track abnormal pap smears and mammograms to ensure timely follow-up.

- Streamline RMC consultation process to decrease wait times and transportation problems.
- Revise the DC4-541 "Periodic Screening Encounter" form to include vaccination as a part of the periodic screening to ensure vaccinations are completed.
- Identify a system or process to provide clinicians with notification reminders to order periodic screening diagnostic tests within the required time frame.
- Create and implement a sepsis management protocol and training plan to help improve the quality of sepsis care, improve outcomes for patients with sepsis, and increase awareness of sepsis among clinical providers.
- Improve administrative systems to track the timeliness of diagnostic testing, receipt of laboratory results, and follow-up care.
- Review staffing levels for physical health staff, including physicians, mid-level practitioners, and nursing staff.

MENTAL HEALTH TREATMENT DELAYS

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

- Ensure indicated laboratory studies are ordered for inmates prescribed psychiatric medication and steps are taken to address abnormal results in a timely manner.
- Ensure inmates on the mental health caseload are evaluated in a timely manner and provided the services listed on their ISPs, including inmates housed in confinement.
- Develop and implement a standardized tracking system to document use of force episodes to ensure inmates on the mental health caseload are referred for evaluation to determine if additional mental health interventions are needed.
- Review staffing levels for psychiatry, mental health professionals, and mental health nursing.
- 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

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 TWO

2017-2018

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

PROFILE OF FLORIDA'S ELDERLY OFFENDERS

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 2017-18 will include demographic, sentencing, health utilization, and housing information for elderly offenders. Also included are the CMA's recommendations related to Florida's elderly population.

DEFINING ELDERLY OFFENDERS

Correctional experts share a common view that many incarcerated persons experience accelerated aging because of poor health, lifestyle risk factors, and limited health care access prior to incarceration. Many inmates have early-onset chronic medical conditions, untreated mental health issues, and unmet psychosocial needs that make them more medically and socially vulnerable to experience chronic illness and disability approximately 10-15 years earlier than the rest of the population. [8]

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

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

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

FISCAL YEAR 2017-2018 ADMISSIONS

DEMOGRAPHIC CHARACTERISTICS

In FY 2017-18, elderly offenders accounted for 13 percent (3,594) of 27,916 inmates admitted to FDC institutions. Males represented 90 percent (3,226) of elderly offender admissions, while females age 50 and older accounted for 10 percent (368) of admissions. When looking at racial/ethnic demographics for newly admitted inmates age 50 and older, 37 percent (1,319) were black, 9 percent (340) were Hispanic, 54 percent (1,926) were white, and 0.25 percent (9) were classified as other. Table 11 further details racial/ethnic demographics by gender.

Eighty percent (2,873) of newly admitted elderly offenders were between the ages of 50 and 59. The average age at time of admission for males was age 56, and for females age 55. The oldest male offender admitted in FY 2017-18 was age 92, while the oldest female admitted was age 77. Demographic data is summarized in Table 11 below:

Table 11. Fiscal Year 2017-2018 FDC Elderly Offender Admissions Demographics

Fiscal Year 2017-2018 Admissions: Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	24,404	21,178	3,226	13%
Female	3,512	3,144	368	10%
Total	27,916	24,322	3,594	13%
Race/Ethnicity				
Black Female	809	715	94	12%
Black Male	10,521	9,296	1,225	12%
Hispanic Female	188	167	21	11%
Hispanic Male	2,851	2,532	319	11%
White Female	2,498	2,246	252	10%
White Male	10,918	9,244	1,674	15%
Other Female	17	16	1	6%
Other Male	114	106	8	7%
Total	27,916	24,322	3,594	13%
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	2,873	10%		
60-69	610	2%		
70+	111	0.40%		
Total	3,594			

COMMITMENTS AND PRIMARY OFFENSES

Most (34 percent or 1,224) of the elderly offenders admitted to FDC in FY 2017-18 had no prior commitments, while 15 percent (549) had one, 12 percent (418) had two, 9 percent (316) had three, and 28 percent (1,028) had four or more prior FDC commitments. Among new admissions, 30 percent (1,078) of inmates age 50 and older were incarcerated for violent crimes, 28 percent (1,004) for property crimes, 23 percent (828) for drug offenses, and 17 percent (625) were incarcerated for offenses classified as other. Table 12 summarizes previous FDC commitments for elderly offenders. Table 13 summarizes primary offense types.

Table 12. Fiscal Year 2017-18 Admissions: Summary of Previous FDC Commitments

Fiscal Year 2017-2018 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	1,224	34%
1	549	15%
2	418	12%
3	316	9%
4+	1,028	28%
Unknown	59	2%

Table 13. Fiscal Year 2017-18 Admissions: Summary of Primary Offense Categories

Fiscal Year 2017-2018 Admissions: Primary Offense Types For Inmates Age 50					
Primary Offense Type	50-59	60-69	70+	Total Inmates Age 50+	Percentage of Total Population Age 50+
Violent	823	197	58	**1,078**	**30%**
Property	836	155	13	**1,004**	**28%**
Drugs	668	143	17	**828**	**23%**
Other	494	110	21	**625**	**17%**
Unknown	52	5	2	59	**2%**

INMATE MORTALITY

It is estimated that two percent (536) of inmates admitted in FY 2017-18 will die while incarcerated and elderly offenders will account for 28 percent (151) of these inmates.

JUNE 30, 2018 POPULATION

DEMOGRAPHIC CHARACTERISTICS

At the end of FY 2017-18, 25 percent (23,338) of Florida's 96,253 general prison population was age 50 and older. Males accounted for 95 percent (22,073) of the June 30, 2018, elderly offender population and represented 25 percent of the total male inmate population. Female elderly offenders accounted for 5 percent (1,265) of inmates age 50 and over on June 30th and represented 19 percent (6,658) of the total female inmate population. The racial/ethnic demographics for the June 30, 2018, elderly offender population are as follows: 42 percent (9,698) were black, 47 percent (10,941) were white, 11 percent (2,596) were Hispanic, and 0.44 percent (103) were classified as other.

Elderly offenders between the ages of 50-59 represented 67 percent (15,674) of inmates age 50 and older. The average age of elderly offenders housed on June 30, 2018, was 58. The oldest male offender incarcerated on June 30, 2018 was age 90. The oldest female offender was age 77.

Table 14 summarizes the demographics of the June 30, 2018, inmate population.

Table 14. Fiscal Year 2017-2018 FDC Elderly Offender June 30, 2018, Demographics

June 30, 2018 Population: Demographics				
	Total Population	15-49	50+	Percentage of Total Population Age 50+
Gender				
Male	89,595	67,522	22,073	25%
Female	6,658	5,393	1,265	19%
Total	96,253	72,915	23,338	24%
Race/Ethnicity				
Black Female	1,855	1,507	348	19%
Black Male	43,444	34,094	9,350	22%
Hispanic Female	429	351	78	18%
Hispanic Male	11,551	9,033	2,518	22%
White Female	4,340	3,511	829	19%
White Male	34,264	24,152	10,112	30%
Other Female	336	243	93	28%
Other Male	34	24	10	29%
Total	96,253	72,915	23,338	24%
Age Range of 50+ Population				
Age Range	Total	Percentage of Total Population		
50-59	15,674	16%		
60-69	6,026	6%		
70+	1,638	2%		
Total	23,338			

COMMITMENTS AND PRIMARY OFFENSES

Forty-five percent (10,445) of elderly offenders housed on June 30, 2018, had no prior FDC commitments. The remaining 55 percent (12,856) of elderly offenders were repeat offenders with one or more previous FDC commitments. The majority of the June 30, 2018 elderly offender population, 65 percent (15,124), was incarcerated for violent crimes, 16 percent (3,813) for property crimes, 11 percent (2,674) for drug offenses, and 7 percent (1,727) for crimes classified as other.

Table 15. June 30, 2018, Population: Summary of Previous FDC Commitments

June 30, 2018, 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	10,445	45%
1	3,643	16%
2	2,566	11%
3	2,031	9%
4+	4,616	20%
Unknown	37	0.16%

Table 16. June 30, 2018, Population: Summary of Primary Offense Categories

June 30, 2018: 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	9,386	4,309	1,429	**15,124**	**65%**
Property	2,999	756	58	**3,813**	**16%**
Drugs	2,021	579	74	**2,674**	**11%**
Other	1,268	382	77	**1,727**	**7%**

INMATE MORTALITY

It is estimated that 15 percent (14,601) of inmates housed on June 30, 2018, will die while incarcerated. Elderly offenders account for 51 percent (7,430) of those expected to die in prison.

HEALTH SERVICES UTILIZATION

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

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

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

SICK CALL AND EMERGENCY CARE ENCOUNTERS

There were 432,491 sick call and emergency encounters in FY 2017-18. Elderly offenders accounted for 28 percent (121,857) of those encounters. Sick call represented the greatest proportion of those encounters. There were 94,838 (33 percent) sick call encounters for inmates age 50 and older.

Table 17 summarizes all sick call and emergency care encounters during FY 2017-18.

Table 17. Summary of Fiscal Year 2017-2018 Sick Call and Emergency Care Encounters

Sick Call and Emergency Care Encounters							
Encounter Type	Total Encounters	Females		Males		Total Encounters 50+	Percentage of Total
		15-49	50+	15-49	50+		
Sick Call	291,239	22,271	7,322	174,130	87,516	94,838	33%
Emergency	141,252	10,096	2,284	104,137	24,735	27,019	19%
Total	432,491	32,367	9,606	278,267	112,251	121,857	28%

CHRONIC ILLNESS CLINICS

In FY 2017-18, 63,729 inmates were enrolled in CICs, and inmates age 50 and older accounted for 50 percent (31,573) of enrolled inmates. Elderly offenders accounted for 50 percent or more of inmates in five clinics: cardiovascular, endocrine, renal, miscellaneous, and oncology clinics. Table 18 summarizes CIC enrollment.

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

Table 18. Summary of Fiscal Year 2017-2018 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	27,171	911	13,937	14,848	55%
Endocrine	9,027	399	4,790	5,189	57%
Gastrointestinal	9,794	259	3,965	4,224	43%
Immunity	2,728	71	1,145	1,216	45%
Renal	6	0	6	6	100%
Miscellaneous	2,523	96	1,349	1,445	57%
Neurology	3,065	62	785	847	28%
Oncology	791	27	572	599	76%
Respiratory	7,237	285	2,596	2,881	40%
Tuberculosis	1,387	12	306	318	23%
Total	63,729	2,122	29,451	31,573	50%

There were 127,102 reported CIC encounters during the fiscal year, and inmates age 50 and older accounted for 52 percent (65,514) of CIC visits. In five clinics, elderly offenders accounted for 50 percent or more of visits in FY 2017-18. Table 19 provides a breakdown of CIC encounters for elderly offenders by clinic.

Table 19. Summary of Fiscal Year 2017-2018 Chronic Illness Clinic Encounters

Chronic Illness Clinic Encounters					
Chronic Illness Clinic	Total Number of Clinic Visits	Females 50+	Males 50+	Total Encounters 50+	Percentage of Total Encounters
Cardiovascular	51,407	1,635	27,730	29,365	57%
Endocrine	18,550	740	10,244	10,984	59%
Gastrointestinal	16,644	430	7,625	8,055	48%
Immunity	8,578	221	3,744	3,965	46%
Renal	11	0	11	11	100%
Miscellaneous	4,542	152	2,607	2,759	61%
Neurology	5,667	91	1,594	1,685	30%
Oncology	1,666	45	1,275	1,320	79%
Respiratory	13,136	490	5,268	5,758	44%
Tuberculosis	6,901	68	1,544	1,612	23%
Total	127,102	3,872	61,642	65,514	52%

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.[13]

In FY 2017-18, there were 3,942 inmates with assigned impairment grades, with 55 percent (2,186) of assigned impairments being among elderly offenders. Inmates age 50 and older comprised 42 percent (763) of inmates with visual impairments, 70 percent (353) with hearing impairments, 72 percent (1,302) with physical impairments, and 52 percent (96) with developmental impairments.

Inmates requiring special assistance or assistive devices are issued special passes to accommodate their needs. FDC issued 23,083 passes for special assistance and/or assistive devices in FY 2017-18, and 50 percent (11,473) of those passes were issued to elderly offenders.

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

Table 20. Summary of Fiscal Year 2017-2018 FDC Impairment Grade Assignments

Impairment Grade Assignments				
Impairments	15-49	50+	Total Population	Percentage of Total Population Age 50+
Visual	1,071	763	1,834	42%
Hearing	151	353	504	70%
Physical	505	1,302	1,807	72%
Developmental	88	96	184	52%
Total	1,815	2,514	4,329	58%

Table 21. Summary of Fiscal Year 2017-2018 Issued Assistive Devices/Special Passes

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

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

HOUSING ELDERLY OFFENDERS

FDC does not house inmates based solely on age, therefore, elderly offenders are housed in most of the Department's major institutions. All inmates, including elderly offenders, who have significant limitations performing activities of daily living or serious physical conditions may be housed in institutions that have the capacity to meet their needs. Inmates who have visual or hearing impairments, require walkers or wheelchairs, or who have more specialized needs are assigned to institutions designated for assistive devices for ambulating.

Table 22 displays the ten institutions with the greatest concentration of inmates age 50 and older.

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

FDC Institutions with the Greatest Concentration of Elderly Offenders			
Institutions	Institution Total Population	Total 50+ Population	Percentage of Inmates 50+
Union CI	1,556	1,258	81%
South Florida Reception Center-South Unit	629	491	78%
Zephyrhills CI	594	369	62%
Central Florida Reception Center-South	76	40	53%
Everglades CI	1,305	665	51%
New River CI	629	291	46%
Dade CI	1,526	614	40%
Avon Park CI	1,066	373	35%
Hardee CI	1,328	461	35%
South Bay CF	1,925	656	34%

CMA 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.
- In response to the complications of poor health associated with accelerated aging, FDC should explore the feasibility and health benefits of providing additional preventive health screenings for inmates age 45 to 49.
- Develop or enhance geriatric training programs for institutional staff. Training should address common health conditions and psychosocial needs of elderly offenders and be offered on a routine basis.
- Mental health policies and procedures should be reviewed to ensure they include guidance for detecting and addressing changes in cognitive functioning for inmates age 50 and older. Additionally, training and education regarding detecting cognitive impairment among elderly offenders should be offered to staff.