Medical Provider Orientation 2020

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Congratulations on joining the Centurion team! We would like to personally welcome you. We hope that you enjoy the practice of correctional medicine within the Centurion family as much as we have.

Our goal at Centurion is to provide excellent health care to our correctional patients and excellent service to the correctional institutions where we work. We promote excellence in health care by practicing evidence-based medicine in a cost-effective manner. We provide excellent service by paying attention to the safety and security of the institutions where we serve and by being open and transparent in our dealings with others.

We also want you to be happy and productive during your employment with Centurion. This orientation program is offered to assist you in being successful in your new role.

One of the core philosophies of Centurion is that we are a team and, as such, we help each other. You will not be alone as you practice medicine with us. You can always ask for help and advice from your peers, your regional medical directors and your statewide medical director.

We will always listen to you. If you ever think of a way that we can improve the quality or scope of our services, please let us know!

Again, welcome to the Centurion team!

Your Colleagues,

Johnny Wu, MD, FACP, CCHP-P
Chief of Clinical Operations
jwu@teamcenturion.com

John P. May, MD, FACP
Chief Medical Officer
jmay@teamcenturion.com

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Re: Provider Orientation

Welcome Aboard. The Orientation binder and process are designed to support you through the first 90 days of your employment. This binder includes four parts:

- **Orientation Checklist**: provides a framework on what, when, and who should review pertinent information over the first 30 days
- **Reference Manual**: provides adequate reading and reference materials addressing critical topics
- **Orientation Workbook**: provides contract and site specific questions for the provider to use while getting acquainted with their work location
- **Contract-Specific**: an open area to add any of your own additional resources, as needed

At 90 to 100 days of employment, you are responsible for logging into our Learning Management System (LMS) through Centurion University. At this time, you will complete two steps in order to mark your Orientation process complete. Those steps are as follows:

1. Submit an attestation statement to confirm and record completion of the Provider Orientation on your learning transcript and;
2. Complete the online evaluation module, which provides you an opportunity to give feedback about your experience

As a final request, if you have not already done so, please take a few moments to complete the 45-day feedback survey (www.45dayfeedback.com). The feedback and results we receive from this survey will provide us valuable insight to be used towards improving the orientation experience for future new employees. In addition, you should be hearing from your supervisor to schedule your one-on-one 90-day feedback meeting. This is a great opportunity to review your job expectations, your performance and your future goals.

Thank you,

Christopher J. Wanza, M.Ed.

Manager, Content and Curriculum
cwanza@teamcenturion.com

Medical Provider Orientation Checklist

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INSTRUCTIONS: The purpose of this document is to provide a structured format to the orientation experience and to ensure all pertinent information whether organizational or contract specific is reviewed, discussed, and/or received. The checklist is designed as a working document for both the employee and assigned contract representative, therefore space is provided to record actions items as you cover each topic.

The expectation is to complete the checklist within a **30 day** timeframe and the recommended format serves as a guideline on when and how to thoroughly complete the orientation process.

DAY ONE: General Orientation

Meet with your Contract Vice President, HSA and Human Resource Business Partner to:

- Provide a company overview
- Complete Confidentiality, HIPAA & PREA
- Review HR orientation and policies
- Complete and discuss re-credentialing

Action Items

Received HR New Employee Manual ☐ Yes

view completion date

DAY TWO: Structure of Health Services

Meet with your Contract Vice President or HSA to review Centurion & DOC contract and site level structure:

- Clinical and administrative staff
- Staff roles
- Communication chain

Action Items

Received contract organizational chart ☐ Yes

Review completion date

DAY TWO: Job Responsibilities

Meet with your HSA and Medical Director to review:

- Clinical job responsibilities
- Administrative job responsibilities
- Performance accountability
- Documentation requirements and expectations

Action Items

Reviewed job description ☐ **Yes**

Review completion date

DAY THREE: Contact Information

Meet with your HSA to review:

- All pertinent contact information

Action Items

Received contract specific contact lists ☐ **Yes**

Review completion date

WEEK ONE: Correctional Healthcare

Read supporting chapters from Medical Provider Reference Manual:

- Chapter 1: The Correctional Environment
- Chapter 2: Security Overview and Awareness
- Chapter 16: Inmate "Wants" vs. Inmate "Needs"

Meet with your HSA and Medical Director to review:

- Correctional healthcare philosophy
- Correctional environment
- Maintaining a safe work environment
- Provider role in care delivery

Action Items

Discussed contract specific polices ☐ **Yes**

Review completion date

WEEK ONE: Tour Facility and Office Space

Meet with HSA and DON for tour of the:

- Introductions to key facility staff & healthcare staff
- Facility(s)
- Office space

Action Items

Tour completion date

WEEK TWO: Health Assessments

Meet with Medical Director to discuss:

- Contract specific requirements for receiving and periodic health assessments
- Purpose of health assessment in initial and ongoing continuum of care

Action Items

Discussed contract specific requirements ☐ Yes

Review completion date

WEEK TWO: Sick Call

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 8: Sick Call

Meet with Medical Director and DON to discuss:

- General population
- Segregation
- Nurse sick call

Action Items

Discussed contract specific requirements ☐ Yes

Review completion date

WEEK TWO: Disease Management & Chronic Care

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 10: Disease Management and Chronic Care Clinics

Meet with Medical Director, DON, and Chronic Care Coordinator at site to:

- Discuss process for tracking and scheduling

Action Items

Received contract specific disease management summaries ☐ **Yes**

Review completion date

WEEK TWO: Special Needs Inmates

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 15: Special Needs Inmates

Meet with Medical Director and DON to:

- Review site specific policies for placement based on healthcare, mobility, and assisted care requirements

Action Items

Discussed contract specific requirements ☐ **Yes**

Review completion date

WEEK TWO: Medication Management

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 9: Medication Management

Read supporting material from Medical Provider Orientation Workbook:

-Utilization Management Overview Supplemental

Meet with Medical Director, DON, and Medication Room Coordinator/Designee to:

- Review current formulary

Action Items

Discussed contract medication ordering process & non-formulary review process ☐ **Yes**

Review completion date

WEEK TWO: On-Site & Off-Site Emergency Services and Hospitalization & Infirmary Care

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 12: On-site Emergency Care, Emergency Department Services, Hospitalization & Infirmary Care

Meet with your Medical Director, HSA and DON to review:

- On call provider responsibilities
- Management of after care post hospital/ER visit and return to site
- Infirmary levels of care and staffing

Action Items

Discussed contract specific requirements ☐ **Yes**

Review completion date

WEEK TWO: Ancillary Services

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 13: Laboratory, Radiology, EKG and Other On-Site Testing

Meet with your HSA and DON to review:

- Laboratory testing
- Radiology
- Other on-site services
- Sign off & review of ancillary services

Action Items

Discussed contract specific vendor list ☐ **Yes**

Review completion date

WEEK TWO: Specialty Services

Read supporting chapters from Medical Provider Reference Manual:

- Chapter 11: Specialty Care and Off-site Services
- Chapter 17: Telehealth

Meet with your Medical Director and Corporate/ Regional Telehealth staff, DON, HSA, and specialty appointment tracking staff to review:

- On-site
- Telemedicine
- Off-site

Action Items

Discussed contract specific requirements ☐ **Yes**

Review completion date

WEEK TWO: Utilization Management

Meet with your Medical Director and Corporate UM staff to review:

- Principles
- Process
- Corporate & contract specific UM staff
- TruCare

Action Items

Reviewed the following:

Contract specific UM Process	☐ **Yes**
Centurion & contract organizational chart	☐ **Yes**
UM policies and procedures	☐ **Yes**
UM process flows, Centurion UM P&Ps	☐ **Yes**
UM Business Rules and Clinical Statements	☐ **Yes**
Appeals process	☐ **Yes**
Review completion date	

WEEK TWO: Documentation

Read the supporting materials from Medical Provider Orientation Workbook:

- Correctional Healthcare Documentation Supplemental
- S.O.A.P Guidelines

Meet with your Medical Director and Medical Records staff

Action Items

Reviewed the following:

Documentation requirements	☐ **Yes**
Contract specific requirements	☐ **Yes**
Medical record format and required forms for documentation	☐ **Yes**
Review completion date	

WEEK THREE: CQI Responsibilities

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 14: Your Role in Quality Healthcare

Meet with your Medical Director and HSA to review:

- Roles/responsibilities in the CQI process
- Medical record reviews
- Mortality reviews
- Peer review
- Grievances

Action Items

Discussed contract specific requirements ☐ **Yes**

Review completion date

WEEK THREE: Risk Management

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 7: Risk Management

Meet with your HSA and Corporate Risk Manager to review:

- Incident reporting
- Legal notification

Action Items

Completed online Incident Reporting Acknowledgement ☐ **Yes**

Discussed contract specific requirements and chain of command for reporting incidents ☐ **Yes**

Review completion date

WEEK THREE: PA/NP Supervision

Meet with Medical Director and Corporate Risk Manager to:

- Complete review and sign off on collaborative agreement, if required
- Discuss roles, responsibilities, and provisions of care by PA/NP versus site Medical Director/ Physicians

Action Items

Discussed contract specific requirements ☐ **Yes**

Review completion date

WEEK THREE: Training Expectations and Availability

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 19: Correctional Organizations and Resources

Meet with Human Resource Business Partner to:

- Discuss CEU requirements & benefits

Action Items

Reviewed Centurion University resources ☐ **Yes**

Review completion date

WEEK THREE: Healthcare Services Coordination

Read supporting chapter from Medical Provider Reference Manual:

- Chapter 18: Mental Health and Physical Health Collaboration

Meet with Medical Director, HSA and DON to review:

- Mental health services
- Dental services
- Care collaboration

Action Items

Discussed contract specific requirements ☐ Yes

Review completion date

Supervisor Signature

Date

Employee Signature

Date

Medical Provider Orientation Reference Manual

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Attorneys Eyes Only

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Chapter 1: The Correctional Environment

Working within a Correctional Setting

Welcome to Centurion and the rewarding field of correctional health care! You are certain to see pathology that is unusual, face patient management issues different from the community and find inspiration from others at Centurion who make this their advocation; but mostly you will find joy and satisfaction in delivering quality care that impacts the lives of others in very meaningful ways.

Whereas traditional medical practice focuses on the dynamic of the provider and patient relationship, and public health focuses on the actions of the community to improve overall health, correctional health is a combination of both. Correctional health care is often practiced within the model of "population health," that is providing care, treatment and advocacy to sustain or improve the health of the entire population, in this case, the patient in front of you and all of those within the jail or prison facility.

Does that seem like a tall order? No worries. You will not go at it alone. Instead, you are joining a team of other dedicated professionals at Centurion who find satisfaction each day in delivering a necessary service and making the lives of others better. Centurion brings together multidisciplinary resources, expertise and support to make this successful.

As a member of the healthcare team, you have an important seat at the table of those entrusted with the security and operation of the facility. A safe and secure environment is the first priority of the jail or prison. As health providers, we defer to the rules and operation of the security officials to achieve that priority. Security, on the other hand, defers to us for the medical judgements and care that is to be provided to ensure good outcomes. For this reason, we must be mindful of the roles within the environment and adherent to the rules of safety, while conscientiously working in the best interest of our patients.

Correctional systems value effective health services. Good treatment makes for good security and fewer grievances and complaints from those in jail or prison or families. Care which is unnecessary wastes resources, takes care away from others and increases security risks. Good medical providers practice necessary care. They identify serious needs and address them.

Good practitioners also learn to work within the often-rigid rules and occasional limitations of the correctional settings and still achieve the desired outcomes for the individual and the whole population. Understanding and respecting these limits is part of being a good correctional health care provider. There are, for example, specific time periods for patient encounters and other times in which security functions must be completed. There are established times designated for meals, medication administration, recreation yard, program activities, such as school, work assignments, visits and so on. Those in custody must be in their cells for a "count" several times a

day. There are also times when security concerns require all to be locked-down in their cells or movement is limited. Lock-downs can last for a few hours or several weeks, yet care and treatment must still be provided. This requires collaboration and partnership with security.

To be a successful correctional healthcare provider, it is important to communicate respectfully and regularly with all members of the healthcare and security staff. As a medical provider, you should recognize the role you have in mentoring and teaching other staff, but also being open to their input, observations and experience. It is important that you are punctual and present when scheduled to treat patients in order to minimize disruptions in the security process. It is not easy for security staff to ensure that all persons scheduled for appointments are available as scheduled. When security staff has made the effort to have the patient available for your appointments and you are late or call to cancel your availability at the last minute, you will disrupt many schedules and can lose credibility among the security staff.

First and foremost, however, be true to your profession. You are a healthcare provider. The same ethics, principles and expectations of the community medical profession apply to corrections, and perhaps even more so. Your patients have limited options of care providers, so you must represent the best of what the profession holds. Patients have right to autonomy, justice, beneficence and non-maleficence. You are to provide them your good judgement, professional care and appropriate treatment.

Differences Between Jails and Prisons

You will be working in either a jail or prison. While both systems are correctional environments, their missions and the requirements for health services are different.

Jails are county or city facilities that provide housing and security for individuals who have been arrested for crimes and are awaiting trial on pending charges. Most are there because they are unable to afford bond or the courts have determined that they are ineligible for a bond. They may be charged with misdemeanors as well as serious felonies. But jails in many jurisdictions also house individuals who have been convicted of a crime but have been sentenced to less than one or two years. Jails may also house individuals convicted of a crime and awaiting transfer to the state's prison system to complete longer sentences.

Health services within a jail, particularly for individuals when initially incarcerated, are similar to those found in emergency departments. The patients who require health services may be psychotic, present a risk of danger to self or others, be at risk for "detoxing" from any number of substances including alcohol, and be injured as a result of altercations during arrest or the commission of a crime. You may often be providing health services based on the patient's report with little or no information regarding prior treatment. Risks of substance use, withdrawal and co-occurring psychiatric and medical conditions are similar to those found in emergency departments. During the following days of incarceration, patients are seen in the clinic for a variety of complaints, both big and small, acute and chronic, new and old.

A jail population is always churning. Typically, half of the individuals arrested are released within several hours to a few days and are replaced by newly arrested individuals. Jails may also house those awaiting trial, some who have been convicted and sentenced to short sentences (less than 12 months) and persons already sentenced to state of federal systems but sent to jail to stand trial on a new charge or serve as witnesses.

Prisons are state facilities that provide housing and security for individuals who have been convicted of crimes and sentenced to more than one or two years of incarceration.

Prisons and jails designate those in custody at various security levels (minimum, medium, close, maximum, supermax). A person's security level is determined by his/her behavior while incarcerated as well as by the severity of the crime that resulted in the sentence.

Health services within a prison are similar to those provided in outpatient ambulatory care facilities and skilled nursing facilities. Persons admitted to prisons may have been treated and stabilized while in a jail; however, a few may be admitted directly from the community. Some will have remained in the community on bail until convicted. Others may return directly to prison from the community due to a parole revocation.

The first stop for a person entering the prison system is an intake or diagnostic facility. Most states have separate diagnostic or intake facilities for males and females. There are many activities performed at the intake facility but the primary responsibilities for health services are identification of infectious disease; identification of patients with acute mental illness and/or at risk for self-injury; continuity of care for needed medications and treatments; and initiation of therapy and care for newly diagnosed problems.

Once incarcerated, the level of health functioning should be similar to that in the community. Some patients will maintain stability with outpatient services or accessing healthcare with episodic illnesses while others will require specialized care that is provided in disease management clinics.

Who is Your "Patient?"

Persons in jail or prison are referenced by many names, officially or colloquially, such as "inmate," "prisoner", "detainee", "arrestee," "offender", "convict", "resident" and more. Individuals housed in jails or detained by the Federal Marshalls are typically called detainees if not yet convicted. After conviction and incarceration in a state or federal prison system, the individuals are typically referred to as inmates or offenders. Incarcerated population may refer to themselves as convicts or prisoners but these terms are generally not used in official communications. Inmate and offender are often used interchangeably in unofficial communications. Inmate or offender for official communications is determined by the preference of the facility or system.

As a healthcare professional, however, the person in your care is your "patient" and should be addressed as such. Often times it may be helpful to ask the patients how they wish to be addressed as some individuals may be transgender. It is appropriate to address the patient as "Mr. ____" or "Ms. _____", or "Patient _____" as well as introduce yourself as "Doctor ____" or "Nurse Practitioner ____" or "Physician Assistant _____",

etc. Exchanging greetings is appropriate and contributes to a trusting patient relationship. Appropriate and professional attire sends a strong message. Washing hands between patients is important for infection control, but also demonstrates to the patient your professionalism which can increase trust.

It is also important to appreciate that in corrections you also have responsibilities for contributing to the security of your facility. In providing appropriate health services for patients, you will make a significant contribution to the safety and `management of the facility. In a sense, the whole facility is your "patient."

As noted previously, health service staff are an integral part of the team within the correctional setting and compliance with the security rules and regulations of the facility is a fundamental requirement. Complying with these requirements is necessary for the facility's security and for your own protection. Correctional officers are also valuable assets when providing health services. Correctional officers are the staff members that have the care, custody and control of persons in custody 24 hours a day, 7 days a week. They can provide important information about how the patient interacts on his/her housing unit and with peers. They can offer non-medical observations to you on the patient's progression or regression under different components of prescribed treatment plans and medications. The security staff of most county jails are deputies and are appropriately called deputies or detention deputies rather than correctional officers (and not "guards.")

Security staff, particularly the front-line staff, has a difficult job and often do not receive community respect for their challenging responsibilities. The expectation is that all of healthcare staff and contractors will treat security staff as professionals with important duties. This is not always easy. In many institutions, you may find a group of security staff who do not promote the provision of healthcare services and may openly harass inmates. While these allegations may be valid, responding to these reports in a confrontational manner is counterproductive. We strive to provide security and healthcare staff training in physical and mental illness issues, but your informal interactions and guidance with staff can be more effective than structured training.

Without the development of a collaborative relationship with front-line security staff, your access to your patients and even the efficacy of your treatments will likely be jeopardized. Further, if security staff do not believe that there is a collaborative relationship, the benefit of their 24/7 observation of persons in custody may not be shared with you. It is not expected that our healthcare professionals will align with security staff to the detriment of health services, but you are expected to consider the responsibilities and potential contributions of security staff in facilitating the provision of clinically appropriate health services. Observations and reports of actions that may compromise health services should be referred to health services administrative staff. Centurion has a model escalation policy accessible through the portal, and each contract should have site-specific escalation policies as well.

Achieving an effective relationship with the security staff of your facility is crucial; however, the way in which you address the reported needs of individual patients will also determine your overall effectiveness. Persons in custody can present a challenge beyond that experienced with patients of the general public.

Most patients will have a bona fide diagnosis. On occasion, you will likely encounter patients who deliberately use behavior or present with complaints or symptoms for their own gain just as in the community. For example, a patient may seek to obtain orders for certain medications from you or ask you to restrict their work assignment due to a non-existent disability. It is never appropriate to dismiss complaints without an adequate evaluation. Beware the frequent complainer who eventually presents with a true finding. On the other hand, you will also encounter patients who have limited insight into their own signs and symptoms of illness. They may mislabel or omit mentioning genuine symptoms. These miscommunications may not be intentional.

It will take reliance on objective data, collaborative investigation with other healthcare team members and security staff and your professional expertise to sort through these cases. Security and healthcare staff are usually very familiar with attempts at secondary gain and simply consulting with them may enlighten you to a patient's previous history and patterns of attempts at secondary gain. Patients may act very differently in their housing unit or on the yard than they do in your office or the healthcare unit.

Healthcare staff who do best in correctional settings feel comfortable consulting security staff to ensure adequate information is available when making a diagnosis. Remember, in corrections, time is on your side as well as the ability to schedule frequent follow-up visits with a patient to monitor their progress. It goes without saying that it is essential for you to review documentation in the medical record to develop a comprehensive picture of the patient. Keep in mind that the patient may have been in the system for years and there may be many volumes to the medical record. There is no requirement that you review each volume of the record but, depending upon the circumstance, this historical information may be helpful to you.

Security and Treatment: A Balance

It can be a challenge to provide health care in a secure setting. Sometimes healthcare treatment and security concerns come into conflict or disagreement, and predetermined relationships and/or mechanisms to work through differences are needed. New providers are wise to seek out the correctional officers and security supervisors working in the various areas where healthcare is provided. Whether the provider is experienced or not, forming working relationships is critical to doing the job effectively. A correctional officer's job is to ensure everyone's safety and security regardless of the nature of working relationships. Open communication, mutual respect and teamwork are the cornerstones to maintaining a balance between security and treatment.

Introduce yourself to officers/supervisors in your work area and let them know that you are new to the facility and ask if they can tell you about "how it works around here" or do they have any advice. Let them know that you value their opinion since they know the inmates on a continual basis and that you would appreciate sharing information that may impact safety or security.

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It is important for you to become familiar with the application of the Health Insurance Portability and Accessibility Act (HIPAA) in corrections. There are differences in its application in the correctional environment, and Centurion offers training on this subject. By way of example:

> **"Health care providers may disclose information to correctional facilities and other law enforcement officials having lawful custody of the offender if the information is necessary for the provision of health care to the individual; for the health and safety of the offender or other offenders, officers or employees at the facility or those transporting the offender; or for law enforcement or the administration and maintenance of safety, security and good order."**
>
> **Nancy Haywood, JD, NCCHC website**

On occasion, certain security staff will not be approachable or act uncaring or unconcerned, thinking or acting as if there should be no reason for a working relationship between healthcare and corrections. Additionally, there may be some correctional officers who perceive healthcare staff and providers as "outsiders" or "do gooders" who should not be in a correctional facility. This is generally the exception, especially in recent times, but it is important to have an awareness that it can occur. Also, new staff can be subject to a kind of initial "hazing" or "rite" of passage." Officers may test new staff to see how they react and what kind of professional they will be working with in the environment. One example is being kept waiting at a gate or door for an inordinate period of time. If this happens, it is best to stay calm and not push the call buzzer/bell incessantly. Smile or say thanks when you are allowed to pass through. Naturally, if there is an emergency or if this practice continues, despite your compliant attitude, try first speaking to the particular officer individually. If the situation persists, you should go to your supervisor for advice and guidance. Learn and follow the facility-specific escalation policy when such challenges arise.

Clinical Boundaries

The goal of this section is to enhance your understanding and awareness of clinical boundaries in the correctional setting and to promote practices to ensure your safety and the safety of others in this workplace. Some of this material has been covered in earlier sections and may be repeated in other sections because the information is critical.

Many healthcare staff are new to work in corrections and are experiencing a new environment of prison/jail culture and those within for which they have had little or no preparation, training or prior knowledge, except perhaps from the media. Initial exposure to the correctional environment can be intimidating and downright frightening.

Providers are accustomed to working in teams located in hospitals, clinics or offices. Walking down locked corridors that lead to cell blocks, dormitories or yards and waiting to be processed into and out of security traps does not come naturally to many people. Being one of a relatively few healthcare staff among scores of uniformed personnel often requires that social barriers are broken down and mutual respect developed. When the

barriers are overcome, you are likely to be rewarded by valuable observations and situational learning.

All healthcare staff working in corrections must be acutely aware of the secure environment that they work in. They must understand and appreciate that a correctional facility has a core mission of providing custody and control. Maintaining the safety and security of the facility, all staff and those in custody is paramount. Care and treatment are integral components of a correctional facility; however, safety and security will always take precedence if proposed treatment or any facility function may jeopardize the core mission.

Clinical Boundaries

Clinical boundary issues arise when individuals encounter actual or potential conflicts between their professional duties and social, sexual, religious, or business relationships. Physicians, psychiatrists, nurse practitioners, physician assistants, psychologists, counselors, nurses, supervisors, and administrators may encounter circumstances that pose actual or potential boundary issues.

Boundary issues occur when providers face potential conflicts of interest, stemming from what has become known as “dual” or "multiple" relationships. A professional enters into a dual relationship whenever he/she assumes a second role with the patient becoming, for example a "friend," "employer," "teacher," "family member," or "sex partner." This can be even more treacherous in the correctional environment than in the community as persons in prison are likely to have many other motives for seeking to create these secondary relationships, and is the reason there are rules and even laws prohibiting such relationships. Such relationships can risk your safety, your family, the safety of your colleagues, your clearance into the facility and your professional licensure.

Another perversion of the professional relationship can occur with the collection of forensic evidence. That is not the role of the provider who delivers care and treatment to an individual. It is Centurion’s policy that treatment staff do not participate in collecting forensic data, such as sexual assault evidence from an alleged perpetrator or conducting forensic evaluations of persons in custody. The classic dual relationship dilemma occurs when a healthcare staff member collects forensic evidence that incriminates the person in custody and then the staff member must testify against that person in court or at a disciplinary hearing. This is a conflict since the healthcare staff member is both the caregiver and the accuser. When it is necessary to collect forensic information or testing, it is better to have that done by someone who does not, and will not, have a clinical relationship with the person in question.

Dual relationships occur primarily between healthcare staff and their current or former patients but also can occur between professionals and their colleagues. For example, writing a prescription for a correctional officer would invite a dual relationship and raise serious ethical concerns. Centurion’s professional liability insurance does not cover such encounters and covers only the services that Centurion is contracted to provide to our government agency clients. It is our policy that healthcare staff should not give other Centurion or correctional staff healthcare advice or prescriptions unless the staff member is being seen as a formal patient in a scheduled clinic and a patient chart is generated and maintained. (Nothing is this paragraph, however, should prevent a provider from responding to a medical emergency and delivering initial care to a colleague or visitor.)

The broader subject of professional ethics, to which the topic of boundaries is closely tied, has received considerable attention in the professional literature, but contemporary correctional healthcare literature contains relatively scarce discussion of boundary issues or guidelines for conduct. Much of the available literature focuses on dual relationships that are exploitive in nature, such as the sexual involvement of healthcare staff with incarcerated persons. These are certainly important, but there are many more subtle boundary issues than these egregious forms of ethical misconduct.

Clinical boundaries require healthcare staff knowing themselves, their biases and their limitations. It is required that we provide care to persons with whom the nature of their criminal acts or behaviors while incarcerated raise issues of personal or professional anger, hatred, resentment, revulsion or loathing. It is not common that healthcare staff have access to criminal charges, but given the "correction's grapevine," often crimes are known or learned through the media. We treat the patient; regardless of the crime.

While it is doubtful that healthcare staff take a position within a correctional setting in order to get involved in a romantic/sexual relationship with an inmate, it happens. The relationship may be same-gender or cross-gender, may seem to be consensual (it is important to note that incarcerated persons lack the capacity to consent, just as minors do) or forced and may occur within or outside of a therapeutic relationship. Persons in custody may be looking for a "mark" and many can easily identify vulnerabilities of staff members. These relationships are almost always discovered and result in grave consequences for the staff member (including termination from employment, being locked out of government agency facilities and reporting to licensure boards) and the incarcerated person.

The motivation of incarcerated persons in these situations is likely to be beyond a romantic or sexual interest in the staff member and may include the intent to inflict physical harm or to coerce the staff member to bring in drugs or other contraband, to reap secondary benefit such as a monetary settlement, to have sex with others, to aid in an escape attempt, or to become involved with outside criminal elements or behavior.

When the staff member is licensed, he/she is generally reported to the appropriate licensure agency resulting in suspension or loss of license for ethical breach and/or criminal prosecution/conviction. In many states, if an employee is involved in a sexual relationship with an inmate the employee is charged with, at a minimum, misdemeanor sexual misconduct or felony rape. This information is presented not only to offer guidance to the individual provider but to alert providers as a professional member of the healthcare team to behaviors that may place other members of the team at risk and how to avoid these pitfalls of "inmate games or cons," as it is commonly referred.

How can these types of situations be prevented? One strong preventive resource is correctional and healthcare staff looking out for each other. In the examples of boundary issues provided later, the individual is often unaware of his/her own physical or verbal behavior and the risks it creates. In a multidisciplinary team or among co-workers who enjoy strong working relationships, individuals have a responsibility for their own behavior, but also have a responsibility to help protect co-workers in the correctional environment. If a co-worker is observed engaging in behavior that may be breaching boundaries with a patient, the observer should bring the issue privately to the co-worker and, if disregarded or of a sufficiently serious nature, to a supervisor. Such action is

truly in the individual's best interest. A primary source of safety and security in corrections is the appropriately reported potential for jeopardy or harm by all employees.

In summary, you want to maintain a professional relationship all of those in custody. You want to be viewed as friendly and accessible but not a "friend." One way you can do this is in the way you address individuals. In most systems the inmate is addressed as Mr./Ms. and clinicians are addressed as Dr. or Mr./Ms. The formalities may seem uncomfortable but they are important in establishing and maintaining professional boundaries.

Strategies Inmates Use to Promote Boundary Violations

Persons in jail or prison often have little to do while incarcerated. Some are carefully observing you to determine whether you have any personal needs or vulnerabilities. They will be trying to tell if you demonstrate: a need to be seen as special and different from other staff members, more caring, more successful; a need to be liked; a need to disclose personal information and problems; or apparent sexual or financial needs.

Some will be carefully testing you to see if you are willing to play favorites and make small exceptions and permit liberties or privileges. They will test whether you will permit some into unauthorized areas; share food or cigarettes; take letters out of the facility; or provide persons with access to unauthorized telephone calls or computer time.

Doing favors, no matter how small or seemingly inconsequential, is prohibited. Favors include: allowing a person in custody to use your telephone; passing messages to family or friends or other inmates; mailing letters; bringing magazines or other any items to a person in custody or receiving any gifts or tokens of appreciation from a person in custody or outside contact. Similarly, providing samples of medications is not acceptable. Although such practices may sometimes occur in community settings, they should never occur in jails and prisons. For many reasons, all medications require written medical orders. Persons in custody may use any small exceptions, whether "favors" or medication samples, as a lever to get you to make larger exceptions. They may "offer" not to turn you in when they have observed you engage in a lapse on the job and even offer to help make you "look good" to your supervisors and the institution. An act as small as offering a person in custody a cup of coffee or a band-aid at times other than an official clinic visit may be construed as a "favor" and should be avoided.

Fair, firm and consistent behaviors are absolutely required of the individual healthcare staff member and collectively for the healthcare team. Fair, firm and consistent treatment requires that the healthcare team know and understand security rules and regulations, conform to practice guidelines especially relating to special inmate accommodations such as special diets, lower bunks, and special shoes and to comply with the established processes for specialty referrals and off-site trips.

"Slippery Slope" of Boundary Violations

As noted previously, healthcare staff rarely, if ever, start out their correctional careers with a deliberate decision that, at some point in the future, they are going to violate professional boundaries by giving a patient a special favor or by engaging in sexual relations. This is probably the last thing on most people's mind as they start a new job. Usually, violating a professional boundary is the final step of a long process, one that starts out with small, seemingly trivial behaviors and ends up with much bigger boundary violations. This process is often described as descending a "slippery slope," because

the little steps cause the staff member to slide down in the direction of boundary violations. The further the staff member slides, the harder it is to stop.

Maintaining good clinical boundaries and safe practices involves not just complying with professional and institutional rules and regulations. It also involves noticing when you have made a small step onto the slippery slope. Noticing these early warning signs can help you get off the slope quickly, and get your behavior back inside appropriate clinical boundaries.

Some of the most frequent early warning signs of a "slippery slope" to boundary violations include:

- Not sharing uncomfortable or embarrassing feelings, whether positive or negative, that you have for a patient with your team or supervisor. The minute you begin to keep silent about important issues in a case, you are contributing to a "secret" that the patient can use against you later.

- Boundary violations are more likely to occur when confidential but important information is not shared with the rest of the treatment team or security. Remember, a patient's right to confidentiality does not mean that what he/she tells you is private and secret. You are a member of a healthcare team, and important information needs to be shared and discussed in the team. In addition, if the information is relevant to safety, security or good order in the institution, the information can and must be shared with security.

- Making special appointments with the patient outside of normal hours. Meeting a patient after normal working hours, coming in on the weekends specifically to see the patient, making arrangements for special levels of privacy to "ensure confidentiality," and even extending the length of individual encounters can be precursors to boundary violations. Obviously, it is sometimes necessary to be flexible in scheduling and emergencies can arise that require you to see a patient off hours; however, a pattern of unusual contact may mark a slide down the slippery slope.

- Not documenting interactions with the patient, or documenting them in a more cursory fashion than you normally do. Not documenting your interactions is like keeping them secret, and secrecy is a major contributor to boundary violations.

- Not holding to the treatment goals and shared treatment tasks in your interactions. As a general rule, keeping true to the treatment needs and being firm, fair and consistent will protect you from violating clinical boundaries. In a correctional setting, it is particularly important to focus on the shared treatment goals (e.g., improved behavior) and the shared tasks that must be accomplished to reach these goals (e.g., specified forms of treatment, such as skills building). Although a patient's treatment needs can and do change over time, if you permit your interactions with the patient to deviate significantly from the purposes set out in the treatment plan, it is likely you are heading down the slippery slope of making the staff-patient relationship personal rather than professional.

- Not discussing with your team any differences of opinion about how to treat the patient; holding grudges against team members or the administration for their

different opinions; and aligning with the patient in your anger and resentment. Persons in custody are adept at getting healthcare staff to become their advocates for special allowances. While it is important to advocate for what is humane and fair, it is equally important to remain dispassionate and objective. It is inevitable that, during the course of your career in corrections, clinical and administrative decisions will be made with which you will disagree. Learning to live with these decisions and continuing to work closely with your team without ongoing resentment is an essential skill. If you find yourself siding with a person in custody against the rest of the team and/or facility administration, you are in serious danger of being lured into a partnership with that person that will cross professional boundaries.

- Finding yourself fantasizing about the patient, whether about "healing" him/her, sexual relations, fear of being harmed, or wanting to punish, and not acknowledging these fantasies either to yourself or to a supervisor. Specialties in clinical training aside, if you unconsciously see yourself, and no one else, as capable of "curing" or "healing" the patient, you are likely to be fantasizing past the boundaries of your clinical competence. Most patients require concerted and integrated team efforts to achieve behavioral improvement.

- Finding yourself engaging in sexual fantasies involving a patient or wearing particularly kinds of clothing in the hope that the patient will notice, puts you at risk of developing stronger feelings of infatuation or "falling in love." While some sexual feelings are a normal component of adult life, strong and unacknowledged sexual feelings towards a patient should be discussed with your supervisor.

- Finding yourself fantasizing angrily about how the person in custody should be punished, you have likely taken something the person did as a personal betrayal. The risk here is that you will become punitive in your interactions with the patient. Discuss these feelings with your supervisor.

- Finding yourself worrying repeatedly about what the patient is going to do to you or your family after he/she is released from prison. In small ways, you may find yourself feeling intimidated and trying to avoid situations in which you have these unpleasant feelings. This avoidance behavior can add up to a series of "lost opportunities" and, ultimately, to a failure to acknowledge and report high risk behavior that threatens or violates institutional security.

- Worrying about being sued by a patient. Often, persons in custody verbalize litigious intent when they do not receive a medication or service that they feel entitled to receive. Some patients attempt to use this strategy to get staff to comply with unrealistic requests. Fear of being sued can generalize into healthcare staff practicing "defensively" or making clinical decisions driven by self-protection and not the best interest of the patient. Again being firm, fair and consistent services should be the mantra for healthcare staff in corrections. Centurion has insurance to cover you in the event of a claim relating to your healthcare services and has a strong in-house legal department that can answer your questions and talk through your concerns.

- Not all inappropriate relationships are of a sexual nature. Any sort of "special treatment" or levels of inappropriate trust in what the patient tells you can lead to

inappropriate relationships. Caution should be taken if any patient chooses only you or requests only you participate in their healthcare.

This section should have increased your awareness of the importance of clinical boundaries in the correctional setting. It should be noted that not all persons in custody play "games" with staff members. Many will genuinely welcome and respect your treatment efforts. It is not unusual for these persons to report that their healthcare services were the "best" while they were incarcerated. Experience confirms that when clinical boundaries are healthy, correctional healthcare can be very rewarding.

There are persons in custody who will do their utmost to improve their situation by "using" staff. We may view their behaviors as "manipulative," but the patients view these attempts as "survival" since they are very limited in improving their daily lives. If a patient can get a "sleep" medication, bottom bunk, job restriction, evening snack, or lay-in from healthcare staff when these measures are not clinically necessary, that person has improved his/her "life."

Working in corrections requires healthcare staff to balance treatment and security needs. You will be treating a population with many needs, and many who neglected themselves or did not have the means to care for themselves. Being fair, consistent, responsive and professional will keep you safe. Your practices will receive scrutiny from those in custody, your healthcare colleagues and the correctional staff.

The correctional staff comes from the public and they see the inmates we treat for many hours a day over months to years. They develop opinions about the relative value of our practices in the lives of the inmates and in the running of the facility. While some of these opinions will be off the mark, there will be a consensus that develops regarding healthcare practices that will likely be trending in the right direction and will influence our ability to practice effectively. Once the correctional staff learns from experience that you can be effective, responsive and respectful of security rules, you will gain credibility and cooperation. With the right balance between treatment and security, you will enjoy working in correctional healthcare environment.

Recommendations for further reading on this topic include:

- Allen, B., & Bosta, D. (1981/2005). *Games criminals play: How you can profit by knowing them.* Berkeley CA: Rae John Publishers.
- Cornelius, G. (2009). *The art of the con: Avoiding offender manipulation, 2nd ed.* Alexandria VA: American Correctional Association.
- Elliott, B., & Verdeyen, V. (2003). *Game over! Strategies for redirecting inmate deception.* Alexandria VA: American Correctional Association.

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Descriptions and reviews of these books are available at Google Books, Amazon.com and at the ACA web site aca.org.

How to Work with Patients Who Do Not Like Your Decisions

As a physician, nurse practitioner or physician assistant, you are not running for political office. If you are doing your job correctly, there will be times when patients will be unhappy with you. Your identification of illness and provision of appropriate treatment will not always coincide with his or her agenda. When a patient with a non-clinical agenda feels you are not going to give him/her something that he/she wants, or that you are about to take away something that he/she desires, the patient may attempt a number of strategies targeted at getting you to change your mind.

Threats:
You learn from nursing or security staff that a patient has been selling his/her medication to others in his dormitory. You order a blood level, and it comes back zero. You inform the patient that you are unable to continue allowing him to hold his medication. He must come to the pill window daily. The patient swears to you that he/she has been taking the medication no matter what information you have. The patient additionally informs you that he/she will file a grievance and report you to your medical board. The patient may "take your name" and let you know officiously that you will be hearing from his/her attorney.

Bargaining:
You obtain reliable information that a patient has not been taking his/her medication, and has probably been selling it to peers. You discuss this with the patient who points out, by name, a number of other people who have been doing the same thing. The patient hopes that by providing you with this "inside information," he/she will earn your favor so that you will continue the medication that has been prescribed.

Some tips for handling patients unhappy with your decisions:

- **Make your diagnosis based on judicious use of subjective information supported by careful objective data and observations**
- **Document your clinical findings and the patient's reaction.**
- **Do not argue with the patient. Stay calm, reinforce your diagnosis, course of treatment, and the risk/benefit profile of the medications that you have chosen to start, stop or titrate. Explain your rationale to the patient and document your rationale explicitly in your progress note. Always schedule a follow-up appointment to re-evaluate the patient.**
- **If needed, invite another staff member to join the conversation and document his/her presence in your progress note. It is useful to make controversial or problematic treatment decisions as a case conference rather than as an individual decision. "We discussed this at our clinical meeting and the decision was made there to discontinue your medication (or whatever the issue)." It is harder to argue or manipulate a group.**

- **If a patient's threat is against himself/herself (e.g. a suicide threat), take the threat seriously, document, and place the patient on suicide precautions in a safe cell.**

Evolution of Correctional Health Care: Courts and Legal Systems

Prior to the 1970s, healthcare in jails and prisons in the United States was under the direction of county sheriffs and wardens. The public, including public officials and the healthcare community, showed little concern for the healthcare of persons in jail or prison. Often the healthcare that received by those in custody was provided and controlled by other inmates and "guards."

In the 1970s the Department of Justice involvement increased to improve medical care in prisons; the American Medical Association and the American Public Health Association began writing standards for the care of incarcerated individuals; and state and federal courts began to rule against many correctional facilities.

There are unique legal principles governing correctional healthcare. Having physical custody of another person creates a legal duty to care for that person. The legal basis for the actual custody, either arrest, detention, or serving a sentence after conviction, determines the particular constitutional amendment that guarantees the access to care, but the legal standard is identical. Custody in a correctional institution is sufficiently restrictive that those incarcerated must depend on their keepers for food, water, clothing, and medical care - the basics of survival. The most fundamental obligation of a jail or prison system is to maintain the life and health of those incarcerated.

A pretrial detainee's right to healthcare comes from the Due Process Clause of the Fourteenth Amendment and a convicted person's similar right comes from the Eighth Amendment's prohibition of cruel and unusual punishment. While the constitutional basis varies, the liability is the same for jails and prisons. All persons who are incarcerated are entitled to the minimal conditions necessary to sustain life and to avoid needless suffering.

The first Supreme Court decision to address prison health, *Estelle v. Gamble* (1976), determined that medical care in the Texas prison system was below a constitutional level. *Estelle* and subsequent decisions established that inmates have a constitutional right to healthcare equal in quality to that available in the community.

The legal allegations of inadequate care for inmates were founded in "cruel and unusual punishment" under the Eighth Amendment to the U.S. Constitution. The Eighth Amendment's prohibition of cruel and unusual punishment has been interpreted to require that prison officials must avoid "deliberate indifference" to the "serious medical needs" of inmates. There are two critical phrases in the statement of the legal

obligation of care owed an inmate who has a serious mental condition: "deliberate indifference" and "serious medical need."

Deliberate indifference is a legal term for a mental state in the same general category as "intention," "reckless," or "gross negligence." From its earliest use in 1976, it was clear that it required more than poor judgment and less than intentional acts or omissions calculated to cause needless suffering.

In *Farmer v. Brennan,* 511 U.S. 825 (1994), Justice Souter states that, "With deliberate indifference lying somewhere between the poles of negligence at one end and purpose or knowledge at the other, the Courts of Appeals have routinely equated deliberate indifference with recklessness." Recklessness, however, does not have a single meaning in law. Once the Court decided on recklessness as the functional equivalent of deliberate indifference, it then had to choose between the more relaxed civil standard and the more demanding criminal standard.

The major difference between the civil and criminal standards is whether the official should have known the illness and risks of harm (the civil standard) or whether the official had actual knowledge (the criminal standard). The Court opted for the criminal law – actual knowledge – version of recklessness but softened the potentially harsh impact of this standard on plaintiffs. The Court noted that a plaintiff need not show that an official actually believed that some harm would occur, only that there was knowledge of a substantial risk of harm.

Thus, the first question for liability is *what* was known. Then one asks:

- What risks flow from that knowledge?
- What duty is thereby established?
- Was that duty breached?

Unfortunately, there is no single definition for what constitutes a "serious medical condition." The test for seriousness begins with clinical necessity and not simply what an inmate may desire. Because the constitutional basis for the right to treatment is in the Eighth Amendment's ban against cruel and unusual punishment, courts tend to equate seriousness with the needless infliction of pain and suffering.

The Eighth Amendment requires that prison officials provide a system of ready access to adequate medical care. Examples of inadequate medical care are:

- Serious denials or delay in access to medical personnel
- Denial of access to qualified health care personnel
- Failure to perform a screening or take a history necessary to make a professional judgment
- Failure to carry out medical orders
- Relying on factors other than medical need to make treatment decisions

Mental health care of persons in custody is governed by the same constitutional standard of deliberate indifference as in medical care. A severe mental illness as defined by courts is one which causes a significant disruption in the everyday life of an incarcerated person and which prevents him or her from functioning in general population without disturbing or endangering others or self. The Eighth Amendment

requires that prison officials provide a system of ready access to adequate mental health care.

Dental care is also governed by the same constitutional standard of deliberate indifference. Requirements include attention to dental care particularly if the patient is suffering pain. Dental care cannot be limited solely to extractions.

Consent decree is a familiar term in the correctional healthcare environment because so many systems have been or currently are subject to class action litigation alleging constitutional inadequacies. When it is alleged that the correctional facility or system does not provide adequate access to appropriate care, lawyers may sue on behalf of a class of those incarcerated to improve the conditions of confinement for all. In many of these cases, a judge will attempt to get the parties to enter into a consent decree, where the lawsuit is settled via a court-supervised agreement to remedy the situation. Many jails and state correctional systems in the 1980s and 1990s entered into these agreements to provide the delivery of more comprehensive health care.

The Department of Justice (DOJ) may investigate conditions of confinement to determine if those conditions violated constitutional rights of those confined. The DOJ conducts these investigations pursuant to several United States Codes including the Civil Rights of Institutionalized Persons Act of 1997. Most often when findings show violation of civil rights, deliberate indifference or other violations of US Codes, a Memorandum of Agreement is entered into between the DOJ and the facility oversight entity. This agreement identifies actions to remedy negative findings and outlines compliance requirements. The Agreement includes scheduled return investigations and reports.

Correctional systems are required to abide by the Americans with Disabilities Act. Incarcerated persons have initiated lawsuits when prison and jails fail to provide reasonable accommodations for those with disabilities. The issue of accommodation extends beyond physical disabilities to include translators and devices for the deaf, access to new treatment modalities, etc.

While the minimum federal standards for correctional medical services that are constitutionally required may be met, healthcare providers may still be liable civilly for malpractice in the omission or provision of medical care. In other words, meeting minimal federal requirements is no guarantee that officials responsible for medical care may be free from liability in state court, under state law. While the deliberate indifference standard is often actuated to gross negligence, medical malpractice cases are based on negligence, i.e. a breach of the standard of care that causes the alleged injury. In general, the best protection against malpractice claims is the provision of correctional medical care in a manner that meets or exceeds community standards of care.

Correctional Lingo

Consistent with most social environments, persons in custody as well as security staff have adopted short hand expressions for common occurrences and have lingo that is

unique to their environment. While there is no universal "Inmate/Offender/Prisoner Dictionary," some more common terms and definitions are offered:

- Ad-Seg (Administration Segregation): Independent units with increased security and decreased privileges that are separate from general population and used as penalty for fighting, causing disturbances and/or danger to others
- Blocks: Cell houses or living units for incarcerated persons
- Books: Person's money account at the prison to buy certain items at the store, stamps, co-pays for medical
- Chain: Chaining in/chaining out process as in going to or coming from another location
- Cheeking: Hiding medication in the mouth for use later – stockpiling for overdose or, more usually, for use as barter among others
- Chow Hall: Where those in custody eat
- C.O: Correctional Officer or Custody Officer. Never refer to these staff as "guards." The correctional hierarchy follows the military or police format with officers, sergeants, captains etc.
- Contraband: Any item unacceptable for inmates to possess. Sharps, alcohol wipes, paper clips, pens, staples, rubber bands, and cell phones are examples of the many items that may be dangerous or used in bartering within the jail or prison population. Different institutions have different lists and lists may vary within an institution based on the classification of inmates. There are severe penalties including legal ramifications for staff who help or allow incarcerated persons to possess contraband
- Count: Times during the day when all traffic or movement of inmates stops and an accurate count of the incarcerated population is taken. Generally, persons must be in their assigned housing unit or in an approved location. "Out-counts" are those who are out of the facility for authorized reasons such as court appearances, specialist appointments or hospitalizations
- D-Seg (Disciplinary Segregation): Persons typically placed in disciplinary segregation for a designated time period as sanction for violation of the institution's rules
- Gen Pop or GP: General Population where persons are housed with the least limitations on movement and independence. Persons in GP typically receive medications through a medication line process, often can have Keep-On-Person (KOP) medications, and access healthcare services by submitting a request
- Hole or The Hole: Isolation ("segregation") cell
- I.M.U.: Intensive Management Unit, ad seg or "the hole"

- Jacket: Prison file containing all information on an inmate
- Kite: A request for services within the prison such as request for dental or medical services or request to see prison personnel or in a broad sense, any written correspondence. Also called "a slip" as in drop "a slip" to see the nurse
- KOP: Keep-On-Person medications include over-the-counter and prescription medications that certain facilities allow persons to maintain in their cell. You will need to become familiar with the medications that can be KOP in your facility and as importantly which medications can never be KOP
- Lay-in: Appointment that requires the patient to stay in his/her cell due to medical condition or to wait for an appointment time
- Lock-down: When incarcerated persons are confined to their cells
- Man-Down: Security term for an inmate suffering from a medical issue or injury that requires medical/nursing assessment/treatment in the yard, housing unit or cell
- ODR (Officer Dining Room): Where staff are served meals often at discounted prices. In many facilities it is considered a prime place to work
- Med-line or medication line, or pill-line: Area and or time that medications which are not Keep on Person are administered
- P.C: Protective custody for inmates who are at risk for physical or sexual assault from other inmates
- Sally port: Secure area in a facility where staff and/or vehicles typically enter and leave
- Segregation: A disciplinary unit (Ad Seg, D-Seg, "the hole"), used for minor and major offenses, where prisoners are kept apart from the main population and denied privileges.
- Shank: A homemade knife that can be fashioned from many objects such as toothbrushes, barrels of pens, etc.
- State Issue: Anything provided by the state such as clothing, shoes, and toiletry items
- Store or Commissary: Where inmates may purchase food, health, and many other items. You should be familiar with the items that are available in the commissary as diabetic and obese patients need education and many over-the-counter medications may be obtained in the commissary.
- Ticket: A report documenting the violation of institutional rules
- Trap: When entering a secure area through a series of locked doors, the area between two doors is the trap. Security staff control the opening and closing and passage through the traps

- Yard: Main recreation yard for general population inmates

Correctional Environment Summary

The information in this section is intended to provide general knowledge and understanding of providing healthcare in a correctional environment. This following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Does this system or facility have any active Consent Decrees? If so, what is medical's involvement.
- How do healthcare staff address inmates and what is the expected way inmates address healthcare staff?
- Are there access to healthcare issues?
- Do patients report for medications and appointments routinely?
- Will I need to go see patients in areas outside the healthcare unit?

NOTES:

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Chapter 2: Security Overview and Awareness

Titles in Correctional Settings

Correctional staff in prisons are typically called correctional officers (COs), security or custody. In jails, security staff are usually called detention deputies. Addressing security staff as "guards" is no longer acceptable. The term "guard" is perceived by many correctional officers as disparaging and disrespectful since their role goes far beyond just "guarding" inmates. Use of incorrect terminology for referring to correctional staff may create unnecessary challenges in creating positive working relationships in the institution.

The security system in corrections is run as a paramilitary operation. Correctional officers serve an important role, providing front-line supervision and control of the inmates housed at the institution. The primary goals of the correctional officers include providing security for the institution and community; promoting smooth and effective functioning of the facility; ensuring incarceration is secure yet humane; and supervising access to programs and services provided in the institution. Understanding the primary mission of a correctional institution is important to providing inmate healthcare. Healthcare must work within the guidelines and assist in maintaining security within the institution. While in a hospital, the Hospital Administrator is the final decision maker; in the correctional institution, the Warden/Superintendent is the final decision maker. The final decision maker in the facility does not focus just on healthcare, but all aspects of the required services for the inmate. These include food service, access to recreation, access to visiting, educational programs, work programs, and maintain security. While the Warden/ Superintendent is the final decision maker regarding institutional operations, clinical decisions related to an individual patient's healthcare is the responsibility of the healthcare clinical leadership.

The correctional supervisory structure for the direct supervision of inmates typically mimics that of the military. The line of increasing supervision usually beginning with the Sergeant, progressing to the Lieutenant, Captain, Shift Commander and generally ending at the Major. It is important to learn the specific hierarchy at your institution and the appropriate titles and to build positive working relationships with the security leadership.

Tips to be a Welcomed Guest

As security operations are the top priority for the institution, healthcare staff might be viewed as "guests" in a correctional institution even though you are an integral part of a successful program. There are several tips that will help you to be a "welcomed guest" and create a favorable impression with security staff.

The majority of the information presented here focuses on items that are generally not allowed in a correctional institution. Items allowed/disallowed in an institution vary by state and may vary by institution within a state. Reasons for the variances can be related to the security level of inmates housed at the institution and may also vary based on the correctional leadership at the institution. It is important to remember, although it may seem inconvenient or the items disallowed may not seem to make sense, the focus

behind the decisions is to maintain the safety of all healthcare staff, correctional staff and inmates.

It is extremely important to know what your institution considers "contraband." Contraband is routinely defined as any item not authorized, not issued by the institution, not received through approved channels, or not purchased through the commissary and whose use could potentially endanger the safety or security of the institution or persons within the institution.

It is important that all staff, including healthcare staff, do not bring items considered contraband into the institution. Examples of items that may be considered contraband include:

- **Guns or firearms of any type**
- **Knives, tools or other sharp objects not approved by the institution. This includes pocket knives, metal finger nail files, scissors, nail clippers, letter openers, ice picks, metal can openers, metal hair picks, disposable razors, or any other items that could be used as a weapon**
- **Hazardous and poisonous chemicals and gases. These include nail polish remover, gasoline, thinners, contact cement, alcohol, or any item labeled "Harmful or Fatal if Swallowed"**
- **Alcoholic beverages and other intoxicants, such as narcotics and illegal drugs**
- **Ammunition or explosives**
- **Cell phones, beepers, blackberries except when authorized by the facility. If these are approved, they must be maintained on your person at all times or secured when not in use**
- **Audio and video recording devices except when authorized by the facility. If these are approved, they must be secured at all times when not in use**
- **Personal radios, CD players and video games**
- **CD and DVD players except when authorized by the facility**
- **Computers, software and jump drives or any device containing the means of accessing the internet or receiving, transmitting or storing information electronically except when authorized by the facility**
- **Personal protection items such as mace**
- **Maps**

Some institutions also consider the following as contraband:

- **Cigarettes, tobacco products, matches, lighters**
- **Chewing gum**
- **Newspapers (even if inmates are permitted newspapers, staff may not bring them into the institution)**
- **Pornographic material**
- **Glass or metal containers**
- **Thermal containers with glass or removable inserts**
- **Purses**
- **Food from outside sources**
- **Cash beyond that needed for the vending machines. We recommend no more than $10**
- **Umbrellas (may be permissible if blunt-pointed)**

- **Toothbrushes except as authorized by the facility**
- **Mirrors**
- **Magic Markers**
- **Even small, seemingly innocuous items like chapstick or a chocolate bar can be contraband if it was obtained outside of the commissary system.**

Contraband is power for those incarcerated. Contraband allows persons to gain power over others. For enterprising persons, trade in illicit goods and the performance of prohibited services are the building blocks of power. With planning and work, the smallest gambling enterprise has the potential to develop into a large trading empire inside the walls. With such an empire, inmates can procure weapons, narcotics, loyalty, and outside help, all of which can destabilize the security of the institution. One of the most common hazards in corrections occurs when staff underestimates the far-reaching nature of seemingly harmless, but forbidden goods and services. The simple trade of candy, for instance, can be a cover for protection services.

It is important that you know what your institution considers contraband to prevent you from inadvertently "breaking" the rules. If you try to bring in something that is not permitted, you will be required to place the item in a locker or return the item to your car.

We do not support staff bringing recreational or religious reading materials such as books, magazines and newspapers into the facility. The posting of religious symbols or posters should be avoided in the medical area so that persons of other faiths or belief systems do not feel alienated or disadvantaged.

Staff working in infirmaries and specialized healthcare units frequently want to bring reading material that they no longer want into the facility for use by the patients. If the institution approves the reading materials being brought in, it is important that all address labels be removed. It is important that you maintain your personal life and confidential personal information just that . . . personal. It is not professionally appropriate in a correctional environment to share personal information with the inmates.

It is not wise to bring in photos of spouses, parents, siblings or children to decorate your office. That also includes photos of you participating in outside activities. Incarcerated persons should know as little about you as possible.

Entering and Working in a Correctional Institution

When entering the institution, there will be numerous steps that you need to remember and/or will be subject to prior to ever reaching the healthcare unit. Some of those steps and reminders include the following:

Ensure that your personal vehicle is locked with the windows rolled up. Any staff member is subject to search at any time. This includes your vehicle. Staff who refuse to have their vehicle searched when requested could be subject to disciplinary action.

Remember that you work in a correctional institution and may be subject to routine searches including screening of all items being brought into the facility, metal detector device or wand scanning or "pat downs" where an officer of the same sex will perform a physical screening. Yes, entering a correctional institution mimics the steps that occur when traveling through airports. Institutions may also perform routine/random spot

searches. If this happens, do not feel like you are being singled out. The searches are conducted for your own safety as well as the safety of all staff.

Only bring in the items that are necessary to accomplish your job duties. You and your belongings will likely be required to go through a scanner. Some institutions will permit a briefcase that has been inspected to enter the institution while others will require any belongings and paperwork to be in a see-through bag. Backpacks, book bags and gym bags are strongly discouraged.

Some institutions will permit you to bring in food items; however, others will not permit personal food items. If you are prescribed medication, bring only the amount of medication that you will need for the hours that you will be working. Some institutions require staff to obtain approval prior to bringing personal medications into the facility.

When you begin working at the facility, you will be issued an identification badge (ID). It is important that the ID be worn consistently in the manner mandated by the facility, typically attached to your clothing or attached to a cloth "chain" or lanyard around your neck. If you choose the chain or lanyard, make sure that it is a type that breaks away to preclude injury if an inmate should grab it. Your ID should be on your person at all times and not hanging on a coat that you are not wearing. If you inadvertently leave your ID at home, some facilities will allow you to use your driver's license for the day, but you should not count on this. You may have to return home to retrieve your ID. If you lose your ID, you must report it immediately to your Program Manager or designee. It is important that the Program Manager or designee knows of the loss immediately to permit reporting the information to institutional security. Reporting missing IDs is crucial to maintaining the safety and security of the institution.

When you enter or leave the institution, you will likely be required to document your presence in two ways. Healthcare staff are required to use KRONOS or a bio-metric process, the company's electronic timekeeping systems, to monitor the hours that you are on-site. The KRONOS/bio-metric systems are used to track the hours worked for employee payroll and also document the hours worked by position for required client reporting. Failure to clock in/out using KRONOS/bio metric system will result in unnecessary follow-up by the administrator or designee; may result in time being paid inaccurately secondary to missed clock in/clock outs; and may lead to disciplinary action. The correctional institution may also require staff to sign-in and sign-out on a log. Usually this log is located as you initially enter the facility and go through security processes. The institutional log serves two purposes. The log verifies the hours spent in the facility by healthcare staff for the client. The log also allows the facility to know who is in the secure area of the facility in the event that there is an inmate disturbance or a hostage situation.

There are additional security processes that you may be subject to when entering an institution. The institution may require that you turn in your car keys. This is a routine security procedure. In addition to your ID, you may have a bio scan fingerprint device or key card that you are required to carry to open doors that must be used to enter the institution. Some facilities will provide and/or require use of a "body alarm" for all staff. The body alarm should be maintained on your person where you can access it in an emergency but should not be kept where it could be easily set-off by mistake.

When entering the institution, you may be required to obtain authorized facility keys. Some institutions will authorize designate specific healthcare positions or assigned duties for a shift to carry applicable facility keys. If you are authorized/required to carry facility keys, you will pick up the keys as you enter the facility and return them when you leave. Access to facility keys is an important responsibility and should not be taken lightly. Keys should be on your person at all times and should never be in a drawer, on a desk, or out of your possession at any time. If you inadvertently take facility keys with you when you leave, you will be expected to return to the facility immediately to turn in the keys.

Doors to storage areas, medication storage areas and other rooms within the healthcare unit where equipment and supplies are maintained should be locked at all times. Even your office door should be closed and locked at all times when you are not in the room, even if you are leaving for only a short time. It is common for only certain sets of keys to be assigned to the healthcare unit. For example, the healthcare administrator, director of nursing, and medication nurse may be authorized to carry keys that access certain areas within the unit.

Healthcare offices and examination rooms used to perform patient care are different. When providing care to a patient, the doors to exam rooms and offices should always remain unlocked. When you are not performing patient services, the doors should be closed and locked. It is important to know that at no time should you leave a patient unattended in an examination or healthcare office area. If you must leave during an examination, you must either have another healthcare staff or the correctional officer come into the exam/office area until you return. If that is not possible, you should have the patient step out into the waiting area until you return. If you are unsure if a room/office should be locked, ask the security staff.

If you have an office on the healthcare unit, it is important that you think about what personal items you maintain in the office. Do not have family photos, medical records, keys/purses/personal items lying around and/or unlocked. You do not want inmates to see pictures of your family. If you have papers on your desk, the inmates will read them. Inmates are skilled at reading upside-down!

You are probably thinking, WOW, there are a lot of rules. Please know that the security procedures will become routine. The safeguards are in place to ensure your safety while in the institution. When in doubt about anything questionable, consult your supervisor or security staff. There are no silly questions in a security-driven atmosphere!

Tips for Ensuring a Professional Presentation

Your presentation while in the institution will have an impact on your development of professional working relationships with security staff as well with the patients.

When dressing for work, it is important to present a professional image and comply with the institution's dress code. You need to know the dress code! Attire that may be acceptable in the community may not be appropriate for a correctional environment. Many healthcare staff that provides direct care will be allowed to wear scrubs as authorized attire. Remember when choosing colors of scrubs to stay away from those colors that are generally worn by the inmates. This tip also applies to healthcare staff who dress in "street clothes."

Jewelry should be kept to a minimum. Jewelry that dangles or is easy to grab, such as necklaces and dangling earrings, can be used against you. Clip-on ties are recommended for male staff since other ties can be used against staff, particularly if the staff member gets too close to an inmate's cell-front door or food slot. Colognes, perfume, heavily-scented lotions, provocative clothing and footwear are not appropriate for correctional work.

A good rule of thumb is to wear attire that shows respect and professionalism but does not stand out. You want the patients to remember you for what you do and how you interact with them, not for how you look. Security staff has the authority to prevent a staff member from entering the facility if the staff member's attire is inappropriate or provocative.

Consistency, consistency, consistency! Providing healthcare services for all patients in the same manner is important to developing a professional image. Consistency is key in how you provide care, how you address the patients and how you treat them. It is critical that you maintain professional boundaries, do not greet or treat persons differently and/or give the appearance of "favorites."

Safe Practices

The work environment in which healthcare staff practiced prior to corrections often influences how he/she physically and verbally interacts with patients. For example, when providing care in a hospital or nursing home, healthcare staff may sit or stand close to a patient or offer a comforting touch on the arm or back or even a hug in some situations. In the correctional environment, these behaviors or gestures for an inmate can have very different interpretations and implications for the patient and correctional staff. Engaging in personal contact with a patient can result in security disciplinary actions for staff that may include being "locked out" by having the staff member's clearance to enter the facility revoked.

The following strategies are offered as safe practices for healthcare staff while providing care in a professional manner.

- When interacting with a patient at cell-front, in a corridor or non-office area, maintain at least an arm's length between you and the individual. The distance not only helps create a professional interaction but also builds in safety for you. The distance minimizes the potential for you to be grabbed or hit and provides distance to allow time for you to react.

- When walking through cell areas, maintain an adequate distance between you and the bars. Do not stand with your back to the bars if persons can come directly up to the bars.

- While it is a natural reaction to show empathy in healthcare encounters, touching a patient's arms or body as an expression of comfort or sympathy is not an acceptable practice in corrections. Physical touch may give the patient an unintended show of intimacy or attraction. Allowing a patient to touch you can be viewed as "power" or a potential unacceptable relationship.

- When conducting patient encounters in an office area, position yourself in the room to allow you to be between the patient and the door to allow you to have first access to the door. This prevents being barricaded in an area with no access to help in case a patient becomes agitated or assaultive. Have a plan and know how to obtain immediate assistance if a patient becomes agitated or violent.

- Entering an inmate's cell is not recommended to provide healthcare, however, this may be required for emergent or urgent care. When necessary to enter a cell, **ALWAYS** allow the correctional officer to secure the cell/area before entering the area.

- **Do not allow unwelcome or inappropriate behavior from an inmate. It is important that the inmate understands that yelling and being threatening are not acceptable**. Sexual exposure or open masturbation can occur within your view when you are walking a cell block, in the yard, corridor or common areas. You should not ignore the behavior and as soon as observed, go directly to the nearest officer and report the behavior by individual's name or cell location if possible. If it occurs with frequency on a cell block or in a segregation unit with one or more persons and your responsibilities require presence on the unit, request that the unit officer either walk the range prior to your activities or escort you while providing clinical services on the unit.

- Ensure that you know the institution's policy related to what employees can do for inmates and, most importantly, what employees CANNOT do for inmates. A common dilemma known as "the hook" starts with an inmate asking for something seemingly simple like asking you to mail a letter for him/her on the way home although this is a rule violation. If you are unaware that this is a violation and mail the letter, chances are the inmate will soon be asking you to do something more and when you object, the inmate may threaten to tell a supervisor about the letter. All too frequently, the employee gives in to the demand and the "hook" is set. The favors become larger and can arise to serious infractions and criminal offenses like providing drugs or other contraband.

- Staff "splitting" is a common ploy attempted by some persons in custody in creating issues between staff members or to obtain something from one staff member that another staff member has denied. All staff need to be mindful of attempts to create barriers between security and healthcare staff as well as between various healthcare team members. Providing healthcare within institutional rules and maintaining open communication between healthcare and security staff are the best defense against such tactics.

  It is always good practice to ask the inmate requesting something like a phone call or a privilege, if he/she has asked any other staff member the same and, if so, what response was given by the other staff member. This allows you to verify if there is cause for suspicion or if the person might be lying or trying to be manipulative. Obtaining the inmate's account is also an important piece of information to be able to share with co-worker(s) if the inmate does succeed at getting co-workers at cross purposes.

- Do not reveal or share personal information. Sharing personal information about your family or co-workers with inmates is not appropriate. Remember that the walls "have ears" when you are talking with fellow co-workers regarding personal information. Ensure that these conversations occur in an area where inmates are not allowed and/or cannot easily overhear the conversation. Close office and break room doors when you are having personal conversations with other co-workers.

- It is important when providing healthcare services for a patient that you do not make promises that you may not be able to keep. It is OK to tell a patient that you will look into a situation if you really plan to follow through. However, it is important to keep in mind that you may not be able to do what you want to promise. Your credibility will be seriously compromised if you are unable to make a "promise" a reality.

- **It is essential that you do not inform patients of the dates or times for off-site appointments or transfers to another institution. If a patient becomes aware of an appointment/transfer date or time, the appointment/transfer must be changed.**

- If you are ever in a hallway or area where inmates are moving from one area to another, do not allow the inmate to walk behind you. Always keep them in your line of sight.

It is important to remember that boundary violations can minimize your own safety and the safety of your co-workers and security staff. Serious violations can lead to discipline of an employee. Don't let yourself get caught up in one of these games. Know the institution's rules and ask your supervisor if you are unsure!

Sharps and Contraband Control

Healthcare staff who work in corrections learn that anything that can be traded or modified can be considered contraband. In a prison, almost anything can become contraband including excessive amounts of allowable property, an altered item, such as a hollowed-out book or an item that can be made into a dangerous weapon, such as a razor blade melted into a toothbrush handle.

As discussed previously, the institution will have an official list of items that are defined as contraband. However, it is important for healthcare staff to be aware and consistently think about items used in the health unit that also are contraband and can be used to bring harm or for the manipulation of others. Often it is something that may not seem dangerous normally in healthcare areas but could be dangerous in the hands of an inmate. Examples include items such as your stethoscope, reflex hammer, forceps and other items we may have in our possession or lying in an area accessible to the inmate. Other items such as money, maps, policy directives, or credit card receipts can be dangerous if in the hands of an inmate.

Healthcare staff play an important part in maintaining a safe environment. There are obvious items and supplies in the health unit that pose a risk within the institution. These items include medications that can be abused and "sharps." Medications that can be abused include medications beyond those identified by the FDA as controlled

medications. "Sharps" is usually used to define objects in the healthcare setting that can penetrate the skin including, but not limited to, needles, scalpels, razors and sharp instruments that are used in providing inmate healthcare. Other examples of items that can be considered "sharps" in the healthcare setting include broken venipuncture tubes, exposed ends of dental wires as well as metal pens, paper clips and staples.

Healthcare staff coming into a correctional environment will quickly see the significant focus placed on the monitoring and use of these types of items. Because of the significant risk posed by items considered "sharps" and controlled medications, health units are required to maintain limited access and strict accountability for these items. The accountability is monitored through processes called "counts." Minimum requirements for the frequency of counts of sharps and controlled medications usually include: at the change of shift; when stock is added to inventory for sharps or controlled medications; and when keys for controlling medications and/or sharps change from person to person.

While nursing and dental services staff are primarily responsible for completing and monitoring required counts, it is the responsibility of all staff to monitor use and location of the items as well as to maintain control of the items when in use. It is also important that these items are properly disposed of in medical waste/sharps containers after use. Items accounted for through counts but left unattended in an exam room for a patient to take jeopardize the safety of everyone in the institution.

Security Overview and Awareness Summary

The information in this section is intended to provide general knowledge and understanding of developing safe work practices and maintaining your safety while working in a correctional environment. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What is the title of facility administrative staff and how should you address them?
- What is the proper title for security staff and how should you address them?
- What is the process for entering your facility?
- What items are you allowed to bring into the facility with you?
- Are you required to carry keys while in the facility? If yes, how to you obtain them?
- What is considered contraband and/or sharps in your facility
- What is your responsibility for controlling access to contraband?
- What are the requirements for security staff escorts when working in the healthcare unit?
- What are the requirements for security staff escorts when moving within the correctional facility?

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Chapter 3: Overview of Human Resources and Credentialing Process

Overview

The mission of the Human Resources Department is to support the company's goals and objectives by providing services that are characterized by fair treatment of staff, open communications, personal accountability, trust, and mutual respect. The Human Resources Department seeks to provide solutions to workplace issues that support and optimize the operating principles of the organization and correctional healthcare. Human Resources staff are focused on delivery quality customer services for staff and are committed to recruiting, developing and retaining a qualified healthcare workforce.

The Human Resources team provides staff with information and resources necessary to be successful in their work with and for the company. In the event you need additional information, clarification or wish to talk with a member of the Human Resources Team, contact information can be found at *Meet the HR Team* on the Centurion intranet/portal.

The Human Resources Department offers a wide array of employee information on the intranet/portal. You can get log-in and access information from your recruiter, site health service administrator or director of nursing. The information on the portal is designed to provide you with "anytime-anywhere" access to current Human Resources information. Information can be found under the Human Resources tab located along the top header. Additional information included in this area is specific to Benefits, Credentialing, HR Administration and Centurion University.

Important Resources

As noted above, the company intranet/portal provides a variety of resources for staff. By choosing the "Human Resources" tab on the Centurion Portal, you can access information specific to human resources policy, benefits, recruiting, our employee referral program, and Centurion University. The information below describes additional information about resources and can be found on the company portal.

- Benefits information – describes eligibility to participate, programs and covered services available by program, forms requiring completion based on benefit elections and information pertinent to our paid time off program. Information available on the portal includes the following:
    - Dental, vision and medical benefits including links to insurers
    - Flexible spending account
    - Health savings accounts
    - Life insurance
    - 401(k) Retirement Plan
    - Wellness benefits
    - Employee assistance program
    - Discount employee programs available
- Centurion University – a continuing education resource for all staff. One important feature is our online Learning Management System (LMS) which provides online training and professional development.

Log on instructions can be found on the portal. This can be done by sending an email to CenturionUniversity@teamcenturion.com

Human Resources Orientation

Human Resources staff will facilitate new hire orientation specific to completing all required employee paperwork, providing information on company policies and benefit programs available to you and helping you understand where/how these resources can be accessed.

Questions specific to Human Resources and/or benefit questions should be directed to your immediate supervisor or to the Human Resources Department.

Credentialing

As a healthcare provider, we strive to ensure that individuals recruited to provide clinical services in correctional facilities have the appropriate training and credentials to perform these services. We use a variety of resources to establish and document that required healthcare licenses and credentials have been verified and that the licenses/credentials remain current.

While specific contracts may require completion of additional credentialing, our Credentialing Process is used as the basis and standard for the company. The process is designed to meet requirements of state, federal and accrediting organizations specific to the provision of services in the correctional environment including the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA).

All medical, mental health and dental staff must provide confirmation of compliance with the licensure, registration, education, and professional standards of the community and be in full compliance with state statutes and healthcare regulations including professional boards and other regulatory bodies. All staff authorized to prescribe medications must have current individual Drug Enforcement Agency (DEA) registration numbers, federal and state where applicable.

Beyond credentialing, our contracts routinely require some type of security background check. All healthcare staff is required to submit to and pass a security background check in order to work within the correctional facility.

Credentials are verified during the recruiting and hiring process based upon primary sources and recognized registries. When licenses are renewed, the verification of licensure is repeated. For staff prescribing medication, dentists and doctoral level licensed psychologists, the National Practitioner Data Bank (NPDB) is also reviewed annually to ensure that the staff member remains in good standing. Credentials are reviewed annually on all licensed professionals.

Credential Files are maintained on a share drive. The regional office has access and utilized those files. Credential files may also be maintained on-site where you provide healthcare services if required by the contracting agency. Information maintained in the credential file include copies or verification of current licensing, certification, and

registration information as required by the state where practicing and are in accordance with NCCHC and ACA standards and contractual requirements. For contracts where all credentialing information is maintained in our Regional Office, required information is shared with healthcare staff administration as required by the contract and accrediting agencies.

The contract's Program Leadership (VPO/PM/HSA) has overall responsibility to ensure appropriate completion of the credentialing process and maintenance of current Credential Files. Credential verification is completed by a credentialing agency and/or our staff who have received training in the credentialing process. The Regional Office will be responsible for running monthly reports out of the Credentialing database to monitor credentialing to look for expired items. These audits are conducted no less than annually.

While the Program Leadership and designated staff is responsible for tracking, it is also your responsibility as a licensed/credentialed professional to know the requirements for maintaining your license in an active and unrestricted manner. If there is a change in your license or eligibility for license/certification during your employment, you are required to immediately report information to the Program Leadership. You are also required to report any investigations or actions that may impact your licensure to the Program Leadership immediately after your notification.

National Practitioner Data Bank (NPDB)

As part of our credentialing process, we obtain a report for each practitioner, physician, nurse practitioner, physician assistant, psychiatrist, dentist, doctoral-level psychologist, and licensed personnel from the National Practitioner Data Bank (NPDB). The NPDB is a national central repository of information on malpractice payments or adverse licensure actions.

NPDB reports provide a history of the following incidents/actions:

- Medical Malpractice Payments – amount, when and type of incident
- DEA/Federal Licensure Action(s)
- State Licensure Action(s) – revoked, restricted, suspended, probation
- Clinical Privileges Action(s) – dismissal, suspended, left prior to investigation
- Professional Society Action(s) – not permitted to participate
- Exclusion or Debarment Action(s) – e.g. Barred from Medicare

This information is reviewed as part of the credentialing process. If information obtained in the report raises questions or concerns, the information is forwarded to the company Credentialing Review Committee for further review, clarification and recommendation.

Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

OIG has the authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act) and maintains

a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP).

Individuals found to be on the LEIE database will be terminated from employment. Rehiring of the individual may be considered once removed from the LEIE.

Credentialing Review Committee

Our Credentialing Review Committees, based on discipline, are responsible to review NPDB reports as well as any further information obtained for physicians, nurse practitioners, physician assistants, psychiatrists, dentists, and doctoral-level psychologists who are seeking employment with us.

The medical provider Credentialing Review Committee is a panel composed of at least two physicians and representative(s) from Clinical Operations. A minimum of three members are required for each vote. An alternate physician and an alternate Clinical Operations representative participate in the committee's activities but only vote when necessary. Members are required to sign confidentiality agreements which prohibit them from discussing sensitive information outside of the Committee meetings.

The purpose of the Credentialing Review Committee is to review referred cases specific to credentialing or re-credentialing and provide recommendations to operations/clinical management regarding employment or continued employment based on review.

Re-Credentialing

Regional Office staff or designees will track current licensure using the Credentialing database. You are responsible for knowing the requirements of maintaining your license, such as continuing education and ensure completion of this and/or other requirements. Staff will be required to submit renewed licensure and/or certifications prior to their expiration. Failure to obtain licensure/certification renewals prior to their expiration may be subject to suspension until the documentation is provided.

Initial and continuing employment with us requires successful completion of credentialing process.

Human Resources and Credentialing Summary

The information in this section is intended to provide general knowledge and understanding of our credentialing process and the information available to you through our Human Resources Department. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Is your credential file complete and accurate? If you have concerns, review with the person responsible for developing and maintaining the file.
- Do you know how to access the Centurion portal and use the Centurion University CME/CEU offerings?
- Do you know how to reach the Medical Director for your facility and the Regional or Statewide Medical Director?
- Do you have any specific benefits or other Human Resources questions or concerns?

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Chapter 4: Orientation for Healthcare Staff

Overview

All new healthcare staff receive an orientation to the correctional environment. For many members of the healthcare team this is their first exposure to a correctional environment. The clinical orientation program focuses on aspects of an inmate's security experience that impact provision of healthcare and how healthcare is provided within this challenging environment.

In addition to this resource manual for physicians, nurse practitioners and physician assistants, our providers are expected to participate in the orientation for all new staff. Many of the topics are covered in this manual but the focus in this manual is on issues that are directly relevant to providers.

General Topics Required for All New Staff

Introduction to Corrections
Boundaries and Safe Practices
Confidentiality, HIPAA, PREA
Infection Control and Bloodborne Pathogens
Hazardous Communication
Continuous Quality Improvement
Emergency Responses
Key Control

Healthcare Overview Required for All New Clinical Staff

Access to Healthcare
Healthcare Requests
Continuity of Healthcare
Documentation
Mental Health Services
Special Healthcare Considerations in Inmate Population
Healthcare Services for Segregated Inmates
Chronic Disease & Healthy Lifestyle Promotion
Specialty Services
Inmate Death
Tools & Sharps Control
PREA for Medical and Mental Health Staff

Orientation Required For Medical/Nursing Staff

Sick Call & Access to Healthcare
Medication Practices in Correctional Environment
Healthcare Screenings
Initial Health Assessment
Intoxication, Drug Overdose & Withdrawal
Tuberculosis
Wound Care & MRSA
Oral Care
Infirmary Care

You are required, at a minimum, to review and complete all topics presented in the General Topics Required for All New Staff. You will be expected to complete the post training tests and return the required documentation to the designated individual at your site.

You are strongly encouraged to complete the orientation modules in Healthcare Overview Required for All New Clinical Staff and Orientation Required for Medical/ Nursing Staff. Available orientation modules may vary slightly from titles listed and/or by contract. As a medical provider, you are an integral part of the healthcare team and your understanding of the processes not only for physical health but for mental health, dental services and the important issues relating to security and administrative activities within the environment are important to providing comprehensive care.

Security Orientation

Many state Department of Corrections and local correctional agencies that contract for our healthcare services require additional, specific orientation for "contracted" and "non-security" staff. The purpose of additional required "security" orientation by a correctional system for contracted staff is to familiarize staff with various aspects of policies, procedures and/or services provided or required to be provided to inmates housed within their system or individual facility.

Specific "security" orientation may not be required and/or we may negotiate with the system to determine that topics/information provided as part of our own new employee orientation may meet some or all of the required information.

When additional training is required the following will be determined by the correctional system:

- Amount of training required in hours/days
- Timing of the orientation including:
  - Prior to providing direct care services
  - Within a designated timeframe from new employee start date
  - Training topics required dependent on your role, clinical versus support
  - Additional training requirements
- Location of the training
  - Individual worksite
  - Regional/state training facility
- Delivery of training
  - Classroom
  - Self-study
  - Computer/web based
  - Supervised on-the-job training

Determination by the correctional agency on required training is usually dependent on the type of position and the amount or degree of inmate contact associated with staff roles/responsibilities. The purpose of the "security" training requirements for contracted or non-security staff is to increase familiarity of staff with policies, procedures that will

assist in the new staff maintaining a safe and secure work environment for themselves, other staff and the inmate population.

The new employee training required by the correctional agency for healthcare workers will vary from no additional requirements to up to 40 hours. Completion of required Department or Agency is considered a requirement for continued employment. Topics covered vary by correctional agency but often include some of the following:

- Use of Force
- Computer End User Training for Inmate Management System
- Critical Issues in Gender and Managing Special Populations
- Discriminatory Harassment
- CPR / First Aid
- Leadership and Hierarchy in Corrections
- Elements of Report Writing
- Traumatic Incident Stress Management
- Self-Defense Training

When "security" training is required, the Program Leadership or designee at your facility will be responsible for coordinating and scheduling your participation. While training completion is important, we also want to ensure that required healthcare services and programs can be maintained. If you have questions, concerns regarding training requirements, please discuss with the Program Leadership or designee.

Orientation for Healthcare Staff Summary

The information in this section is intended to provide general knowledge and understanding of topics provided as part of health services and security orientation. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What is the process and timing for completion of any required department security orientation, if applicable for your contract?
- What is the process and timeline for initiating and completing employee orientation resource manual sections?
- Who are the staff at the site and regional level to use as resources, mentors for specific orientation topics?

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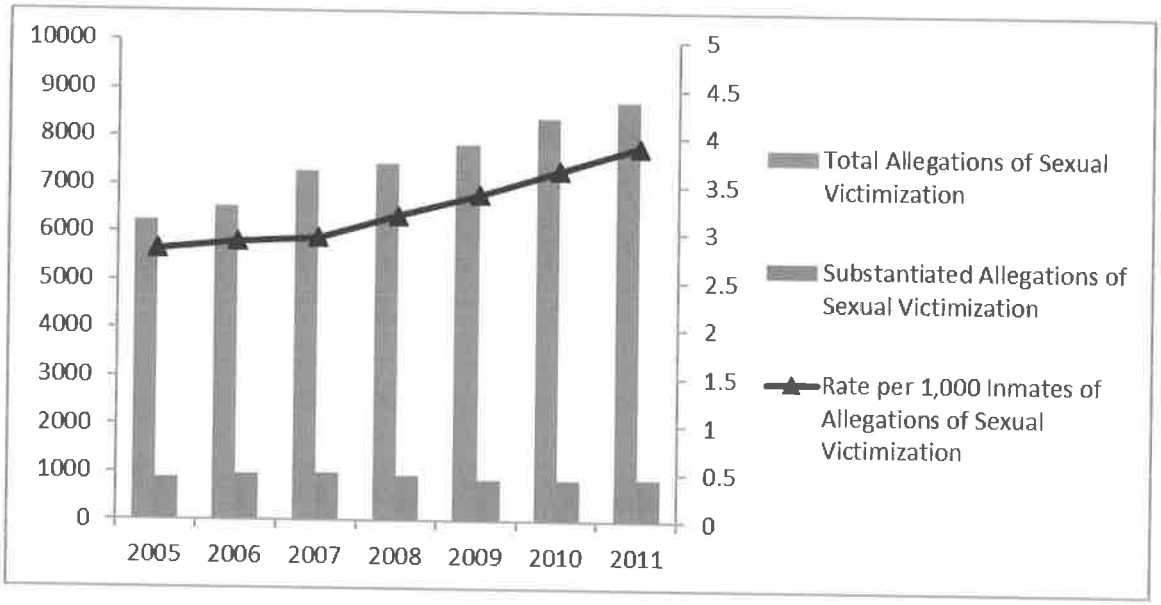
Federal Prison Rape Elimination Act (PREA)

The Federal Prison Rape Elimination Act (PREA) governs all employees and volunteers working in correctional environments, including healthcare staff. Unfortunately, rape and other forms of sexual aggression do occur in prisons and jails. Following increased awareness of sexual violence in correctional institutions, Congress passed the Federal Prison Rape Elimination Act (PREA) 2003. The PREA legislation establishes a zero tolerance for sexual violence, including inmate-on-inmate nonconsensual sexual acts, inmate-on-inmate abusive sexual contacts, staff-on-inmate sexual misconduct, and staff-on-inmate sexual harassment. PREA governs all employees and volunteers working in correctional environments, including psychiatric staff.

Despite efforts to address this challenge, inmates experience sexual assaults and abuse at rates that are three or four times greater than the general population. The most recent publication of the Bureau of Justice Statistics (June 2018) confirms that alleged sexual victimization rates in adult correctional facilities have continued to rise:

National Rates of Alleged Sexual Victimization
Adult Prisons and Jails 2005-2011



Source: Bureau of Justice Statistics (January 2014),
Sexual Victimization Reported by Adult Correctional Authorities, 2009-2011.

In 2015, 24,661 allegation of sexual victimization occurred, nearly triple the number recorded in 2011 (8,768 allegations). Substantiated allegations rose from 902 in 2011 to 1,473 in 2015 (up 63%).

Overall, the rise in these allegations has primarily involved increased reporting of inmate-on-inmate sexual victimization. In 2015, 58% of substantiated incidents of sexual

victimization were perpetrated by inmates, while 42% were perpetrated by staff members (BJS 2018). The BJS (2018) reported the increase in allegations of sexual victimization from 2011 to 2015 coincided with the release in 2012 of the *National Standards to Prevent, Detect, and Respond to Prison Rape*. As a correctional healthcare provider, you may be called upon to report, evaluate and/or treat inmates who have been involved in such behaviors, either as victims or perpetrators.

The PREA legislation applies to all correctional institutions, including jails and prisons; adult and juvenile facilities; public and private facilities. It had four primary goals:

1) Establish zero tolerance standard for correctional sexual violence
2) Make prevention a top priority in each correctional system
3) Increase accountability of correctional officials
4) Protect the 8th Amendment rights of inmates/offenders/prisoners/detainees against cruel and unusual punishment

After the goals were established, a Congressional committee developed regulations to achieve the goals. In 2009, the committee published draft Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails. After review, public comment and revision, final National Standards to Prevent, Detect, and Respond to Prison Rape were issued in May 2012. These standards were enacted to prevent, respond to and report sexual abuse, including sexual harassment, in correctional environments.

It is important for you to be familiar with these standards and what the standards require of you. Under PREA, all correctional staff including healthcare staff have mandated reporting requirements when they become aware of any form of sexual abuse or sexual harassment. Offering a voluntary physical and mental health assessment to the victim is required once sexual abuse or harassment has been alleged or identified. The initial examination for the extent of physical injury that may require emergency care is carried out by healthcare staff. Mental health assessment and treatment must be provided to the victim if clinically indicated and the victim consents. Assessment and treatment by mental health staff includes dealing with the trauma as well as assessment of suicidality.

The examination, which includes the collection of forensic evidence from the victim, is preferably provided at a local medical facility using approved evidence collection techniques and handling of the evidence for laboratory determination. PREA standards require that both assessment and treatment must be offered by properly trained clinicians. Prophylactic treatment for sexually transmitted infections and follow-up care are offered to all victims.

Assessment and, when appropriate, treatment must also be offered to perpetrators of inmate-on-inmate abuse. Of course, staff-on-inmate sexual contact, abuse and harassment are strictly prohibited. We maintain a zero tolerance policy towards such behaviors. If you become aware of such behavior you must report it to your supervisor immediately. A report is made to correctional authorities to effect a separation of the victim from the assailant in their housing assignments.

PREA has many additional elements and requirements that can impact psychiatric and physical health staff working within correctional facilities. We have developed

comprehensive staff training on PREA, and you will be receiving the training as part of your orientation with annual refresher training provided at least every other year. The client will have specific policies and procedures to ensure compliance with PREA. It is important for you to be familiar with these policies and to obtain clarification whenever PREA requirements are not clear to you.

Forensic Health Information

Forensic information is physical or psychological data collected from an inmate that may be used against him/her in disciplinary or legal proceedings. There are instances in the correctional environment when conducting body cavity searches and blood or urine testing may be done for legal/forensic reasons, not for medical purposes. Performance of these forensic procedures by healthcare staff undermine the credibility of the professional relationship with the inmate/patient and expose healthcare staff to participation in acts that may be performed without the inmate's consent.

Alternatives to having healthcare staff participate in forensic testing and searches often include services provided by outside professionals who do not have a therapeutic relationship and testing that can be performed by trained security staff.

Healthcare staff typically may:

- Collect court-ordered laboratory, tests, examinations or radiological procedures only with the consent of the inmate
- Comply with state laws that require DNA blood samples only with the consent of the inmate
- Collect evidence from the victim of sexual assault only with the consent of the inmate/victim

PREA and Forensic Health Information Summary

The information in this section is intended to provide general knowledge and understanding of the requirements of the Prison Rape Elimination Act and the appropriated involvement in forensic health investigations. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- How many PREA Reports are received by the institution?
- How many inmates receive examination and testing at community facilities and are test reports automatically sent to the facility?
- Do medical staff receive directives for court-ordered healthcare? If so, where are the correctional system's administrative directives or policies and procedures maintained.

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Chapter 6: HIPAA and Confidentiality

Overview

Confidentiality of health/medical information refers to the right to have personal health records private and the obligations of individuals using/monitoring the personal health records to ensure the privacy of information is maintained. Maintaining privacy of medical record information requires healthcare staff to take necessary steps to prevent unauthorized third parties from having access or discovering an inmate's healthcare information. The first line of defense in protecting inmate health information depends on our employees. It is important to understand that just as your private healthcare information is protected, so is the healthcare information of the inmates.

Maintaining Confidentiality of Healthcare Information

The first rule in maintaining inmate health information is to be aware of where and when you discuss a patient's confidential health information. All healthcare encounters should occur in an area that protects the patient's privacy. Medical records should be maintained in a limited access area when not being used and, when in use, the healthcare records should never be left open or in an area where inmates have access. There will be situations where correctional staff may need to be present during an evaluation/assessment to ensure patient or staff safety. It is important to remember that correctional staff are required to comply with the same rules of confidentiality as healthcare staff.

Protecting Your Personal Information

While protecting the patient's health information is important, it is also important for staff to understand the need to maintain their personal information . . . personal! As noted in previous chapters maintaining a professional relationship with the inmate is key to a successful and safe work experience. Following are several tips to helping you maintain your personal information in confidence:

- **Be aware of when/where you discuss information about yourself**
- **Avoid sharing personal information with other staff when in a public area or in an open door room where inmates are waiting or working within listening distance**
- **Do not bring items to work which contain personal information**
- **Do not engage in discussions with inmates about personal or family specifics**
- **Always be aware of whereabouts of inmates when discussing personal or health information**

Patient Consent

The general rules regarding release of a patient's medical record information to community agencies are consistent with rules in community for release of medical information. Information contained in the inmate-patient's medical record may be released to third parties only if the inmate-patient, or their healthcare guardian if one is

assigned or appointed, has consented to such disclosure. Therefore, we obtain written authorization from a patient when requesting confidential medical information regarding the patient's previous healthcare treatment/history and when we receive an external request for a patient's medical records.

In instances when information is necessary to ensure medically necessary continuity of care, an inmate-patient's consent to release information regarding current medications and the current problem list may not be required.

Limits to Confidentiality in Correctional Settings

While standard practices are followed related to confidentiality of healthcare records, there are specific circumstances that limit confidentiality in the correctional setting. All persons are advised of the rights to confidentiality of their healthcare information as well as the specific circumstances which limit confidentiality. This information is provided to the inmate at the time of reception into the correctional system.

Many of the limits to confidentiality in correctional settings are the same as those present in the community and include:

- **Risk of harm to self**
- **Risk of harm to others**
- **Risk of harm to an identified victim**
- **Ongoing abuse of children, elders, or disabled persons (in some states this includes individuals with serious mental illness)**

There are also limits to confidentiality unique to correctional settings to include:

- **Risk to safety and security of the institution, such as in the instance of providing medical isolation secondary to communicable disease or placement on one-on-one watch due to risk of suicide**
- **Information related to transportation needs, special housing needs and special diet needs**
- **Issues related to the Prison Rape Elimination Act (PREA)**
- **Abuse or mistreatment of an incarcerated person**

Nearly all correctional facilities have policies and regulations regarding reporting issues that may lead to a threat to the security of a facility. You will want to be familiar with the policies and procedures of your facility. If you have questions or concerns regarding specific situations you should direct those questions to the healthcare department Program Manager or designee.

Some examples of situations that would be considered a threat to security include (but are not limited to) the following:

- **Possession of weapons or weapon making material**
- **Riots, or a 'hit' placed on an inmate or staff member**
- **Plans for escape**
- **Possession of contraband**

- **Illicit substance use**

At any time in the course of your work you become aware of any such information you should immediately report it to your supervisor and the correctional administration. Failure to report suspected incidents can increase the risk to inmates and staff as well as result in possible penalties or corrective actions for you.

Health Insurance Portability and Accountability Act (HIPAA)

The guiding principles of HIPAA indicate that you cannot disclose any inmate-patient healthcare information without proper authorization. The Health Insurance Portability & Accountability Act of 1996 was designed to ensure protection of protected health information (PHI). Examples of PHI include inmate-patient's diagnosis, laboratory reports, allergies and reasons for medical or mental health isolation. HIPAA further discusses disclosure and sharing of medical record information verifying that disclosure is permitted only for purpose of treatment, healthcare operation and payment and discusses the ability to share medical record documentation to perform health services oversight activities such as quality improvement.

Important reminders when working in corrections and protecting patient health information include:

- **Never** give a patient information from his/her medical record unless otherwise indicated by a specific policy. Policy may allow patients to request copies of their records or request an appointment to sit and read their records while supervised
- Always make reasonable efforts to protect PHI in the work place to include proper handling and storage of medical records
- Keep computer screens from view of other staff and inmates, password protect your computer and do not share or allow others to use your password
- When faxing or emailing information, mark the transmission as "confidential"
- Shred all documents that have identifiable information prior to discarding
- Medical information cannot be shared, copied or removed from the premises without authority from the institution or for a necessary medical reason
- Violation of HIPAA has disciplinary and potential legal consequences for both the staff member and the correctional system

We provide staff training in confidentiality and HIPAA during orientation and annually. Staff are expected to complete these mandatory trainings.

HIPAA and Confidentiality Summary

The information in this section is intended to provide general knowledge and understanding of maintaining confidentiality of inmate health information and personal information in a correctional environment. The following space is for your notes and

questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What are examples of inmate-patient health information that might be shared, who can it be shared with, and why might the information be shared?
- How and who is responsible for providing information requested by security or administration staff?
- What is the process for obtaining medical records at the facility?
- When are consents for health services used at the facility?

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Chapter 7: Risk Management

Overview

As a professional healthcare provider, you are no doubt familiar with the general concept and principles of risk management. In the past, depending on the area in which you practiced, risk management most likely conjured up thoughts of incident reports, medication errors, missed diagnoses, peer and mortality reviews, and basically anything one could do to avoid litigation.

A new paradigm for risk management is Enterprise Risk Management (ERM). The ERM approach is holistic in nature with the following goals:

- To identify risk in all departments and areas of practice
- To be proactive versus reactive by identifying areas of concern and potential exposure
- To promote transparency and communication in an attempt to improve outcomes

The ERM approach realizes that many errors are due to system failures and not to individual actions. Investigations and follow-up are designed to be positive and not punitive in nature. The intent is to identify the cause of the problem and implement changes to prevent such an occurrence from happening again.

In the field of correctional medicine, risk management takes on an even greater importance. Employee safety can be influenced by the level of security available and the conditions of the facility. Most employees are working in facilities operated by a state or county, oftentimes creating additional safety and administrative challenges.

Our Risk Management Program is multi-faceted. Key to this Program is our comprehensive Incident Reporting Policies which require employees to report serious incidents and injuries and all litigation and legal matters. The Legal Department then facilitates proper reporting of incidents, events and claims to the insurance carrier(s) and, in cases of litigation, ensures the appropriate assignment of local defense counsel and coordination of the legal defense. Each case is monitored closely to ensure that legal deadlines are met and the case comes to as favorable a close as possible.

In addition to actual lawsuits, providers sometimes receive Notices of Depositions, Subpoenas, requests for records, etc. Outside attorneys or their staff often call a provider directly wanting to speak with him/her about inmate care. Employees are instructed **NOT** to speak with the attorneys, but rather to notify their supervisor and the Centurion Legal Department of any verbal or written request. The Legal department will verify the validity of the request, obtain an adequate signed release from the inmate and intervene with the requesting party, if feasible.

The same is true of media requests: employees are **NOT** to speak without authorization with media. If approached or contacted by media, kindly indicate that you are not permitted to comment and refer them to your Program Leadership.

Additionally, contracts utilize our Online Sentinel Event Log (oSEL) to identify and track events, provide real time notification of events to Regional staff and/or our client as well as alert CQI leadership and the Legal Department. The oSEL entries are entered as events occur and are monitored daily/weekly by the site and Regional Medical Director(s) as well as CQI leadership for the contract. Talk to your CQI staff or Site administrator to ensure you have access to enter and/or review your oSEL.

A final aspect of our Risk Management program is compliance with regulatory and accreditation standards. In the field of correctional medicine, the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA) are the two main accrediting bodies. Each publishes standards of care which we use in the development of policies and procedures and clinical guidelines. (For example, see model ***policy Sentinel Event Reporting and Investigation P/J-A-06a***).

It is important to remember that not all adverse or unexpected outcomes of medical treatment are caused by negligent acts. Many times it is determined that such outcomes are a consequence of the illness or an unpreventable and/or unforeseeable complication of the medical service(s) provided. Even if no Claim arises from the incident it is still important to properly report incidents in order to assist in the development of better loss control procedures.

Employees are encouraged to consult Centurion's General Counsel when in doubt as to whether or not a matter is reportable under this policy.

If you are interested in making a presentation at a conference regarding your work, write a paper or publish an article, all such work must be first vetted and approved by the compliance department. In many cases, the client or your facility must also approve. Centurion encourages scholarship and dissemination of best practices, but requires that such public work first receive proper clearances.

Centurion's Compliance and Legal departments work closely with all of our corporate departments to develop policies that address any aspect of potential risk. The Compliance department identifies and analyzes areas of risk for the company and to develop strategies to reduce, or mitigate the risk. The Compliance department acts as a coordination point with regard to risk management issues.

In summary, risk management should be a part of everyone's practice. You are the eyes and ears of the organization when you are working on the front lines. Please take some time to review the Incident Reporting Policy: https://portal.mhm-services.com/Legal/IncidentReporting/default.aspx. Feel free to contact the Legal Office at (404) 347-4134 or the Compliance Department at (314) 779-6929 if you have questions.

Deana Johnson, our General Counsel, has written two *CorrDocs* articles relevant to risk management. These articles are:

- *Another Subpoena Another Day: The Increasing Call for Testimony of Correctional Healthcare Providers*, CorrDocs, Volume 15, Issue 2

- *The Current State of HIPAA in Corrections*, CorrDocs, Volume 16, Issue 4

Another Subpoena Another Day: The Increasing Call for Testimony of Correctional Healthcare Providers

CorrDocs, Volume 15, Issue 2

Upon arrival to work on a typical Tuesday, Dr. Jones is told to report to the warden's secretary to pick up some paperwork. There, she is handed a subpoena to appear in court the next day to testify in a case involving one of her inmate patients, a man with several significant mental health issues who has been on her caseload for months.

Dr. Jones knew when she went to work in the correctional environment she might have to go to court to defend a prisoner lawsuit or two. However, when she reviewed this subpoena, she was shocked to discover it had nothing to do with her provision of care to the inmate: instead, the State was calling her as a witness in a child deprivation hearing it filed to try and strip the inmate of his rights as a parent.

Increasingly, correctional providers are being called to offer testimony in a variety of matters. Some examples include:

Inmate challenges to criminal sentences
Inmate challenges to civil commitment decisions
Domestic matters
Civil rights claims against other providers or correctional staff

Set forth below is an analysis of possible reasons why this trend is developing and advice on what to do to best protect yourself if you do get called to testify.

The Benefits to the Lawyer and Litigant in Calling Correctional Providers as Professional Witnesses

In many types of court proceedings, testimony from expert witnesses is necessary to prove a claim or defense. For instance, if you are sued for malpractice, the plaintiff must present testimony of someone holding licensure similar to yours to testify that your treatment fell below the standard of care and caused the alleged damage. Such experts charge a hefty price for their services.

1. *Cost*

In criminal matters particularly, the prosecutors and public defenders do not have sizable budgets for their cases. They can hire a forensic evaluator, for instance, to do an independent psychiatric exam of the criminal defendant but those funds deplete their limited resources. If, instead, they can get the defendant's correctional psychiatrist to testify as to diagnosis, treatment, progress, etc., it is cheaper. Plus, most criminal defense attorneys hope a treating doctor is more apt to side with their patient, the

defendant, and provide helpful support for their theory of the case. Once the lawyer has you under oath on the stand, he hopes to press you to give opinions as to the likely state of mind at the time of the crime, mitigation or the like.

Now that so many states have comprehensive civil commitment laws governing crimes such as sex offenses, public defenders' offices are even more strapped for resources. After their clients have been convicted in the criminal arena, sentenced and served their time, they now have to fight off the potential for a long-term civil commitment for the same offense. The best way to fight this result is to offer evidence that the inmate's state of mind has changed and they are no longer a danger to society. What better way to accomplish this goal then by having the treating mental health providers testify in the inmate's defense?

2. *Credibility*

In the purely civil arena, while cost is still a factor, credibility is a bigger concern. The attorneys who issue the subpoenas in civil cases have the same goal as those in the criminal cases: get the treating provider to give favorable testimony about the medical or mental health condition at issue. In the civil case, however, the greatest reward is the ability to argue to the fact finder that the treating provider is more reliable and credible than the paid experts of the other side (the "hired guns").

The argument goes like this:

> Ladies and gentleman of the jury, you have heard from John's treating doctor at the prison. That doctor has a difficult job and took time off from his very busy schedule to come and speak to you today. He wasn't paid $2,000/hour like the "doctors" that the defendants hired. In fact, he wasn't paid anything over and above his normal wages. Unlike the defendants' so-called expert, this prison provider sees John on a regular basis and is in charge of his healthcare. He is far more credible than those witnesses who have never even met John and render their so-called expert opinions based only upon review of a select portion of his volumes of prison medical records.

The power in that argument is so strong, it is hard to resist. Unless you want to become a participant in the legal proceeding, it is important to know your rights as a witness and the risks inherent in your potential testimony.

What Rights Do You Have in Response to a Subpoena?

Many people incorrectly presume that once they receive a subpoena, they have to obey it no matter how inconvenient or objectionable. While the court rules do demand that legal orders be obeyed, they do not render you powerless. Subpoenas for medical records, for instance, do not entitle the issuing lawyer to speak to you about your treatment of the patient. They only cover production of the requested records.

Subpoenas for attendance at a trial or hearing require personal service to be effective; therefore, Dr. Jones from our storyline above has a legitimate challenge to the trial subpoena she received because it was served on the warden's secretary, not the doctor.

Next, subpoenas must provide at least notice of a personal appearance. They should be accompanied by the statutory witness fee.

That brings up the issue of compensation for your lost time from work. The statutory witness fees run about $25/day, not nearly what most people earn. Many states, however, have statutes requiring that when professional persons are called as witnesses, they are entitled to compensation for lost time from work rather than the standard witness fee. Insisting upon proper compensation is not only your right, it may encourage counsel to release you from the subpoena rather than incurring the cost of your appearance.

Next, trial subpoenas usually mandate that the witness appear on the first day of the case at the hour it is set to begin. The result is that the witness sits around for hours or even days waiting to be called to testify. As a professional, you should be granted the courtesy of being provided a specific date and time to appear by the lawyer issuing the subpoena. Make sure to get that change of date and/or time in writing so you can prove that you were complying with instructions given subsequent to issuance of the subpoena.

So, now that you have ensured proper service of the subpoena, insisted upon adequate compensation and narrowed down the time to appear, you take the stand. Do you have any further rights? The answer is yes. While you are obviously obligated to testify truthfully, you are not required to provide the free expert opinions that the lawyer is seeking.

1. *Example in a criminal case*

If the lawyer asks you the inmate's state of mind at the time of the crime, it is perfectly legitimate to state you do not know and cannot to a reasonable degree of medical certainty offer such an opinion. You did not begin treating the inmate until sometime after his arrest or conviction. Also, point out you have not been asked to and have not conducted a forensic mental health exam.

2. *Example in a civil case*

If you are asked whether you believe another provider committed malpractice, you are allowed to state that you have no opinion. You should not be forced to provide expert opinions if you legitimately have not formed them. Do not comment on what you might have done if you were treating the inmate for that condition at that time.

If you are unclear whether or not you are required to give an opinion (rather than answer a factual question such as the last time you saw the patient), ask the judge for clarification. Listen carefully to the response as that answer gives you direction for future questions of a similar nature.

What Risks Accompany Your Testimony?

1. *Does Your Employer or Professional Liability Insurance Protect You if You Testify?*

If you work directly for a government agency, you may enjoy some immunity from routine civil claims, such as allegations of medical malpractice. If, instead, you work for a private company providing services in corrections, while you don't get those same protections, your employer likely provides you with professional liability insurance.

Be careful, however. These protections do not apply once you leave the realm of provider and enter the world of witness. Liability insurance is designed to cover claims arising out of your provision of care to patients, not claims stemming from your testimony in criminal or civil cases. Thus, if you are sued regarding the testimony you provided, you may well be on your own in defending the claim.

While you may rightly be thinking that it is hard to win a case against a provider based on testimony in a court case, the cost of defending the matter can be staggering.

2. *If You Give Them Everything They Want, They Will Likely Call You Again*

If the risk of liability is not enough reason to be careful about what you say on the stand, revisit the major theme of this article: attorneys are increasingly calling correctional providers as witnesses to give them a benefit they would not otherwise have: i.e. inexpensive and/or very persuasive expert testimony. If you willingly provide those expert opinions and do not limit your testimony to simple facts of which you have personal knowledge, the attorney issuing the subpoena got just what he wanted.

Word spreads fast. Soon everyone in the public defender or prosecutors' office is going to be calling you to court. If, on the other hand, all you did was discuss your chart notes and refuse to be led into giving expert opinions, that lawyer is going to realize there is no real benefit to calling you as a witness.

Of course, if instructed to answer specific questions by the court, you are obligated to do so. That, however, is rarely the issue when it comes to rendering expert opinions. It is usually an overly zealous witness who, when the spotlight is placed upon them on the witness stand, cannot resist educating the courtroom about anything and everything. Think twice before doing so and remember your rights as the witness.

The Current State of HIPAA in Corrections

CorrDocs, Volume 16, Issue 4

When the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996, one aim was to standardize a set of privacy rules to apply to all patient's protected health information. However, for many of us working in correctional healthcare, HIPAA's applicability is still far from clear even now, 16 years later.

One main reason for this confusion is the varying positions taken by the government in applying HIPAA to corrections. The U.S. Department of Health and Human Services

(HHS), the government department charged with interpreting and regulating HIPAA, has taken inconsistent positions on the issue over time.

A second major source of confusion lies in the application of HIPAA's electronic transmission provision to correctional institutions: not only does the application seem counterintuitive, the result is that HIPAA applies to some correctional systems and not others. It all depends whether the system electronically transmits certain specific types of data, explored in detail below.

History

HHS was charged with creating standards for the privacy of medical information. In doing so, HHS released several versions over time. The competing versions of the regulations generated misunderstanding among many correctional officials and medical providers alike.

The original draft regulations, issued in 1999, specifically provided that inmates' health information was not protected under HIPAA. Many people continue to operate under the misunderstanding that this original interpretation is still in place. It is not.

HHS later revised this aspect of the regulations and found that "individually identifiable health information about inmates is protected health information under the final rule." As such, certain correctional institutions have been required to comply with HIPAA since April 2003. So why, almost a decade later, is it still unclear which information is protected and which correctional institutions are impacted?

The Text of HIPAA Does Not Easily Translate For Correctional Institutions

In order to determine whether HIPAA applies to corrections, the natural starting point is the statute itself. HIPAA applies to covered entities, which are defined as: (1) health plans; (2) healthcare clearinghouses; and (3) healthcare providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

HHS has determined that correctional institutions are not health plans or healthcare clearinghouses. So what about the last choice? HHS now classifies correctional institutions as healthcare providers. So the remaining question is whether your institution electronically transmits health information for one of the specific transactions regulated by HHS.

Of course, most electronic transmission of health information concerns billing and payment for services or a determination of insurance coverage and rates: i.e. hospitals sending patient information in order to be paid by Medicaid or private insurance. However, the electronic transmission provision is broader than that.

There are eight standard electronic transactions regulated by HHS. Although a correctional institution is unlikely to engage in many of these, the three that could apply are: (1) transmission of encounter information for the purpose of reporting health care; (2) requests for the review of health care in order to secure an authorization for the health care; and (3) payment of healthcare claims from a private/public health plan. It is

important to note that contracting out the transmission of this information, the provision of healthcare or both to private entities does not exempt the correctional institution from HIPAA.

So what are the most likely scenarios that would fall under these three types of electronic transmissions? One of the most common is sending patient information to request approval for a non-formulary medication or a non-standard procedure. If your institution electronically sends these requests to the person or oversight committee with authority to approve the request, it just became a covered entity under HIPAA. Another example would be electronically transmitting health information for purposes of conducting quality control, audits or other oversight activities. Less likely in the correctional environment is seeking payment of claims from private health insurance, but it does occur in some systems and, should the expansion of Medicaid currently expected under the new healthcare law go into effect, even more inmates will have in-patient hospital care covered by public insurance, necessitating this type of electronic communication.

So if HIPAA Does Apply, What are the Obligations of Your Institution?

For the average covered entity, HIPAA requires:

- Notifying patients about their privacy rights and how their information can be used
- Adopting and implementing privacy procedures
- Training employees so that they understand the privacy procedures
- Designating an individual to be responsible for seeing that the privacy procedures are adopted and followed
- Securing patient records containing individually identifiable health information so that they are not readily available to those who do not need them

In creating its Privacy Rules, HHS recognized that correctional institutions are not the same as traditional healthcare institutions and have unique security concerns. Thus, the Privacy Regulations exempt correctional institutions from compliance with some of the law's provisions. See 45 Code of Federal Regulation (C.F.R.) § 164.512(k).

In summary, correctional healthcare providers can disclose an inmate's health information to the correctional staff or other law enforcement personnel having custody over the inmate as necessary for:

- **the provision of health care**
- **the health and safety of the inmate or other inmates**
- **the health and safety of correctional institution personnel**
- **the health and safety of those personnel responsible for transporting of inmates**
- **law enforcement on the correctional institution's premises**
- **the administration and maintenance of the safety, security, and good order of the institution**

Also, a correctional institution is permitted to deny an inmate's request to obtain a copy of his medical records if access would create any of the risks outlined above. Finally, if an inmate has escaped from custody, HIPAA does not restrict the use or disclosure of an inmate's health information.

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Chapter 8: Sick Call

Overview of Sick Call

Sick call is a process in correctional healthcare designed to provide patients with access to initiate or request medical, dental and mental health services. The method in which that access is provided will vary depending on security level, layout of the institution and the scope of services of the institution. The sick call process is required since the incarcerated persons generally do not have unimpeded access to health care. Access to care must be available. The sick call process addresses episodic, non-emergent healthcare needs. The sick call process is an integral component of meeting the basic principle of access to care for serious health needs established by the Supreme Court in *Estelle v. Gamble.*

Sick call services are routinely accessed through a written sick call request, commonly referred to as a Health Services Request (HSR), sick call request or by the inmates as a "kite." Correctional officers and other staff can also refer a person for healthcare needs through a written request, direct communication with the healthcare unit or through urgent/emergent processes available through the institution (man-down, self-declared emergency). Inmates have access to emergency/urgent care by declaring an emergency to the housing officer.

Health Care Requests in general population housing units are usually placed by the patients in "locked" collection points designated at each institution. The requests are collected by healthcare staff daily. Requests in units where persons are in locked cells or with restricted movements are typically collected at the completion of one of the two medication administration passes that occur in that unit. Each request is date/time stamped immediately upon return to the healthcare unit after collection. This and other timed steps in the process provide verification that required timeframes from collection to triage of the slip to patient encounter with medical staff are maintained.

Health Service Requests are "triaged" by trained nursing staff. Triage refers reviewing the written request from the patient, conducting a face-to-face encounter and determining the urgency and healthcare service most appropriate to address the request or need. Requests are usually defined into one of these categories:

- Urgent/emergent
- Routine
    - Scheduled for nurse sick call
    - Scheduled for provider sick call
    - Administrative review required (general question regarding services, complaint about staff, etc)
- Routine referral to another service area
    - Mental Health
    - Dental
    - Other non-healthcare area (i.e., religious diet - refer to pastoral services)

For requests that suggest urgent/emergent needs, security staff will be notified of need to see the patient immediately and coordination will occur to bring the patient to the

healthcare unit for assessment. If urgent requests are received during hours that a medical provider is not on-site, the appropriate on-call provider will be contacted and the nursing evaluation and other pertinent information presented to the provider. The on-call staff will provide orders and a disposition. Any patient receiving prescription medications based upon a telephone consultation and telephone order will be scheduled for a provider appointment for recheck.

For routine medical requests, most standards and contracts require a face-to-face encounter with inmates within 48 hours. This follow-up is addressed in nurse sick call where the inmate has an encounter with a nurse. In these encounters, the nurse can handle minor complaints and healthcare needs with over-the counter medication; contact the provider immediately for advice; or schedule the inmate for care by the provider based upon timeframes specific to the urgency of the request and based on contract, accreditation standards and site-specific policy.

Follow-up of a patient's request related to dental services are scheduled by dental staff. Routine referral requests are delivered daily to the dental staff for follow-up. For sites with limited dental services, triaged requests that relate to urgent/emergent dental care such as tooth pain are scheduled and assessed using nursing guidelines for common healthcare complaints to ensure that care is not delayed.

Mental health services in response to a patient's request is scheduled for follow-up by behavioral health staff. Routine referral requests are delivered daily to the mental health staff for follow-up. Urgent/emergent requests for mental health services are immediately referred to mental health staff when on-site. If urgent/emergent requests for mental health assistance are received during hours that mental health staff are not on-site, the patient will have a face-to-face encounter with nursing staff and the on-call behavioral health staff will be contacted by nursing staff for follow-up orders and a disposition.

Times and places where sick call is conducted are determined by healthcare administrative/clinic team and institutional administration. Clinical encounters with patients for assessments should be performed in an area that promotes privacy and permits the degree of physical examination required by the complaint.

Sick call is routinely required to be provided five – seven days a week at each institution. Medical staff are to ensure that all patients have access to request services each and every day. There should be a mechanism for follow-up of patients who are "no shows" for appointments or "call outs." This follow-up is required to ensure that the patients have unimpeded access to services. It is important to collaborate with security staff in conducting sick call; however, it is critical to ensure that security staff do not restrict movement unless institutional operation require.

For specialized housing areas, such as restricted housing units, segregation units, mental health units, and special management units, the sick call process is usually modified due to the limited movement outside the housing unit. In these circumstances, access is ensured by medical staff performing cell-to-cell rounds in these units; verifying the patient's health maintenance; and allowing patients to request sick call services as part of these rounds. In mental health units, infirmary areas and other units specific to meeting medical or mental health special needs, access to services may be provided by designated nursing/medical providers who follow and monitor patients on those units. It

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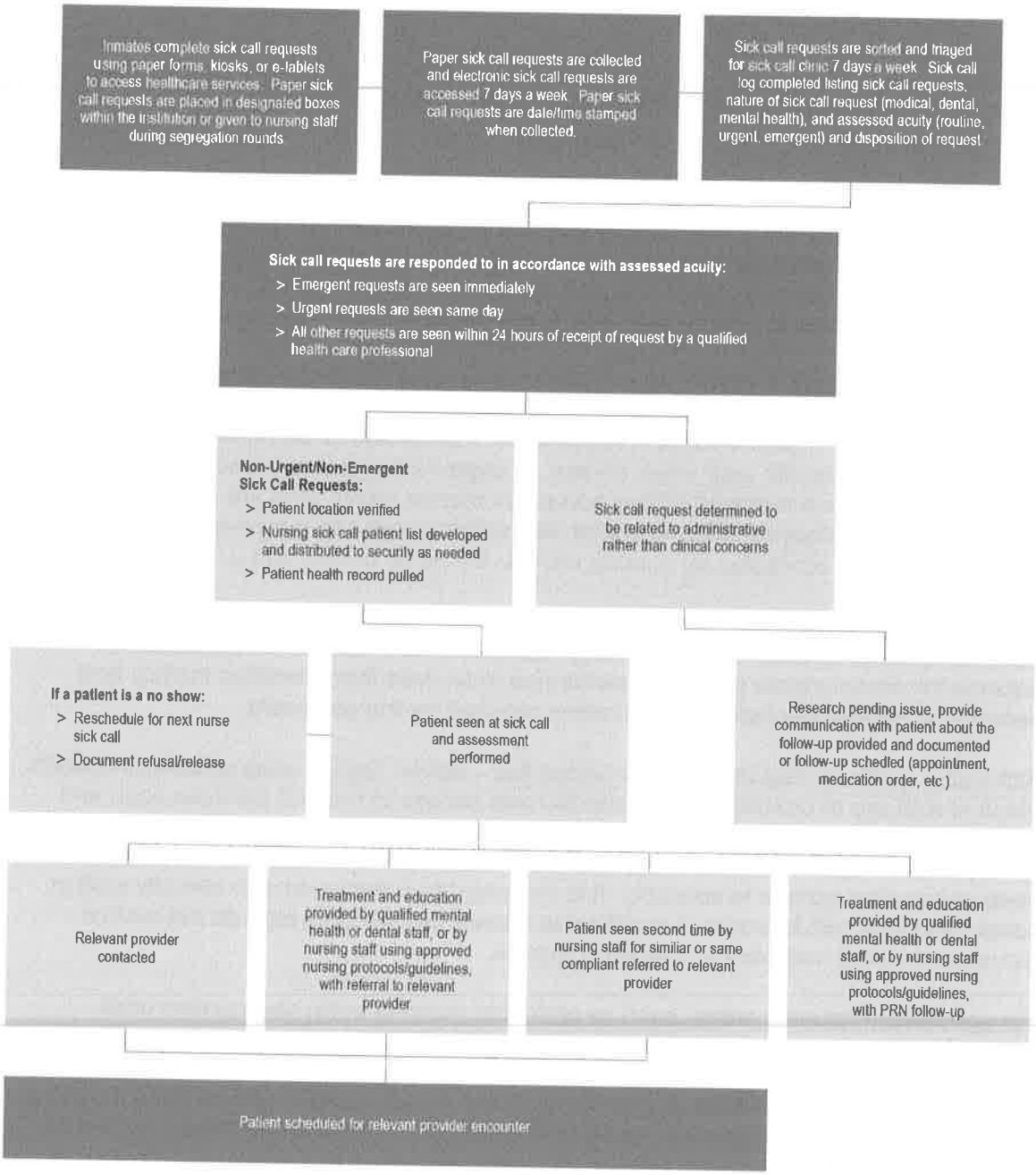
is important to understand that no matter the level of security or where patients are housed within an institution, all must have timely and routine access to request and be provided healthcare services that provide services for medically necessary care.

Our generic Sick Call Process Flow is presented below. The flowchart includes all healthcare services, including behavioral health, medical, and dental services.

Centurion Sick Call Process



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Primary Care Program and Provider Sick Call

The key elements of our on-site primary care program include:

- Care by a multidisciplinary team coordinated by a provider
- Early identification of healthcare issues
- Aggressive case management and coordination
- Active participation and education of the patient
- Providing timely access to needed on-site services

Provider sick call is routinely performed by a physician, nurse practitioner or physician assistant. The following strategies are used in providing primary care/practitioner sick call within the institution:

- Improve patient access to care using the most appropriate level of provider
- Plan and manage healthcare based upon early recognition of needs and evidence-based guidelines
- Encourage and facilitate offender involvement in self-care
- Use available technology to track and coordinate care
- Adopt health goals, measure patient satisfaction, clinical outcome, healthcare staff performance and improve performance and services provided

Services routinely provided as a part of the provider sick call will tend to be similar to services provided as part of a general medical practice clinic or urgent care center. The services include evaluation and treatment for self-limiting illnesses and follow-up .encounters for illnesses not responding to current treatment

Nurse Sick Call

The use of nurse-driven sick call is fairly unique to the corrections environment. The purpose of nurse-driven sick call is to improve access to care and identify when a particular health need requires a higher level of care. Nurse sick call is driven by written guidelines. The purpose of these written guidelines is to outline the steps to be taken in providing first aid and interventions commonly provided as self-care in non-correctional environments. We refer to the written guidelines used by trained nursing staff as "Guidelines for Common Healthcare Problems," also commonly referred to as nursing protocols. The table of contents for our guidelines is provided on the following page to demonstrate the types of interventions that are included in nurse sick call

Licensed nursing staff practicing within the scope of their licensure are approved to use the Guidelines for Common Healthcare Problems after attending training on the use of the guidelines and completing verification of understanding/competency in their use. Only approved over-the-counter medications listed in the Plan section of a Guideline for Common Healthcare Problems are used. Use of medications not defined in the guidelines requires consultation with and an order from the physician, nurse practitioner or physician assistant. Policy requires that a patient seen more than two times with the same problem within a month and not yet evaluated by a physician, nurse practitioner or physician assistant will be referred to these staff. The use of nursing protocols or guidelines requires initial and annual review and approval indicated by the signature of

the Medical Director and Director of Nursing as well as initial and periodic training/verification of competency of nursing staff that are approved to use them.

Guidelines for Common Healthcare Problems
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Sick Call in Segregation Areas

Segregation is usually defined as special housing units or cells that are used to separate inmates from the general population housing areas. Individuals receive services and activities apart from others. Segregation units have many titles that vary from system to system and may be for disciplinary or protective purposes. In any case the purpose of segregation areas is to maintain the safety and/or security of the person in custody and/or the institution.

The importance of segregation to health care is that patients in segregation have limited ability to access healthcare through the normal process and could have mental or physical health problems or injuries that deteriorate because of restricted contact. A process must be provided that allows adequate access, monitoring and provision of healthcare services.

Patients in segregation typically have access to healthcare by filling out sick call requests that are collected during daily medication administration. Nursing staff may also be required to conduct rounds for persons housed in segregation daily or three times a week. Nursing staff will coordinate triage and associated nursing sick call visit within the segregation unit, depending on the complaint and ability to appropriately assess the complaint. Interventions for patients requiring assessment and/or services that cannot be provided in the segregation unit requires coordination with security staff to provide services in the healthcare unit or a satellite medical unit that may be within the segregation area.

It is important to be mindful of the complications involved in transporting persons housed in a special housing unit to the healthcare unit; therefore, we routinely work with the facility to identify an area within the segregation/special housing unit to perform healthcare services that permit privacy of care and ability to perform examination appropriate to the complaint. However, there are times when the patient's medical needs require a higher level of care than what can be accommodated in the special housing unit. When this occurs, we work closely with security staff to communicate the need and identify a time and process for treatment in the healthcare unit to occur. Depending on the institution, movement of patients from segregation/special housing units to the healthcare unit can create the need for complete shut-down of access to the healthcare unit by other persons and routinely requires multiple security staff to complete the movement. While providing healthcare services in institutions with large segregation units can be challenging and usually creates challenges to productivity, the services are important for maintaining safety of the institutions.

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Sick Call Summary

The information in this section is intended to provide general knowledge and understanding of providing nursing and practitioner sick call services in a correctional environment. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- How is sick call process managed at the facility for patients in general population and for those in specialized housing units?
- What are the contract-specific guidelines for common healthcare problems (also referred to as nurse protocols)?
- What nursing staff can perform sick call?
- What training do nursing staff receive before conducting sick call?
- How are patients scheduled and/or referred to be seen by the on-site medical provider?
- Are there specific documentation/templates used to document encounters completed by the medical provider and/or nurse?

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Chapter 9: Medication Management

Overview

Medication management in the correctional environment typically differs from community medication management in two very distinct ways: medication procurement processes and patient access to medications. Despite these differences, the provider will also observe medication management techniques that are familiar and consistent with community primary care provider practices. Some of the similarities include:

- A formulary process that includes preferred medications for each class and non-formulary review procedures
- Initial ordering and renewal of chronic disease medications based upon nationally accepted guidelines and formulary preferred medications
- Reconciliation of medications at the time of intake into the system, return from hospitalizations or procedures, return from emergency department visits or specialist appointments and at chronic disease management appointments
- Participation in Pharmacy and Therapeutics Committee as requested
- Dashboard reports on medication management performance measures
- Access to consultant pharmacists who are skilled in correctional medication management
- Medication compliance monitoring

It is worthy to note that the prevalence of HIV, psychiatric illness, and various forms of viral hepatitis is much higher in corrections than in the community.

Medication Procurement Processes

Correctional facilities usually receive medications from a pharmacy contractor that ensures medication management procedures are compliant with federal, state and contractual rules, regulations and policies. Medications are provided to the institution either as an inmate-specific prescribed medication or as a stock medication to be used based upon provider orders. The availability of stock medications and the approved methods of use are detailed in the Formulary and Pharmacy Manual.

The pharmacy does not typically operate within the institution. New prescription medication orders that are received Monday through Friday before a predetermined cut-off time are filled and shipped to the institution for next-day delivery. Refill and stock medication orders may not be completed on a next-day delivery timeframe. It is important to know the stock medications that are available for initiating treatment during the evenings and on weekends. The pharmacy contractor will make arrangements for access to a local back-up pharmacy for urgent situations, but this service should be infrequently needed when there is compliance with formulary stock medications and careful medication management practices on-site.

The pharmacy contractor profiles patient prescriptions for the following:

- Duplicate therapies from medications in the same therapeutic class

- Medication interactions and incompatibilities (including drug-drug, drug-order, and drug-age interactions)
- Excessive or sub-therapeutic dosages
- Allergies
- Non-formulary medications (which may need to be addressed prior to dispensing the order)
- Appropriateness of medication therapy
- Medications that are refilled too soon, based on established system-specific parameters
- Medications ordered past the designated stop date
- Potential for abuse or misuse
- Medications to be administered as directly observed therapy (DOT) only

Medication order transmission to the pharmacy contractor may be by fax, by web-based order entry, or by electronic health record interface. You will receive instruction on the required method for medication order entry. Of course, legibility when using the fax system is critical. Compliance with the formulary and non-formulary process will facilitate the patient receiving the medication in a timely manner.

Medication packaging from the pharmacy contractor typically includes:

- Solid medications dispensed in 30-count blister cards with one unit per bubble. Blister cards provide a sanitary delivery system and provide protection, accountability, and ease of delivery
- Patient-specific single packets containing of the prescribed medications for that particular dosing schedule (usually prepared by an automated machine)
- Over-the-counter (OTC) medications sent in bulk original manufacturer's packaging, except when ordered by the provider for individual patients or when prohibited by law or board regulations. If not sent in bulk, these medications are dispensed in blister cards
- Liquid medications provided in unit-of-use containers, as ordered
- Eardrops and liquids provided in original manufacturer containers or repackaged from their original glass containers into plastic, if requested and when permitted by FDA. Glass containers are perceived as a security threat as they can be fashioned into a weapon
- Creams and ointments provided in original manufacturer's containers or in plastic jars, if requested and when permitted by FDA. Metal tubes may be fashioned into a weapon. Plastic ointment tubes can be used as a weapon by spraying chemicals or body fluids onto staff or other inmates
- IV mixtures shipped compounded, labeled and ready to administer or dispensed in Mini-Bag Plus packaging for easy self-mixing on site, upon request

Packaging is often impacted by the administration method that is appropriate for medication prescribed and the security regulations of the institution. This impact on patient access to medication is discussed below.

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Patient Access to Medications

There are three ways that patients may access medications in correctional facilities. These include:

- Medical, dental or mental health provider with prescriptive authority
- Specially-trained nursing staff using approved guidelines for minor complaints using over-the-counter medications (OTC)
- Limited number of over-the-counter medications for purchase by patients in the correctional system's commissary(s)

Access to certain specialty medications requires that an on-site primary care provider reviews and approves medications recommended by off-site medical staff and specialists.

You will need to become familiar with the formulary, nursing guidelines OTC list, and commissary OTC list for your assigned institution(s).

The two ways that medication can actually be taken by an inmate are Direct Observation Therapy (DOT) medications or Keep-On-Person (KOP) medications.

- DOT medications must be administered by appropriately trained and licensed staff approved by the applicable state boards of pharmacy and nursing to administer medications.

- KOP (keep on person) medication programs are available in many institutions. This program allows approved patients to maintain approved medications for self-administration in a restricted amount. The policies and procedures for KOP programs vary from system to system, but always delineate which medications are not approved for KOP, which housing locations are not approved for KOP, and which inmates may participate in KOP medications. There are certain medications that are not allowed to be KOP because of abuse potential and/or the experience of individual system or institution. Medications that are not allowed to be KOP are all DEA schedule controlled substances, psychotropic medications, injectables, and in many instances medications that are easily abused or bartered in the corrections environment such as Benadryl.

DOT medications are administered either from specific medication lines or windows where patients report for medications or cell-to-cell (or housing unit) administration when inmates are in segregation or restricted housing areas.

DOT medications are typically administered twice daily. Confer with nursing staff to identify these times. Patients who need around-the-clock access to medication administration require housing such as infirmary placement where 24-hour nursing care is provided.

Regardless of the administration delivery method, it is important to remember:

- Persons in custody do not normally have unlimited access to 24-hour medication administration. Ask what your facility capabilities are before prescribing any medication on a PRN basis. For medications which do not require consistent dosing, however, such as pain medication outside of an acute event, PRN prescribing is preferred.
- Know the medications that are not available for KOP
- Understand that pill window and pill lines may create conditions that impact patient medication compliance, such as long lines, lengthy distances to pill line, poor weather conditions.
- Once daily or twice daily is preferred unless the patient is in the medical infirmary.
- Participation in KOP is a privilege and not a right and that privilege can be rescinded for non-compliance or abuse.

OTC medications may be available from the commissary. These medications are maintained and taken by the individual patient purchasing the medication. The Medical Authority will periodically review the list of available OTC medications. Healthcare staff has access to an individual's commissary list for review with the patient. Medication education should include the side-effects of misuse and contraindications of those commonly available OTC medications such acetaminophen and NSAIDs. You should become familiar with the practices for prescribing OTC medications at your facility.

Medication and Treatment Compliance

Patients have the right to refuse treatment except in emergency situations in which there is an imminent risk of danger to self or others or when there has been an administrative or Court review authorizing involuntary medication. The refusal of treatment should be an informed decision with the consequences explained to the patient. The refusal should be in writing and describe the medication and/or services which are being refused; the risks/benefits of refusing; and alternatives discussed. The requirement for written refusal generally is satisfied by the signature of the patient on the refusal document with a witness who acknowledges that the patient read the refusal form or had it read to him/her in a language understood by him or her. When the refusal becomes a pattern or has substantial effects on the individual's well-being, the prescribing practitioner should conduct face-to-face counseling with the patient and document that discussion in the progress note and obtain a signed release of responsibility.

When a patient does not appear for a scheduled appointment, it can be easy to assume that the person is refusing treatment and indicate in a progress note that the patient was a "no-show." There can be many reasons for a patient not coming to an appointment, however, including decline of mental or physical health status, schedule conflict with work/school/recreation/court/visitation, unavailability of security staff for movement to the healthcare unit and more. It is important to follow-up on "no-shows" for the sake of the individual patient, but also to find out if reasons represent a pattern. Identifying patterns for "no-shows" or missed appointments and modifying processes is a mandatory practice in most quality improvement programs as this represents an access to care issue. If the

patient does not appear for a scheduled provider appointment, the correctional officers can be notified and bring him or her to the healthcare unit. The patient then has the right to refuse treatment after the potential consequences have been explained.

Medication non-compliance can also be an issue in corrections; however, according to Donald Meichenbaum in his book, *Facilitating Treatment Adherence*, it may be an even greater problem outside of corrections. According to Meichenbaum, treatment compliance with recommended treatment in the community is in the range of 40% to 50%. Treatment compliance may be better in corrections because it is a controlled environment where staff scrutinize and report patient behavior.

"Watch-take" or "direct observation" methods of medication administration are most effective when both a nurse and correctional officer are checking to verify the patient has ingested the medication. However, patients are "experts" at distracting the staff. They are also "expert" at cheeking and palming medications. If a medication has substantial abuse potential, for example an opioid, patients might resort to any and all means necessary to accumulate and distribute such medications including regurgitation of ingested doses. Some may do this for their own benefit or may be coerced into doing so by others. Persons with a plan to commit suicide have been known to regurgitate and store up lethal doses of medications such as tricyclic antidepressants for later ingestion as a single fatal dose.

As you have seen in other practice environments, many medications that are clinically effective have the potential to be diverted or abused. Examples of these medications in a correctional environment include but are not limited to Seroquel, Wellbutrin, Neurontin, muscle relaxants, Albuterol, decongestants, amphetamines, antidepressants, dextromethorphan, any controlled substances and sedating antihistamines.

If staff observing ingestion are not attentive or are diverted from their duties, patients can accept but not ingest the medication. It is important to understand the medication compliance policy and process at your facility. Check with your medical and/or administrative leadership about the process for monitoring medication compliance for DOT and KOP medications as well as the process for medication delivery at your assigned institution.

It is important that you receive specific guidelines for your correctional system that identify:

- Formulary medications
- Non-formulary request process
- List of medications that must be DOT
- KOP policies and procedures
- Access to the pharmacy contractor manual

Pharmacy and Therapeutics Committee

Our statewide Medical Directors and pharmacists participate in the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is responsible for managing the

formulary system. The committee is composed of actively practicing physicians, other prescribers, pharmacists, nurses, administrators, quality improvement managers, and other healthcare professionals who participate in the medication-use process. Customarily, P&T Committee member appointments are based on guidance from the client, medical staff as well as other clinical and administrative staff.

The statewide Medical Director chairs the committee and his/her assistant or pharmacy representative serves as secretary. The P&T Committee serves in an evaluative, educational and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications (including investigational medications). The P&T committee is responsible for overseeing policies and procedures related to all aspects of medication use within the facilities. The P&T Committee is responsible to the medical staff as a whole, and its recommendations are subject to approval by the organized medical staff as well as the administrative approval process.

P&T Committees are designed to increase practitioners' knowledge about medication therapy, to improve the safety of medication therapy and to improve therapeutic outcomes. Consideration of patient care and unbiased reviews of the biomedical literature are the cornerstone principles of formulary decision-making.

The P&T Committee is a structured, evidence-based process in the evaluation of medications for formulary consideration. The P&T Committee reviews information that reflects a thorough, accurate, and unbiased review and analysis of the evidence available in the scientific literature. The evaluation process encourages objective consideration of clinical and care delivery information, facilitates communication, fosters positive patient outcomes, and supports safe and effective medication ordering, dispensing, administration, and monitoring. Decisions made by the P&T Committee support improved patient care outcomes across the continuum of care.

Tips for Practicing within a Formulary and Submitting Non-Formulary Requests

Practicing within a Formulary

- Formularies are well intentioned and are updated frequently to represent physicians' and other experts' clinical judgment on the use of SAFE, APPROPRIATE, and cost-effective medications; therapies that best serve patients
- Providers are encouraged to comply with prescribed formulary medications. A medication's cost does not determine its efficacy
- Decision to provide proper treatment supersedes cost considerations
- Use non-pharmacologic treatments such as sleep hygiene, cognitive-behavioral therapy, or relaxation techniques when possible. This approach reduces polypharmacy.
- Non-Formulary Request can be submitted to prescribe a medication not included on the formulary.

Submitting a Non-Formulary Request

- Reference evidence-based information to support your request.
- Document your drug trials, dosages, clinical response failure, and adverse effects to expedite review of non-formulary requests
- Ask the patient about family history of response to a medication. Such pharmacogenetic data may predict response in first-degree relatives and support a non-formulary request
- Document pharmacokinetic or pharmacodynamic interactions between the formulary drug and other medications that the patient is taking.
- List known interactions with foods and disease

Pharmacy Department Medication Management

Our Pharmacy Management team monitors the medication prescribing practices each month by contract, by site and by prescriber. This information is provided to the statewide Medical Director to permit review of facility-specific as well as staff-specific prescribing practices. Based on this review, the Medical Director may contact individual prescribers or may consider specific training sessions.

In most contracts, the statewide Medical Director meets with the prescribers at least quarterly to discuss medication practices. Some contracts may handle these discussions through monthly conference calls. Our Corporate Office uses the reports of prescribing practices to review practices by contract to determine trends and potential areas for improvement.

If a Medical Director has concerns about the use of a specific medication or group of medications, he/she can request a focused report of these medication(s). For example, after reports of increased abuse of a medication, the Pharmacy Management team will provide a utilization report for all patients who are on that medication to ensure that there is a valid diagnosis and need for that medication.

We complete an analysis of the current drug cost and utilization trends inherent our clients we serve. The analysis elicits meaningful data to support the business case for change, and also provides the baseline on the current outcome indicators listed below. Some of the areas evaluated are:

- Current utilization rates/cost trends
- Therapeutic duplication in classes
- Multiple prescribers for the same inmate-patient
- Utilization of hypnotics and benzodiazepines
- Prescribing of sub-therapeutic dosing
- Analysis of top therapeutic classes, including cost drivers
- Analysis of generic utilization patterns
- Average number of prescriptions per inmate-patient (polypharmacy)
- Analysis of prescriber outliers
- Comparison of utilization patterns with national averages

The Pharmacy Management team serves as a resource for drug information and will come on-site to provide pharmacotherapy education, current literature research reviews and provide presentations on formulary compliance and cost trends.

Medication Management Summary

The information in this section is intended to provide general knowledge and understanding of providing healthcare in a correctional environment. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Where is the most recent Formulary available?
- How are non-formulary requests handled?
- What are the medication administration times for this facility?
- Do we have KOP medications? If so what medications are not KOP?
- What OTC medications are available in the commissary and should inmate purchasing be encouraged?
- What training is needed for medication ordering (i.e. electronic or handwritten prescribing)?
- How is the medication order refill process handled?
- How are controlled substances managed?

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Chapter 10: Disease Management/Chronic Care Clinics

Overview

Disease management/chronic care program is based on the following five principles:

- Identification and tracking of patients with chronic disease(s)
- Application of nationally-recognized, evidence-based clinical guidelines
- Promotion of wellness and prevention strategies
- Expectation and encouragement for the patient to take an active role in care
- Support for the chronic care team

At minimum the following clinics are offered at each institution:

- Pulmonary
- Endocrine/Diabetes
- Infectious Disease
- Cardiovascular including Hypertension
- Neurology
- Gastrointestinal

Chronic care encounters are based upon disease acuity and control. The encounters include testing and treatments based on clinical practice guidelines as well as patient education handouts for use in individual and group sessions. As a primary care provider you are a consistent part of the chronic care treatment team to provide management and routine involvement in treatment and care planning. This active involvement includes, at minimum, clinical evaluation every six months based on the acuity and control of the patient's chronic disease.

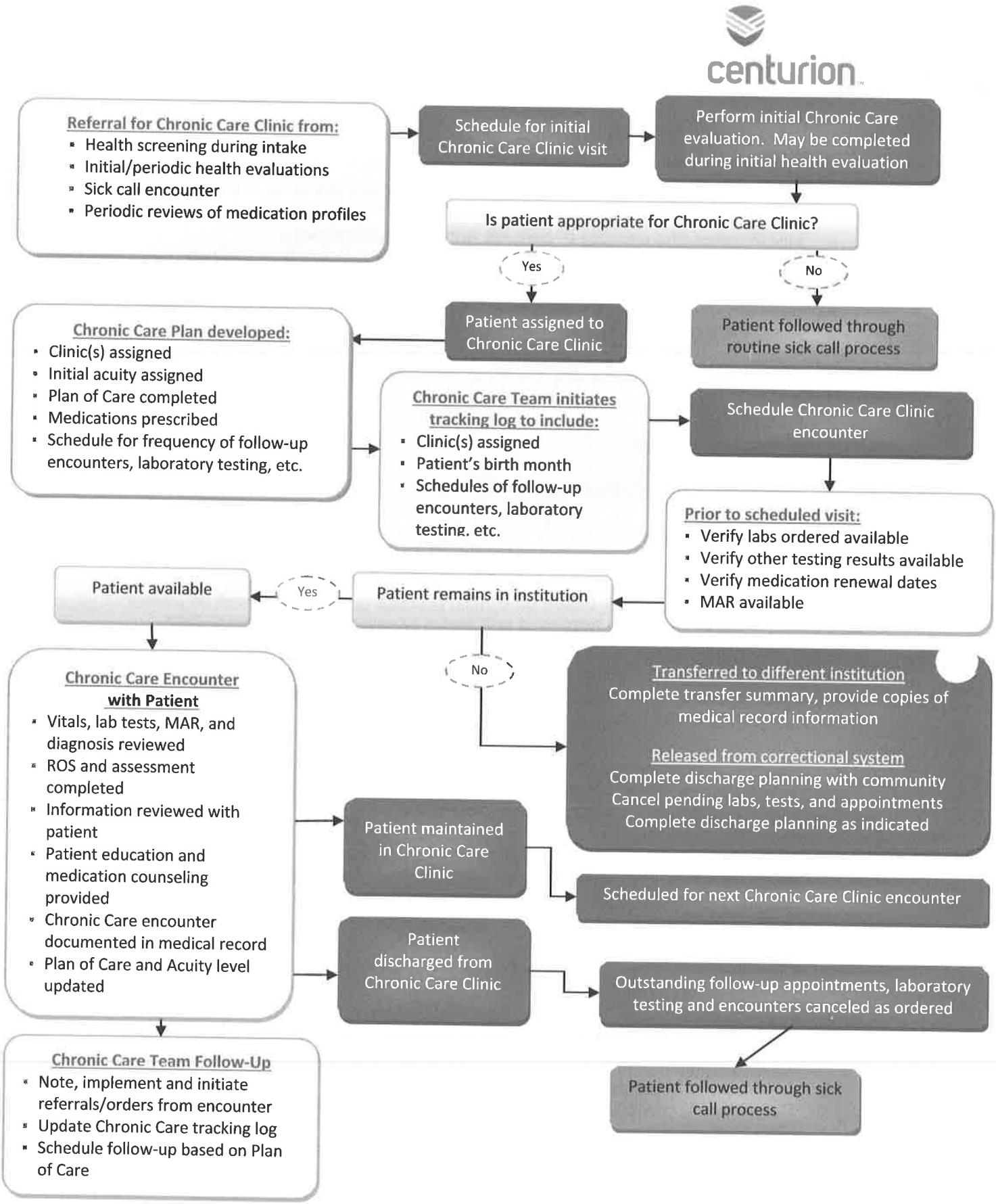
The nurse assigned to chronic care will educate patients about their specific primary and co-morbid conditions. They will empower patients to be more involved and effective in self-care and management of their health to encourage the patients to:

- Be proactive and effective partners in their care
- Understand the appropriate use of resources needed for their care
- Identify precipitating factors/appropriate responses before acute intervention needed
- Be compliant and cooperative with the recommended treatment plan

Process Flow

The Chronic Care Clinic process is illustrated on the following page. You will receive orientation to aspects of the program from the Medical Director that will include the:

- Clinics provided at your assigned institution(s)
- Resources to evidence-based clinical practices guidelines that form the basis for chronic disease care
- Documentation requirements
- Introduction to resources available to the on-site Chronic Care Team for patient education, complicated case management and other enhancements.



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Disease Management/Chronic Care Clinics Summary

The information in this section is intended to provide general knowledge and understanding of disease management and chronic care within correctional settings. The following space is for your notes and questions. Include information that you need to discuss with the statewide Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What types of chronic care clinics are provided?
- What is the average number of patients in each chronic care clinic?
- How are chronic care clinics scheduled?
- Who coordinates and assists with the clinics?
- Are there special forms required for documenting chronic care clinics?
- Are Disease Management Summary treatment guidelines readily available?
- Are there multidisciplinary team meetings available for discussion of treatment for difficult patients?

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Overview

As part of healthcare services, we are required to provide not only primary care but also ensure access and coordination of specialty care when medically necessary for a patient. Centurion makes available the resource of "RubiconMD" for all providers. RubiconMD connects clinicians to a broad range of specialists through electronic consultation.

For Specialty services that require face-to-face or in person encounters with the Specialist, these are typically provided one of three ways:

- At on-site clinics at designated institutions or located at one central or regional hub
- At specialist office or clinic locations
- On-site using telemedicine capabilities

Specialty services typically include but are not limited to:

Audiology
Cardiology
Dermatology
Ear, Nose & Throat
Endocrinology
Gastroenterology
General Surgery
Infectious Diseases
Nephrology
Neurology
Neurosurgery
OB/GYN
Oncology
Ophthalmology
Oral Surgery
Orthopedics
Orthopedic Surgery
Podiatry
Physical/Occupational/Speech Therapy
Pulmonology
Radiology
Radiation Therapy
Reconstructive Surgery
Thoracic Surgery
Respiratory Therapy
Urology
Vascular Surgery

Dialysis services including nephrology care is typically provided at one centralized institution that is usually at or near the reception facilities for male and female patients. Dialysis services are typically sub-contracted to an organization that has experience in providing dialysis in the correctional environment.

Utilization Management (UM)

Our utilization management process will conduct prospective review of requested specialty services as well as concurrent and retrospective review of inpatient and outpatient services to determine medical necessity

Our specialty services program routinely demonstrates use of a two level medical necessity review as well as an appeals system. Aspects of each level of review and the appeals process are discussed in the grid on the following page.

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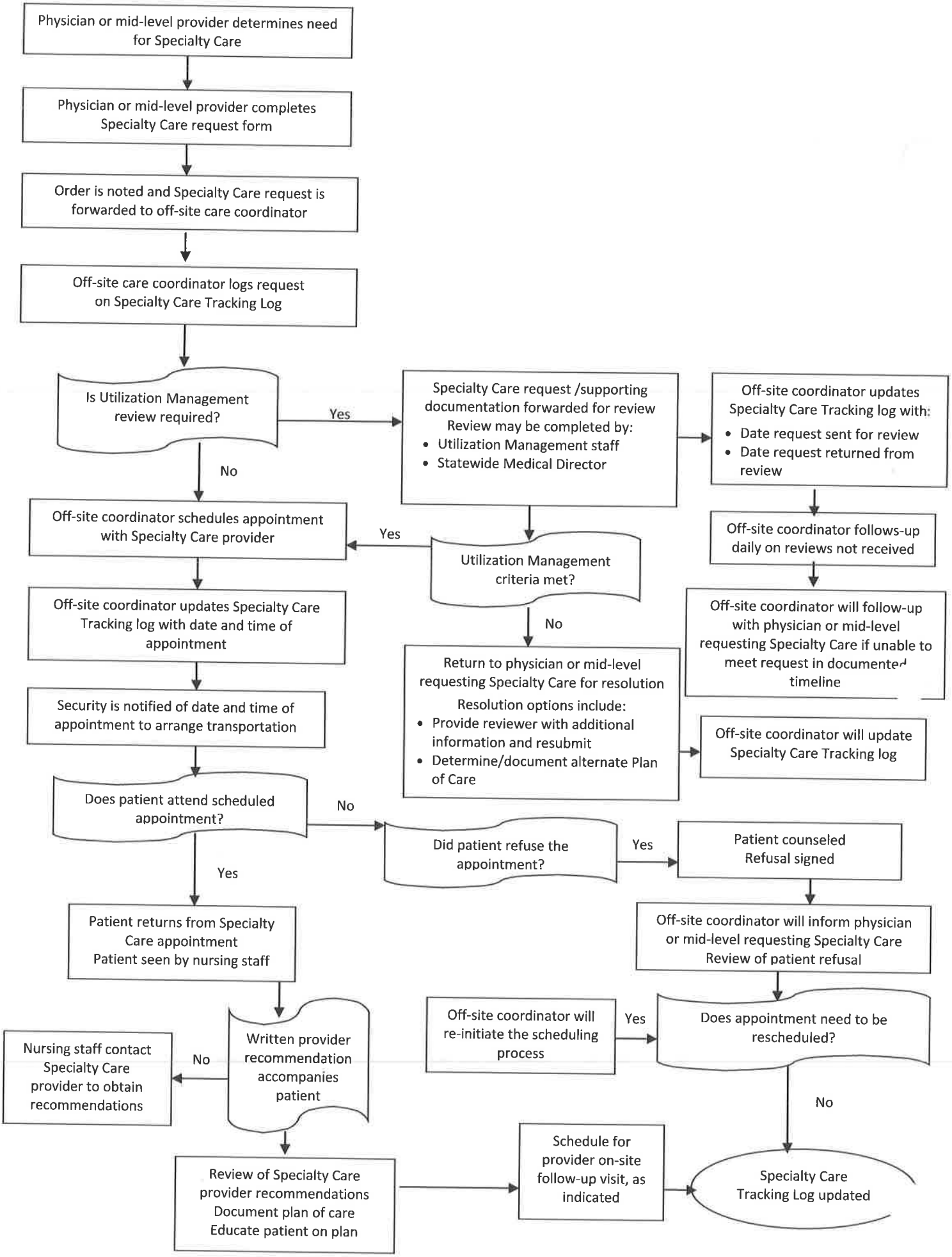
Level 1 Review	◌ Review conducted by trained utilization management nursing staff based on nationally recognized guidelines and Department approved medical treatment guidelines ◌ Submission of request to the statewide Medical Director if request cannot be approved based on nationally recognized guidelines and Department approved medical treatment guidelines ◌ At no time will Level I review result in a reduction, denial or termination of service
Level 2 Review	◌ Review conducted by statewide Medical Director or designated qualified healthcare professional. If request is for specialty oral surgery services, the Dental Director will conduct the Level II review ◌ Level II review conducted with consideration given to individual inmate healthcare needs, potential complications at time of the request, agreed upon policies and procedures, and continuity of care considerations ◌ Statewide Medical Director will consult with the Department and specialty medical experts when needed ◌ Denial of specialty services request by the statewide Medical Director requires discussion with requesting primary care provider and/or on-site Medical Director and provision of alternative treatment strategies
Appeals Process	◌ Primary care providers may appeal initial utilization review denials to the statewide Medical Director ◌ Appeal process will include submission of the original request, additional medical history and data pertinent to the appeals review ◌ Statewide Medical Director's appeal review will include case discussion with the requesting primary care provider and/or on-site Medical Director ◌ Appeal process will be completed and decision provided to the requesting on-site primary care provider within five business days of receipt of the appeal ◌ If original decision stands, the requesting primary care provider has option to request a second appeal ◌ As always, a final decision from the Department will be implemented when necessary

Specialty Care /Utilization Management Process Flow

The flow chart on the next page represents the standard on-site Specialty Care/ Utilization Management Process Flow process. The Statewide Medical Director, utilization review staff will assist in providing training and answering questions specific to the process, items requiring review, appeals process and other information specific to utilization and case management.



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Centene Resources

Centene is one of the largest Medicaid managed care organizations in the nation. Centene Corporation, a Fortune 500 company, is a leading *multi-line* healthcare enterprise that provides programs and related services to the rising number of under-insured and uninsured individuals.

The majority of Centene's approximately 2.4 million patients are chronically ill, low-income, disabled citizens. Centene operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including behavioral health, life and health management, managed vision, telehealth services, and pharmacy benefits management. More information regarding Centene is available at www.centene.com. The relationship with Centene allows us access to state of the art patient centric-resources and tools for monitoring and managing inmate care. Following are some of the resources available:

- *TruCare*™, a patient-centric integrated disease, care and utilization management product. *TruCare*™ offers clinical appropriateness tools based on evidence-based criteria, customized assessments and care plans for inmates, stratification of risk, and tracking/reporting/improvement data.

- Utilization Management (UM) provides support, training and oversight for our utilization management program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and improvement activities. Our UM staff will have access to standard and ad hoc reporting and analysis support as well as the ability to capture and analyze data from internal, sub-contractor and external sources.

- Centene's *Electronic Data Warehouse* (EDW) is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, laboratory, pharmacy, dental and vision; individual and organizational providers); financial information; medical management information (referrals, authorizations, disease management); inmate information (including demographics); and provider information (participation status, specialty, demographics).

- *Centilligence* houses all information in the EDW to allow staff to generate standard and ad hoc reports from a single data repository, using *Centelligence* suite of reporting systems to build and tabulate key performance indicators and provide drill-down capability to the individual provider or inmate level for investigation of suspected under- or over-utilization.

- *Nurtur* is a health and lifestyle management company focused on chronic diseases. The primary objectives of services provided by *Nurtur* to our correctional healthcare staff are to assist in achieving a reduction in recurrent morbidity associated with identified disease condition and in focusing on the effective control of high cost chronic medical conditions. *Nurtur* does this by providing individual evaluation and development of multidisciplinary treatment plans, providing educational information and performing grand round style case

management discussions. All services are coordinated in conjunction with on-site healthcare staff to implement and monitor identified interventions.

Specialty Care and Off-Site Services Summary

The information in this section is intended to provide general knowledge and understanding of how specialty medical care is provided in a correctional environment. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What paperwork or electronic information must be generated for a specialist referral?
- What training is needed to initiate and follow-up on specialist referrals?
- What is the mechanism for you to be informed if an appointment exceeds the length of time appropriate for the patient's need?
- Will patients returning from specialist appointment be automatically scheduled for an appointment to see an on-site provider?
- Who schedules appointments
- Who are the medical specialists used?

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Chapter 12: On-Site Emergency Care, Emergency Department Services, Hospitalizations and Infirmary Care

On-Site Emergency Care

In institutions with 24-hour healthcare coverage, our staff provide emergency triage and stabilization for inmates, institutional employees, contractors, volunteers, and visitors. That level of care usually is basic life support and first aid awaiting arrival of local Emergency Medical System (EMS) response team(s). In institutions that do not have 24-hour healthcare coverage and typically house a healthier population, security staff are trained in basic first aid and life support and will either call EMS in life-threatening situations, contact healthcare staff at another institution or directly contact the on-call provider.

All healthcare staff receive training in CPR, Basic First Aid and AED. These requirements are included in the new employee orientation program, disaster preparedness training and emergency response training and are provided in close collaboration with the correctional system and institutional management teams to ensure our emergency response meet expectations and needs.

Emergencies within an institution are often referred to "man-down" emergencies. Healthcare staff are expected to respond to "man-downs" within a four-minute timeframe, the standard established by the American Correctional Association and many correctional systems. Our staff are trained on how to respond to health-related emergencies that occur on or within institutional properties or settings. The "man-down" training includes:

- Recognition of signs and symptoms and knowledge of required actions
- Administration of Basic First Aid and CPR
- Methods of obtaining assistance
- Suicide intervention
- Signs and symptoms of mental illness, violent behavior
- Acute intoxication and withdrawal
- Procedures for inmate transfers to appropriate medical facilities

"Man-down bags" and emergency supplies such as oxygen, resuscitation bags, airways and AEDs are maintained in designated areas of the healthcare unit and remote medical areas, if applicable. It is important to remember that most institutions will not have on-site advanced life support capabilities.

Emergency Department Services and Hospitalizations

In the correctional environment most often an acute hospitalization is the result of a trip to an emergency department and less frequently directly from a specialist's office. Hospitalizations for procedures and/or testing may also be necessary.

Since emergency situations occur 24 hours a day, 7 days a week and provider coverage is often not available, it is necessary to have trained staff at the facility who understand

the necessity of contacting the primary care provider or on-call provider prior to transferring a patient to an emergency department. Communications between the emergency department provider and staff and the primary care provider on-site or on-call is also required. We advocate the use of SBAR communication techniques when nursing staff communicate with providers. SBAR techniques and communication tools are discussed later in this chapter.

When there is a medical order to transfer a patient to an emergency department, the order will indicate the mode of transportation that is required such as life-support ambulance, basic ambulance or correctional transportation. This detail is carried out by the healthcare staff on-site and is necessary to ensure that the security shift commander is notified as soon as the order is received or when there is reasonable anticipation of an order. This notification facilitates emergency vehicle entry into the institution and arrangement of security escorts for the inmate. Generally, at least two security officers are required when a patient leaves the institution. The patient's security level dictates the number of officers and the level of security required.

A patient returning from an off-site medical trip is taken to the healthcare unit prior to returning to his/her housing assignment. This practice permits healthcare staff to review orders and aftercare instructions from the emergency department or hospital and have a face-to-face encounter with the returning inmate. The primary care provider or on-call provider is contacted when indicated to report the patient's status and to review and receive orders. Patients returning from an emergency department or a hospitalization should routinely be scheduled for an appointment with the primary care provider to complete follow-up needs and discuss/review on-going plan of care with the patient.

Utilization/Case Management – Inpatient Hospitalization

The utilization management program includes review of concurrent inpatient reviews. Inpatient hospitalization and emergency department visits resulting in an admission require coordination with the Utilization Management Program, the treating hospital and the site primary care provider.

The site will have a process for providing notification to the Utilization Management Department when a planned or unplanned admission occurs. The primary care provider and Director of Nursing or designee will work closely with our utilization management staff to monitor progress, treatment and facilitate timely, appropriate discharge back to the patient's original institution or to an institution with infirmary capabilities where the patient's on-going care requirements can be managed.

Communication will be facilitated between the receiving hospital/healthcare facility and the site by the utilization management team and will include routine care updates provided to healthcare staff at the sending facility. Discharge planning will begin at the time of a patient's admission as will the site's planning for any special needs or required services anticipated at the time of discharge.

Data specific to inpatient and emergency department utilization will be maintained for each institution and reported monthly to our client. Review of this information will be incorporated into monthly statistical and quality monitoring review specific to the contract and individual site.

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Infirmary Care and Utilization

An infirmary is an area of the institution accommodating patients who need closer observation or higher level of healthcare services. Infirmary care is defined as care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living that require a level of skilled nursing intervention. Not all institutions have infirmaries. Patients requiring infirmary level of care may require coordination for transfer when needed.

Healthcare services in infirmaries will be directed by the site Medical Director or physician. Infirmary nursing care will be supervised by the site Director of Nursing or registered nurse designee seven days a week. Qualified healthcare staff will be on-site 24 hours a day, 7 days a week. All infirmary inmates will be within sight and sound of facility or healthcare staff. Staffing skills and levels will be based upon the numbers and acuity of inmates within the infirmary. We routinely staff institutions with infirmaries with sufficient staff to meet the standards of care as indicated in the correctional systems policy and consistent with correctional healthcare standards.

Infirmary care provided includes skilled nursing services, convalescent care, pre-and post-surgical management, limited acute care, limited IV therapy, as well as medical observation monitoring. A physician, nurse practitioner or physician assistant will order the infirmary admission of an inmate. A primary care provider will be available 24 hours a day, 7 days a week either on-site or on-call. Discharge from an infirmary requires an order from a physician or nurse practitioner or physician assistant. The following actions are needed at the time of discharge:

- Discharge note and discharge orders for continuing care from on-site provider
- Discharge summary note from the healthcare staff that addresses the patient's status at the time of discharge
- Instructions for follow-up self care and medications given to the patient

The provision of end of life care varies in correctional systems. Typically, when a patient is determined to be suffering from a terminal illness, a primary care provider will identify healthcare needs for the patient and assist in establishing a multidisciplinary treatment plan for care and support services during the final stages of life. End-of-life care may focus on pain management, personal and comfort care needs, safety from falls and injury, and skin integrity preservation. Healthcare staff assigned to provide hospice and related end-of-life care collaborate with mental health staff, security staff, and clergy to provide persons with the care needed to "die with dignity" regardless of the setting.

The multidisciplinary treatment plan for end-of-life services typically includes:

- Pain management program
- Patient mental status, particularly as it affects healthcare decision-making abilities
- The Do Not Resuscitate process through a palliative care/hospice program
- Durable medical equipment
- A plan to execute and communicate patient's living will and identification of next of kin or guardian to act on their behalf, if necessary
- Providers need to be aware of state-specific legal requirements since these vary

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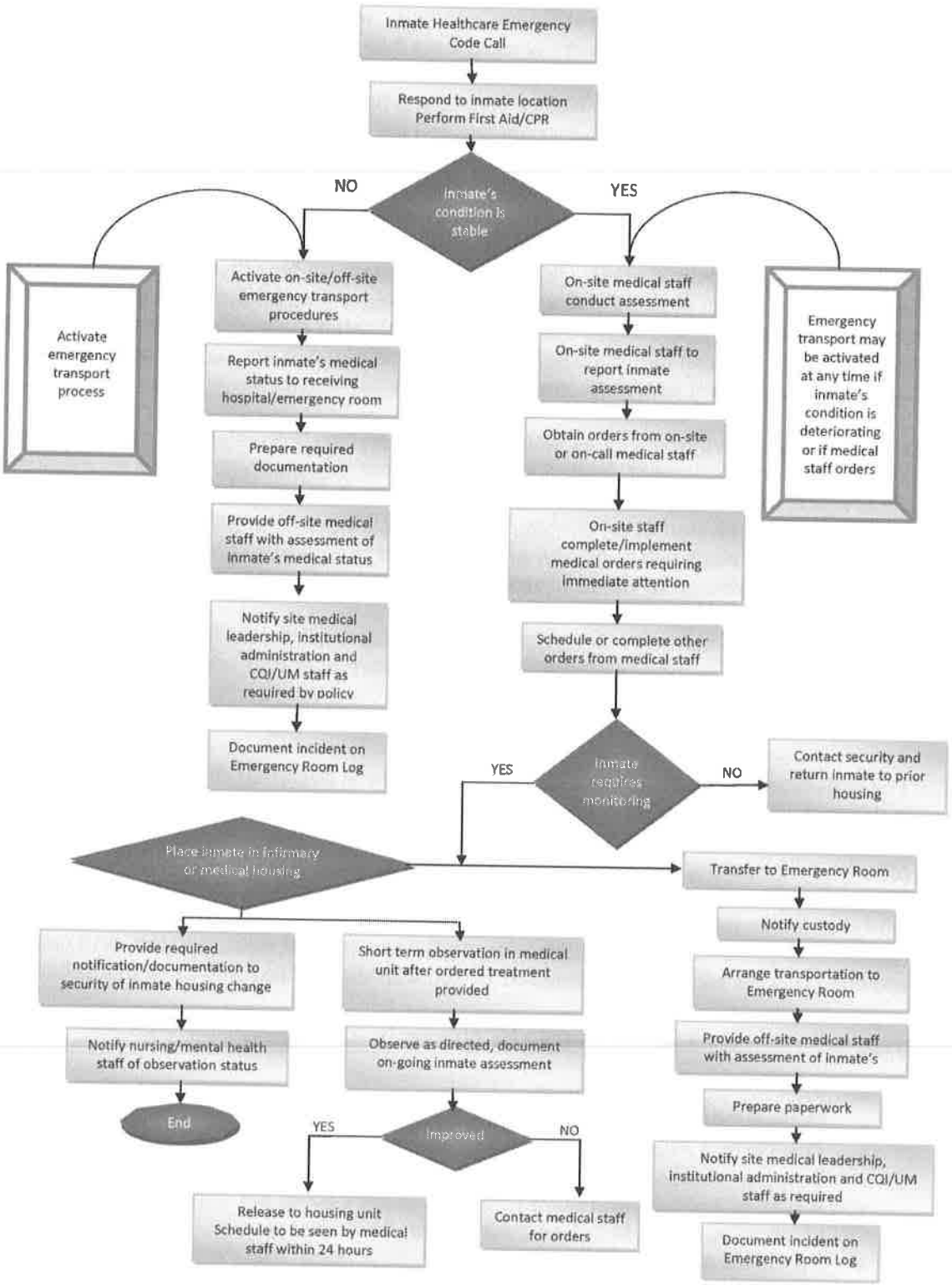
Emergency Response Process Flow

The following illustrates the flow of emergency response for a typical facility with on-site healthcare staff



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SBAR Communication Tool

Situation Background Assessment Recommendation (SBAR) is a standardized way of communicating. SBAR assists healthcare staff to communicate with a shared set of expectations to achieve consistent and organized communications.

SBAR stands for:

- *Situation*: Providing a concise, brief statement of the problem (why we are calling)
- *Background*: Providing pertinent and brief results of patient examination and information related to the current situation (what did you find)
- *Assessment*: Providing options for what is happening (what do you think is going on)
- *Recommendation*: Requesting or recommending actions (what needs to be done)

Process:

1. Healthcare staff member consulting with on-call provider will examine the patient, review the medical record and gather pertinent health history prior to calling the on-call provider.

2. Patients experiencing a crisis or life threatening situation require appropriate emergency responses which may necessitate abbreviated use of the SBAR process, or bypass altogether and immediate EMS activation.

3. The healthcare staff member will use the SBAR Communication Form to record the required information. Minimum information obtained to include:
   - Patient name, facility and housing location
   - Relevant recent healthcare encounters, results of recent tests and off-site care
   - Code status
   - Allergies
   - Current medications and compliance history if known
   - Vital signs including pulse oximeter and blood sugar when indicated
   - Current mental health status examination
   - Current physical health status examination

4. The (A) Assessment and (R) Recommendation section of the SBAR document help to guide in:
   - Communicating your considerations of what is going on with the patient
   - Focusing provider responses (orders) for where inmate should be treated; what needs to be done; and what follow-up needs to occur.

5. The information documented on the SBAR Communication Form must be part of the patient's medical record. This form should be filed in the medical record or the information contained on the document should be transcribed or scanned into the electronic health record.

6. Any orders received from the provider must be documented on the appropriate order form within the patient's medical record or electronic health record. Orders should be implemented and the appropriate actions taken.

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SBAR COMMUNICATION TOOL

Pre-Communication Preparation

- Assess the patient. If life threatening, activate Emergency Medical Care.
- Review medical record for most recent healthcare encounters
- Obtain list of current medications or copy of current MAR
- Obtain results of recent significant labs or test results

Inmate Name: _____ Number: _____
Institution _____ Housing Location _____

Situation (Briefly describe current situation) Introduce yourself, institution calling from I am calling about patient _____ I am concerned about _____ _____ _____	Notes
Background (Briefly state current and pertinent history) Patient is currently/has recently been treated for _____ Vital Signs: B/P _____ Pulse _____ RR _____ Temp _____ Pain Score (1 – 10) _____ O2 Sat _____ % on _____ Oxygen OR _____ Room Air Patient is complaining about _____ _____ Physical assessment demonstrates _____ _____ Mental status is _____ _____ Skin is _____ Patient is allergic to _____ Code status is _____	
Assessment (Summary of what you think is going on) I think the problem is or what might be happening is: _____ _____ _____	
Recommendation (Actions and follow-up) ☐ Transfer inmate to Emergency Department ☐ Other _____ ☐ Tests, Medications or Monitoring Needed? ☐ Call back for the following reasons ☐ When do you want to see the patient? **Provider decision must be documented on order sheet**	

Signature/title _____ Provider Name/Title _____
Date: _____/_____/_____ Time: _____ AM / PM

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On-Site Emergency Care, Emergency Department Services, Hospitalizations and Infirmary Care Summary

The information in this section is intended to provide you with general knowledge and understanding of the role of on-site emergency care, off-site emergency department services, on-site infirmary care, and off-site hospitalizations in correctional healthcare. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Are infirmary services offered at this facility?
- If infirmary services are offered at this facility, what is the capacity of the infirmary, nursing skills provided, staffing levels, typical diagnosis, and typical length of stay?
- If infirmary services are not offered at this facility, where are patients transferred for infirmary level of care?
- How often do emergency "man-down" calls occur in the facility? Are there any recurring issues?
- What is the typical response time of the ambulance? Are there any issues in emergency services accessing inmates?
- What emergency department is used by this facility?
- What is the relationship with the emergency department?
- Does the emergency department routinely send discharge notes including copies of lab and other studies for patients released from the emergency department?
- How many hospitalizations does this facility average monthly?
- Do patients return to this or another facility when discharged from a hospitalization?

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Chapter 13: Laboratory, Radiology, EKG and Other On-Site Testing

Laboratory Services

Routine laboratory services are provided to each institution through a sub-contractor agreement. This agreement is commonly with Bio-Reference Laboratories but may be another laboratory services provider specific to/or required by use as part of our overall contract. Specimens are typically picked up from each facility Monday through Friday and delivered to the laboratory as soon as possible. All laboratory results, except those requiring a longer processing time, will be provided to the institution within 72 hours and often results will be returned the next working day. The institution is notified immediately by telephone of critical laboratory results that indicate a potentially dangerous condition requiring immediate attention by a provider. Results are routinely provided by fax or by electronic receipt through a computer interface provided by the laboratory contractor.

Tests, panels and specimen requirements are readily available in a lab reference manual located at your institution. Typically tests performed on-site (CLIA waived) include capillary blood glucose monitoring, dip-stick urine testing, stool quaiac testing, urine drug testing (for MAT management), urine pregnancy test, non-routine PT/INR, peak flow and pulse oximetry. The nursing staff can inform you of how to obtain these tests and if other point-of-care testing may be available at your site.

Stat laboratory testing is available usually through a contract with a local hospital. The use of stat laboratory testing should be limited to true medical necessity or in decision making on whether to send a patient to the hospital. Turn-around time varies by facility and mostly depends on the accessibility of a specimen courier. The following stat tests are available at most contracts:

Bio-Reference Test Code	Test Name	CPT Code
0035-6	Ammonia	82140
2555-1	Basic Metabolic Panel (BMP)	80048
0069-5	C-Reactive Protein (CRP)	86140
0053-9	CBC	85025
3427-2	Comp Metabolic Panel (CMP)	80053
0068-7	Creatinine Kinase (CPK)	82550
5743-0	D-Dimer	85379
0083-6	Digoxin Level	80162
3646-7	Lactic Acid	83605
0119-8	Lithium Level	80178
0521-5	Lipase	83690
0120-6	Magnesium	83735
0084-4	Phenytoin Level	80185
0137-0	PT/INR	85610
0086-9	Sedimentation Rate	85651
2163-4	Troponin – I	84484

State or county laboratories may provide some testing for sexually transmitted disease including HIV testing. In these case, we are often obligated to provide the treatment and follow-up.

Radiology Services

Capabilities for body structure x-rays are available at most institutions using stationary or portable radiologic machines. At smaller institutions, it may be necessary for patients to be transported to a larger institution for routine X-rays. Radiology services are often provided by a company with whom we have sub-contracted. No matter the method for providing/performing X-rays, the X-rays are completed by appropriately licensed and registered technicians that conduct, process and transmit images. Interpretation is completed by a board-certified radiologist and results are available within 24 hours of the X-ray. On-site fluoroscopy and special studies may be available at larger institutions. Emergency radiology services are available at the local contracted hospital. In addition, mobile services for mammography, ultrasound, CT and MRI may be available.

EKG Services

EKG services are available at many institutions and are routinely performed by our trained nursing staff. Generally, the site-level provider is able to read and interpret the EKG. In the event that you would like a reading by a cardiologist, these can be transmitted electronically for a stat or routine reading 24-hours a day.

Acknowledgement of Results and Reports

Results of tests that you have ordered will be placed in a location designated for information that requires your immediate attention and action. This location may be either electronic or paper depending upon the record system that is used by the system. It is your responsibility to review and acknowledge review by electronic or written signature, date and time. Significantly abnormal test or report results require further documentation, modification of a treatment plan and explanation face-to-face with the patient. Patients are to be informed of all laboratory or procedures results, positive or negative. This may be by written communication sent to the patient through procedural communication channels. In the event that a patient is released from custody prior to receiving significant results for which the patient is advised to take additional action or follow-up, notification must be made to the patient and documented. Sometimes this involves a certified letter sent to the address of the patient notifying them of the need to follow up for a lab test result which you can make available to them upon proper identification.

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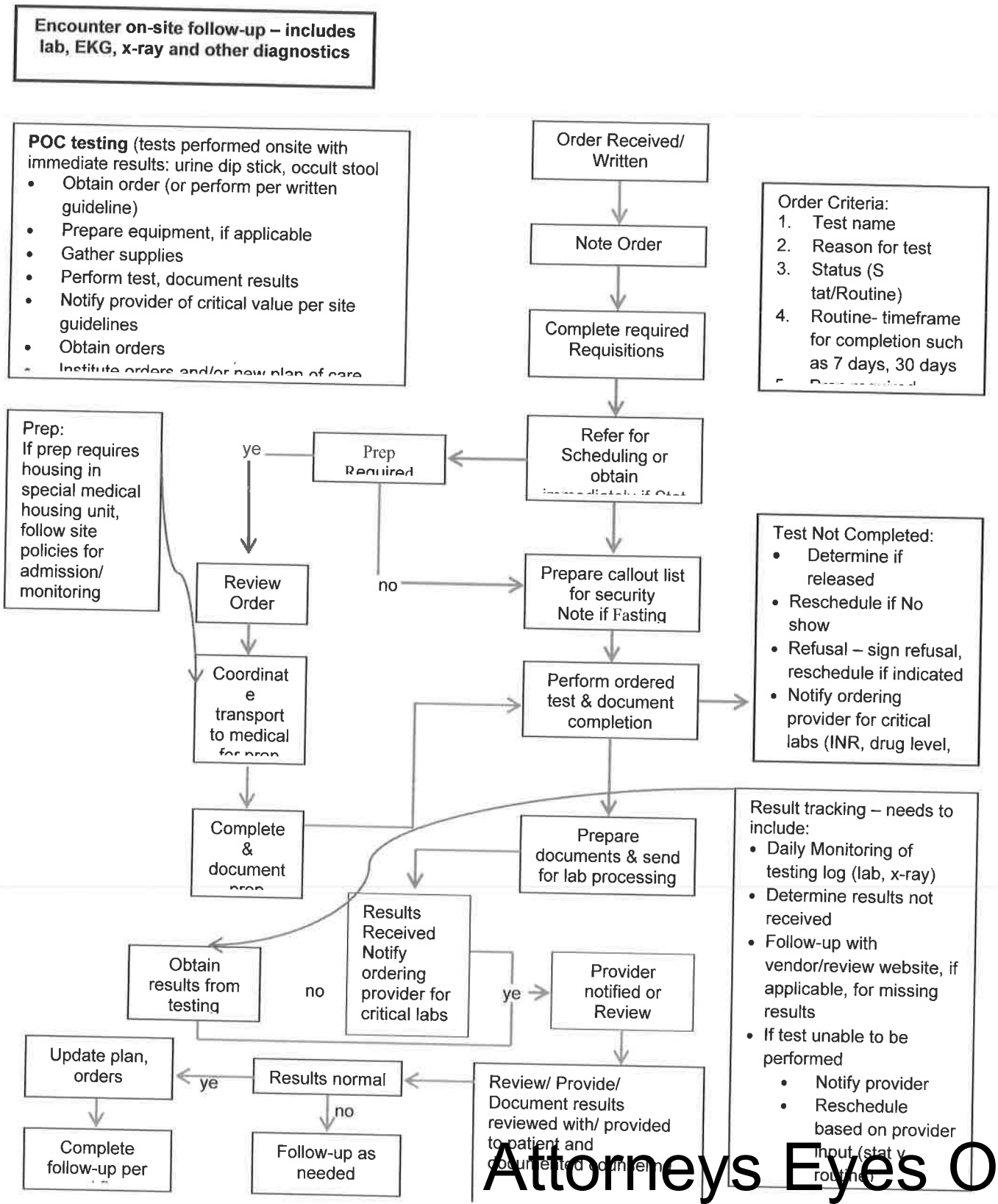
Laboratory and Other Testing Process Flow

A typical process flow for on-site healthcare staff in completing laboratory and other testing is provided on the following page.



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Laboratory and Other On-Site Testing Summary

The information in this section is intended to provide you with general knowledge and understanding of the process for obtaining laboratory and other testing in a correctional environment. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What testing is available on-site?
- Where are testing results recorded?
- How testing is ordered and scheduled?
- What is the typical turn-around time?
- Where are results found for provider review?
- How are critical values reported to the site and to the provider?
- What happens if a patient does not get scheduled test? Is it rescheduled? Is provider notified?
- Are laboratory preferred testing groupings used?
- Is a state laboratory used for any testing?

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Chapter 14: Your Role in Quality Healthcare

Principles for Health Services Delivery

Centurion's Purpose Statement provides a consistent understanding across the organization of why we are in business:

Transforming the health of the community, one person at a time.

All Centurion staff are expected to fully accept responsibility for acting in accordance with the following six Centurion Values:

- Uncompromising Integrity
- Collaborative Leadership
- Candid Communication
- Disciplined Growth
- Purposeful Innovation
- Entrepreneurial Spirit

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Our success in providing correctional healthcare can be attributed to our ability to attract staff who share these principles. Correctional healthcare is a challenging profession that requires the best of people to be effective in their duties.

Our principles for healthcare services include:

- Healthcare services consistent with community standards
- Healthcare services consistent with correctional standards
- Healthcare services that are both clinically and cost effective
- Healthcare services integrated within a multidisciplinary approach and in collaboration with the treatment team to help screen, diagnose, and treat

Correctional healthcare requires a multidisciplinary approach to be effective. Providers will receive inappropriate referrals. These referrals may be due to inadequate triage or the perception that there are limited alternatives to provider intervention.

Experience has shown that the best approach to quality healthcare is to strictly comply with providing the *right* care to the *right* person at the *right* time with the planned and expected outcome being achieved. Patients in custody often have high-risk and complex needs and may require ongoing frequent medical engagement and care. Our on-site healthcare teams focus heavily on coordination of acute primary care, diagnostic intervention, pharmaceutical treatment, dental care and services through case management to identify, prevent, and manage avoidable admissions, unnecessary emergency room use.

Typical Patient Health Benefits Summary

A handout typically provided to patients when entering the correctional system is provided on the following pages. The handout, Summary of Healthcare Services & What They Mean to You, briefly outlines the healthcare services that are available to the person incarcerated.

Your responsibility in the coordination and provision of specific services as a member of the healthcare team will depend on overall contractual requirements, types of inmates housed at the institution, the institution's mission, and the healthcare services offered at the institution.

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Summary of Healthcare Services & What They Mean to You

Important Service	How Do I Access	Why is This Important
Intake Health Assessment	All new admissions receive an Intake Health Assessment. Healthcare staff will schedule this appointment for you	Establishes your medical care baseline; provides needed continuity of care for chronic care, medications
Intake Mental Health Assessment	All new admissions receive an Intake Mental Health Assessment. Healthcare staff will schedule this appointment for you	Establishes your mental health baseline; provides continuity of mental health services and medications
Intake Dental Examination	All new admissions receive an Intake Dental Examination. Dental staff will schedule this appointment for you	Establishes your dental baseline and develops a dental treatment plan
Routine Sick Call	If you want to be seen in sick call, complete a sick call slip and deposit the slip in the designated box. Generally you will see a nurse the next day unless it is a weekend	Sick call is used when an illness occurs that you feel you should see medical, mental health or dental staff for treatment. This is your access to care for needs that are not chronic
Chronic Care Clinic	If you have a chronic health problem, you will be scheduled by healthcare staff for Chronic Care Clinic appointments.	Allows routine monitoring of your chronic illness by healthcare team. Helps you to learn about your disease, your medications and teaches you how to take care of yourself based on your illness
Infirmary Services	You will be admitted to an infirmary based on a medical provider's order. Healthcare staff will coordinate your admission and discharge with security staff based on the medical provider's orders	Allows healthcare staff to more closely monitor your health. Inmates may be placed in the infirmary before or after a procedure/test, after returning from an emergency department or hospital or when the provider wants to monitor/watch how you are feeling
Medications (prescribed)	Medications will be prescribed for you by a medical provider, psychiatric staff or dentist based on your health complaints. You will receive your medicine from the nurse at a pill window, at your cell or in your unit usually once or twice a day	Medicines ordered by a provider are an important part of your treatment. Taking them as ordered can help treat or control symptoms of your disease and help you get well or feel better.
Medications (over the counter) Like Tylenol, Motrin, Tinactin, dandruff shampoo, antacids	These are medicines that can be obtained without an order from a medical provider. Some over the counter medications will be available in the commissary	These are used for occasional muscle aches, headaches, stomach upset. Having these medicines available allows you to take medicine when you may only have a cold or other minor illness that does not require a provider's visit. If the over the counter medication does not help you, submit a sick call slip to see a healthcare staff member
On-Site Emergency Care	You can self refer, may be referred by security staff or healthcare staff based on a true emergent complaint or healthcare need	This allows for medical or mental health staff to evaluate and provide necessary healthcare for a life threatening or potentially life threatening healthcare problem.
Periodic Health Assessment	You will be offered health assessments based on your age, chronic health problems and DOC policy. Immunizations and testing for tuberculosis	Allows medical to perform a physical exam and check your overall wellness. Allows you to learn about staying healthy

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Important Service	How Do I Access	Why is This Important
	are completed periodically.	and taking care of yourself
Inmate Complaints	You can submit concerns about healthcare services using a sick call slip and drop in designated box or you can submit an institutional grievance form	Expressing concerns about healthcare services allows healthcare staff to discuss and follow-up on concerns in a timely manner
Medical Records	You can request to review their medical records while still in the facility by submitting a sick call slip	Questions about your care are important to review and discuss with healthcare staff
Co-Pay	You may be responsible for a fee when you request clinic visits that are not emergencies or not for chronic healthcare issues. This fee is determined by the institution, not Centurion.	Accessing routine sick call services should be based on identified need. All patients will be seen by healthcare no matter their ability to pay
Optometry Services	Services will be provided when vision needs are identified by healthcare staff	Vision examinations are performed by an optometrist and eye glasses are provided when indicated
Mental Health Care	Mental health staff will determine your follow-up needs based on evaluation and ongoing clinic appointments. You will be scheduled by mental health staff as indicated	Allows diagnosis, treatment and individual or group therapy appropriate for your mental health diagnosis
Dental Care	Dental staff will determine follow-up based on examination and medically indicated dental services. Dental staff will schedule your appointment	Allows evaluation and care for acute and medically indicated dental care. Allows for learning about the benefits of good oral hygiene practices
Hospital Emergency Care or Inpatient Hospitalization	On-site medical provider will order evaluation if your complaint warrants further examination in a hospital emergency room or community hospital setting	Access to off-site services for care when your healthcare needs require services not provided within the institution
Specialty Care	The doctor, dentist or psychiatrist will order evaluation by a specialty provider such as a cardiologist, orthopedist or oral surgeon to assist in treating complicated treatment issues. Care may include evaluation or diagnostic testing	Evaluation by a specialist assists our medical providers, dentists and psychiatrists in providing care and determining medically indicated treatment
Women's Healthcare	Your healthcare needs related to being a woman will be addressed at your Initial Health Assessment, Routine Sick Call and Periodic Health Assessments	Services will include pre-natal care, mammograms, testing for sexually transmitted disease, PAP smears. Other specific women's healthcare issues will be identified and treated as medically indicated

Assistive Devices and Other Medical Equipment

- **Devices and equipment are provided when medical provider determines medical necessity**
- **You are responsible for taking care of any devices or equipment issued to you**
- **Replacements are not normally provided and/or you may be responsible for the cost to replace**

Eyeglasses	Wheelchairs	Walkers	Prosthetics	Crutches
Dentures	Canes	Oxygen	CPAP or BiPAP	Hearing Aids

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Quality Improvement Multidisciplinary Team

The institution's Continuous Quality Improvement (CQI) team will typically meet each month. Participation in the meetings and audits is an expectation for physicians, nurse practitioners and physician assistants at the direction of the site and/or statewide Medical Director. Medical record audits are outlined in an annual CQI audit calendar. Results of these audits are reported to a Statewide CQI committee and our client.

The CQI committee will identify corrective action to be initiated based on the results of the audits. Any corrective action items will be documented. If no improvement has been noted in an area identified on a Corrective Action Plan, additional ideas for corrective action such as staff training, more frequent monitoring or a change in process will be discussed and integrated into the plan with progress being monitored by the committee.

Each institution will maintain a set of institutional healthcare statistics to provide data regarding on-site and off-site services provided by the individual healthcare unit. These statistics will be reviewed at each CQI meeting to discuss any changes in activity. For example, a review may reveal that the incidents of inmate medication non-compliance have increased.

Physicians, nurse practitioners and physician assistants also participate and provide integral input into the following CQI activities.

Review of Major Occurrences

The CQI program requires that a major occurrence report is initiated for any death, serious suicide attempts requiring off-site or infirmary medical care, and other significant patient issues related to healthcare treatment (see Chapter 7, and oSEL program). Occurrence reports are also generated for medication errors, adverse drug reactions, errors in medical records, errors in medication count reconciliations and other healthcare system gaps. Root cause analysis is one of the tools to effectively identify causal factors and develop plans of action to monitor and sustain improvement activities.

Mortality Review Process

A multidisciplinary mortality review of the death of any person in the custody of a jail or prison is an assessment of the clinical care provided and the circumstances leading up to a death. The purpose of a mortality review is to identify any areas of care or the system's policies and procedures that can be improved.

Mortality reviews are conducted in compliance with the correctional system's policy and correctional standards. The statewide Medical Director and other medical providers participate in each review. Mortality reviews are the responsibility of the Mortality Review Committee which will include membership of the statewide CQI Coordinator, statewide Medical Director, the correctional system's Medical Director or designee, medical staff, mental health staff, and facility administration.

Staff are expected to cooperate fully with investigations in the event of the death of a person in custody. We have specific policies, procedures and clinical guidelines to

support the mortality review process. Deaths that occur within the institution are reviewed by institutional staff with the client's administrative authorities as the entity with final responsibility for each person incarcerated.

Participation in an administrative review and complete clinical mortality review is generally required to be completed within 30 days of the death. Issues addressed will include but not be limited to the following:

- Whether adequate investigations were made to arrive at the correct diagnosis
- Whether treatment was available and appropriate
- Whether communications between security, medical, mental health and other stake holders were open and productive
- Changes to policies, procedure or guidelines which might be beneficial in light of the events

Autopsy and toxicology results may not be available within 30 days. In these cases, it is necessary to reconvene the Mortality Review Committee following receipt of autopsy and toxicology reports from the Medical Examiner's Office or the correctional system's healthcare leadership. At this time the Mortality Review Committee reviews prior findings in light of the new information.

The intended outcome of the mortality review process is the identification of systemic issues that may have contributed to the individual's death. The recommendations for systemic improvements related to an inmate death are incorporated into the CQI Program.

Review of Grievances Related to Healthcare

A formal grievance system has been developed by all correctional systems in response to legal mandates including the Prison Litigation Reform Act of 1996 and standards to provide all incarcerated persons a method to have serious needs and issues addressed. Each person is advised at the time of admission to jail or prison that he or she has the right to challenge or grieve conditions of confinement. Formal grievance processes were established as a mechanism for the incarcerated person to challenge conditions of confinement without burdening the court systems. The procedures associated with the formal grievance process are well defined by the correctional agency. Healthcare grievances are investigated and responded to in the manner described in the correctional system's policies and procedures.

We use patient grievances as another method to identify systemic issues in service delivery that are in need of improvement. Grievance statistics and trending are reviewed monthly by the CQI Coordinator and quarterly by the Centene/Centurion Compliance Committee. Our policy and procedure for responding to patient concerns begins with an informal complaint resolution process and proceeds through the client's formal grievance resolution process. Attempts to resolve complaints informally are not used to delay the grievance process nor restrict the patient's right to file a formal grievance, but instead to manage the complaint/concerns at the lowest level in a timely manner. Our physicians, nurse practitioners and physician assistants often assist the administrative staff in researching and responding to the informal and formal grievances.

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Patient Safety Initiatives

We are dedicated to the reduction and minimization of risk and harm to our patients in custody. Our leadership fosters a safety-centered culture that encourages staff to identify opportunities to reduce harm or potential harm to patients or the facility. Patient safety initiatives focus on strategies that improve clinical practice through policy, monitoring and a culture that supports error reporting. We promote patient safety through development of a non-punitive, professional and supportive work environment. Through our CQI processes, each adverse or near-miss clinical event is analyzed to determine the cause. When the cause is due to a failure of policy or procedure, the healthcare team collaborates with the client to remedy the issue. When at least part of the cause is due to individual competency, local supervisory staff, in collaboration with regional leadership, will initiate a performance improvement plan aimed at enhancing clinical skills through training, supervision and on-going monitoring. Depending on the specifics of the issue, we may perform a skills competency review, counsel the staff member, require clinical supervision, require specific training, and/or offer employee assistance.

Peer Review and Supervisory Requirements

The Peer Review Committee works within the CQI Committee framework to ensure review of the clinical performance of physicians and dentists. Nurse practitioners and physician assistants are included in the routine peer review process. The statewide Medical Director will chair the committee and appoint members to this committee. The state CQI Committee will assist in the coordination and execution of the annual peer review process through development of a calendar for annual reviews as well as monitoring completion of peer reviews throughout the year.

Results from peer reviews are discussed between the reviewer and the staff member being reviewed. A letter of verification is submitted to the client confirming the completion of a peer review and is placed in the credential file. This procedure and process forms for notification of a completed peer review meet correctional standards and other applicable ethical standards for the peer review process to ensure confidentiality of the findings.

Completed peer review audit tools are maintained in a confidential file in the Regional Office. It is important that the detailed findings of the peer process remain protected and confidential to support the intent of the process to be a peer-to-peer review of performance. You should request a copy of the Peer Review criteria for your discipline.

We meet the supervision requirements for nurse practitioners and physician assistants to comply with the rules and regulations of the respective requirements. This includes the development and maintenance of collaborative agreements and treatment protocols, if applicable, as well as the professional review by the supervising physician of historical, physical and therapeutic data contained in patient medical records. The frequency and extent of these reviews will be in compliance with rules and regulations of the State Licensing Boards. Compliance with practice requirements remains the professional responsibility of the physician and the nurse practitioner or physician assistant.

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Administrative Meetings

You may be asked or required to attend meetings that occur between the Warden/Superintendent/Chief or other Institutional Authority and those departments that report to him/her. The Institutional Authority or designee may have morning meetings or weekly meetings that you may be asked to attend on an as-needed basis. These meetings are an important way to address issues and network with other members of the security and program leadership staff.

Healthcare services chair a meeting with the Institutional Authority or designee and members of security leadership typically once a month. You may hear them referred to as MAC meetings. The meeting is dedicated to identifying and solving issues and sharing healthcare reports with the security and health leadership. Investment in good outcomes and process is required of all members of the healthcare team to provide a quality health services program for our client and the patients to whom we provide service.

Your Role in Quality Healthcare Summary

The information in this section is intended to provide you with general knowledge and understanding of your role in quality healthcare. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Is there an outline or process to follow for mortality reviews?
- Who performs my peer review? When are peer reviews performed? Is there a standard format for peer reviews?
- What meetings should I attend?
- What types and how many grievances do healthcare services in this facility receive each month?

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Chapter 15: Patients with Special Needs

Overview

In the correctional environment, patients with special needs are those who require periodic medical, mental health, or multidisciplinary care or accommodations beyond routine maintenance. Typically, persons with chronic diseases are managed in a chronic disease program or Chronic Care Clinics for medical conditions and by the mental health staff for chronic serious mental illnesses. These programs have been discussed in Chapters 10. This chapter will introduce other issues and conditions that require persons to be followed routinely and aspects of the correctional environment that influence or impact care decisions.

The medical provider's responsibilities may include determination and recommendation for work restrictions and/or accommodations and housing needs. Incarcerated individuals with disabilities are protected under most aspects of the Americans with Disabilities Act. Responsibility for programming for this population rests with the government agency and the its legal counsel to review statues and guide the system's responses.

The Master Problem list should identify long-term special needs conditions and the Plan in the SOAP note or treatment plan should identify housing recommendations, supportive or rehabilitative services ordered, and the date for next scheduled provider appointment.

Compromised Mobility: Wheelchairs, Walkers, Canes

Mobility issues can be a significant problem in corrections for two reasons:

- Many of the facilities are old and built before mobility disability requirements were adequately recognized or addressed
- Commonly used mobility devices represent security safety concerns. For example, a cane can be used as a weapon in a fight.

The mobility accommodation status of any facility may be as obvious as ramps for wheelchairs and as subtle as the walking distance to the dining hall or medication line. It is the responsibility of medical providers to inform security and classification departments of the type of device needed and the anticipated duration of the need. It is important that the provider recognizes that reclassification to another institution may be required but also that the patient may have identified a secondary gain for the transfer.

Providers should become familiar with the devices that are restricted and alternatives that have been identified. It is also important to know the process for notifying the facility's classification staff of a patient's short and long term needs.

Other conditions that may limit daily functioning include visual, hearing, and/or speech impairments. If the impairments are significant, the patient may require accommodations which will impact their classification and facility placement. The

provider should become familiar with the classification process used by the correctional system and the role of a provider in the medical classification and reclassification.

Developmental/Intellectual Disabilities

Medical providers can expect to provide interventions for patients with developmental/ intellectual disabilities.

- Developmental disability is a severe, long term disability that can affect cognitive ability, physical functioning, or both. The term "developmental disability" encompasses intellectual disability but also includes physical disabilities. Some developmental disabilities may be solely physical, such as blindness from birth. Others involve both physical and intellectual disabilities stemming from genetic or other causes, such as Down syndrome and fetal alcohol syndrome

- Intellectual disability refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness.

Persons with intellectual impairments in custody:

- Are slower to adjust to routine
- Have more difficulty in learning regulations resulting in the accumulation of rule infractions
- Free time is spent in meaningless activities not programs
- Are often the brunt of practical jokes and sexual harassment
- Desire to seek approval
- Have been taught to be compliant
- Typically, will "mask" disabilities

These and many other difficulties that are associated with these disabilities place these persons at risk. The medical provider should collaborate with the mental health team and corrections staff to identify appropriate housing, use proven communication techniques, and support efforts to provide for the patient's physical safety.

Dialysis

Care for patients receiving hemodialysis or other treatment for advanced kidney failure is directed by a contracted nephrologist and provided at a designated facility or location for men and women. When hemodialysis is performed on-site, the equipment and staff are often provided by a subcontracted dialysis company that has experience in corrections. On-site medical providers are part of the multidisciplinary team and provide care for the co-morbid conditions and episodic needs of such patients.

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Overdose and Withdrawal

Jails and State facilities which take individuals directly from the street including those newly arrested or parole violators are likely to see patients at risk for withdrawal from drugs and alcohol, and also at risk for drug or alcohol toxicity or overdose. Meanwhile, any person in any correctional facility may have access to medications, drugs and alcohol and may have acute symptoms of overdose and alcohol intoxication.

Overdose should be suspected in any person with an onset of confusion and/or altered mental status that may range from sleepiness to decreased alertness to coma. Often cellmates and correctional staff may offer some history or have found evidence of drugs or alcohol in the cell.

Medical providers in correctional settings should be familiar with the types and occurrences of overdose and withdrawal among persons under their care. The signs of opiate overdose (respiratory depression, pinpoint pupils, reduced alertness) should be quickly recognized. Familiarity with signs, symptoms and treatment protocols is recommended. The medical provider should also be aware of the capabilities of the nursing and correctional staff to provide required monitoring and treatment.

Hunger Strikes

There are a variety of reasons for persons in custody to engage in hunger strikes:

- Protests for some real or imagined right or cause
- Manipulation of the system to receive special items
- Bring attention to self
- Lingering, but serious, suicide attempt

The healthcare team and the correctional agency needs to be prepared to deal with persons embarking on hunger strike. It has been recommended that hunger strikes lasting more than two days are supervised by an interdisciplinary team of correctional and non-correctional personnel including clergy, mental health and medical staff and that the patient be housed in an area that facilitates medical monitoring.

The medical provider's role in a patient's hunger strike is to be advocate for the patient and meet his or her needs. This includes supervision, monitoring and intervening for worsening status. The healthcare team should be familiar with the policies and procedures and guidelines of the agency and Centurion.

At some point, a hunger strike can lead to the necessity of making a decision about forced-feeding versus the patient's right to refuse medical and/or nutritional interventions. Ethical committees and legal authorities for the correctional system or the applicable jurisdiction should be apprised when a prolonged, serious hunger-strike occurs.

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Pregnancy

It is not uncommon for a woman to be pregnant when she begins her incarceration. Being pregnant while in custody can be stressful and emotionally challenging. The patient is to receive the level of care for herself and unborn baby as provided in the community. Sometimes the pre- and post-natal care is provided onsite by obstetrical specialists, sometimes the patient is transported off-site to the obstetrician. Delivery of the child is done in the hospital. Most agencies have prohibitions against shackling or restraints of pregnant women during transportation or childbirth. A pregnant woman should not be isolated in a single cell during the later stages of pregnancy.

Most pregnancies of women in custody are identified as "high risk" secondary to commonly limited or no prenatal care prior to incarceration coupled with high risk lifestyles including use of drugs or alcohol. Therefore, prenatal care and delivery are directed by a qualified obstetrician. The patient receives access to dietary, exercise and education programs during pregnancy. In most correctional systems, care of the newborn is not the responsibility of the correctional system and on-going care of newborn becomes the responsibility of family members in the community or the newborn becomes a ward of the state at the time of delivery. The patient returns to the institution after delivery and postpartum care and counseling are provided by on-site healthcare staff. Post-partum depression can be more common in women who are incarcerated. Women entering a jail or prison who have been breast feeding might need to continue breast pumping and should be provided a pump. Some facilities will store the milk and allow family members to pick it up, while others require that it be dumped.

Special Needs Summary

The information in this section is intended to provide you with general knowledge and understanding of the "special needs" of patients who require medical attention. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What is the prevalence of persons with "special needs" at the facility?
- What is a provider's responsibility for classification determinations and communications with security?
- Is housing available for patients with "special needs"?
- Are there templates for documenting treatment plans for "special needs" or is the plan documented in the Plan section of a SOAP note?

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Chapter 16: "Wants" vs. Medical Needs

Overview

The lives of persons in custody are governed and controlled by rules, regulations and expected conformity to these rules and regulations. Most correctional facilities have rules that define clothing and shoes that can be worn by persons in custody; when and where they will eat and sleep; what personal belongings they may possess; and other restrictions too numerous to detail.

The system's rules and regulations are given to the individual in custody at admission into the facility usually in the format of an inmate handbook. It is beneficial to become familiar with the inmate handbook because healthcare staff especially medical providers have the authority or expectation to order many special items and to issue "lay-ins" to avoid certain activities or assignments.

While persons may have a medical necessity for special treatment or accommodation, the medical provider should be alert to the person who wants special "perks" because:

- Special "perks" set the person apart from his/her peers and/or offer special status
- Getting special "perks" from medical can be a "game"
- Special "perks" can be used to barter for other contraband

The following sections represent a few of the dilemmas that the correctional healthcare provider may encounter. The accompanying articles highlight some common issues related to "wants." The most effective ways to address these issues include:

- Know the custodial rules at your facility
- Know what items are available in the commissary for persons in custody
- Talk with experienced staff to learn the most common requested "wants"
- Learn the fair, firm and consistent response to "wants"
- Realize that once you deviate from the fair, firm and consistent response, other persons will submit the same requests
- Understand that new healthcare providers will be tested

Getting advice and help from seasoned staff for how to handle requests for "wants" can help new providers avoid becoming perceived by the inmate population as an easy "mark."

Lay-Ins or Work Excuses

Persons who cannot work or participate in programs must have written excuses from a medical provider or nurse to "lay-in" or stay in their cells. Persons have many secondary gains from missing work assignments, will think of a million excuses and will cajole the healthcare staff into granting lay-ins. This is particularly true for those assigned to tedious institutional jobs. Programming such as working toward achievement of a GED and substance abuse treatment programs are considered a type of "work" and persons may request a lay-in from these activities.

Correctional officers are particularly helpful in informing medical staff when a person in custody receives a lay-in from work for medical reasons but then witnessed playing basketball or other activity. Security staff responsible for the activities of a person in custody will appreciate very judicious use of lay-ins.

Bottom Bunks and Other Extras

One visit to a typical housing areas will help the medical provider understand why bottom bunks, extra mattresses and extra pillows are desired commodities. These items have been the cause of arguments, written complaints and even lawsuits. In many institutions issues related to mattresses and pillows are addressed by Unit Managers or other similar correctional staff. It is important to identify the staff responsible for these issues in your facility.

Bottom bunk assignment is first based upon medical needs and requires notification to the institution's classification or security supervisors. There are a finite number of bottom bunks and an almost endless request from persons who want them. Your facility or system may have established medical requirements for bottom bunks. This list helps medical providers to be fair, firm and consistent; is helpful in responding to grievances on this issue; and will eventually filter through the inmate "grapevine" and impact the number of requests.

Shoes

Shoes are issued as part of the correctional uniform. Shoes are also one of the few items that can differentiate one person from another when allowed to have "special" issues. Persons in custody may try many ploys to convince medical providers that their feet are not able to tolerate the system-issued shoes.

Shoe requests handled in a prescriptive manner will reduce or halt these requests. Decisions based upon documented medical conditions including diabetes, peripheral vascular problems, or gross foot deformities that cannot be handled by the medical provider will support consistency among medical providers. However, it is important to consider:

- Podiatry referrals require transportation and often result in orthotic shoes prescriptions that could be addressed in other ways
- Corns and calluses can be handled on-site with pumice stones and occasional trimming
- Arch supports may be available for the patient to purchase from the commissary

The following information written by correctional physician Dr. Jeffrey Keller offers practical advice on the correctional medical topic of "shoes" found at www.jailmedicine.com. The information is offered not as an official endorsement but as an insight into the intricacies of correctional healthcare.

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A Quick-and-Easy Solution to those Pesky "Own Shoes" Requests

Posted on March 6, 2012. www.jailmedicine.com

Everyone who works in corrections is familiar with inmates wanting medical authorization to wear their own shoes. A typical case would go something like this:" I have chronic back pain and walking on these hard concrete floors makes it worse. Will you authorize me to wear my own shoes? You did last time I was in here and it really helped."

We need to keep in mind, however, that allowing an inmate to wear his own shoes gives that inmate secondary gain. Shoes from home are more comfortable than the typical jail sandals. Also, any inmate who is granted a special privilege, like wearing his own comfy shoes, gains status among the other inmates. When we approve inappropriate requests for "own shoes," we are bestowing prestige upon that inmate. And we are denying that prestige to those who we refuse. The unfairness of this is not lost on inmates.

Finally," own shoes" are occasionally used to smuggle contraband into the facility. I remember one pair that had an ingenious hollow space carved out of the sole that was not easy to find on a typical security examination. If you routinely grant requests for "own shoes," you will inevitably get burned in this way.

The second important point is that it is the responsibility of the security staff to provide footwear to inmates; not the medical staff. The question we are being asked in these encounters is this: Is there a medical need for this patient's own shoes? I argued in "A Quick and Easy Solution for Second Mattress Requests" that there is never a "medical need" for a second mattress. That is not the case for footwear.

Orthotics

There are indeed cases when special footwear is medically indicated. In fact, medically prescribed shoes have a medical name; they are called Orthotics. Examples of orthotics are walking casts, splints like the CAM walker and special shoes with, say, a special built-up heel for patients who have one short leg. The key here is that orthotics are 1) prescribed by a physician and 2) fitted in a medical clinic. They are not purchased "off-the-rack" in a store. This includes arch supports that patients can purchase in a store, like Dr. Scholl's.

So the first part of this Quick and Easy Solution is this: orthotics, as described above, may be approved on medical grounds for use within the facility. Orthotics must fulfill both criteria: they must be both prescribed by a physician and fitted to the specific patient in a medical clinic. It is not enough to just get your outside doctor to write you a prescription for your Air Jordan's (as I have seen many times). Orthotics still must also be cleared by the security staff, however! Orthotics can be used to hide contraband, too. Orthotics sometimes have metal that could be made into a shank. One inmate with a short leg had his special built up heel on a pair of pointed-toe cowboy boots that could be dangerous in a fight and so were not permitted on security grounds.

The second part of this Quick and Easy solution is this: the inmate's own store-bought shoes are never medically indicated. This takes the whole issue of store-bought "own shoes" out of the medical arena entirely. There is no reason for an inmate to go to the medical clinic to ask – it is not a medical issue. Such requests can be routed to security

to handle. If they want to give "own shoes" to an inmate, they may, but there is never a reason for a deputy to say to an inmate, "The only way you will get to wear your own shoes is if medical approves it." In this system, medical never does. In some jails, security has taken over the shoes issue entirely. Medical is seldom involved.

However, there are a few special cases that require a special discussion.

1. What about diabetics and diabetic foot disease? Don't diabetics need special protective footwear? In my mind, this is debatable. Diabetics need to manage their diabetes properly and take care of their feet. I think they can do this wearing jail footwear. However, others disagree with me. The best solution I have found to satisfy both opinions is for the jail to purchase slip on or Velcro sneakers, which medical can then prescribe to appropriate diabetic patients. Note that this makes them orthotics by definition: they are prescribed by medical and hopefully fitted in diabetic clinic, at which time foot care is reviewed, as well. Giving these patients prescribed jail sneakers also eliminates the other hazards of "own shoes" we have discussed, such as being used to smuggle contraband and enhance status.

2. What about patients with neuropathy of the feet? The problem with non-diabetic neuropathy of the feet is that it is hard to objectively evaluate. Often, it is what the patient says it is. I don't disbelieve my patient necessarily, but I also do not want to get into the situation where inmates can get their own shoes just by saying their feet hurt and tingle. Once they figure that out, I will see a lot of patients with tingly feet. A better solution is to take patients with documented neuropathy (they have seen a neurologist, say and have had nerve conduction studies) and fit them with jail sneakers just like the ones we discussed for diabetics.

3. What if the jail does not have the right size shoes? I call this "The Shaquille O'Neal" dilemma. What would you do if Shaquille O'Neal (7' 1" tall, 325 pounds) was booked into your jail? One immediate problem with Shaq is that he wears size 23 shoes. Your facility probably does not stock that size. In my mind, this is not a medical issue. This is a clothing issue. If the facility does not have footwear that this man can wear, one solution would be to allow him to wear his own shoes. However, this is not a medical issue. There is no need for a medical memo.

4. Are there any other patients who might qualify for more comfortable footwear? There is a long list of other subjective complaints that could potentially be eased by more comfortable footwear. Rather than going into them one by one, a better solution is to place the jail sneakers we have already discussed on commissary, where any inmate can purchase them without having to go through the medical clinic. Outside of jail, if your shoes aren't comfortable enough, you don't go to a medical clinic. You go to a shoe store and buy better, more comfortable shoes. I think we should allow inmates the same right by making jail sneakers available on commissary as part of the OTC commissary program. Consider making arch supports available on commissary, as well. Some jails give these jail sneakers to the elderly and to women in their third trimester of pregnancy.

Summary: The key points in creating an "Own Shoes" policy for your facility are:

1. *The only medically necessary footwear is orthotics, which are prescribed by a physician and fitted in a medical clinic.*
2. *There are no medical indications for "own shoes" from home.*
3. *Diabetics and neuropathic patients may be fitted with facility-purchased sneakers as part of their medical management plan.*
4. *It is a good idea to offer sneakers and arch supports in the commissary so inmates can purchase them without having to go through medical.*

Dietary Issues

Many prison and jail facilities have adopted heart healthy options that have replaced or at least mitigated the problems with institutional food historically filled with sugars, starches and fats. Review the Dietary Manual and understand how to prescribe medically indicated special diets. Long term special diet needs should be addressed as part of chronic care/disease management. Other departments may have oversight for dietary issues. Chaplain Services typically have the responsibility to determine religious diet needs.

Medical providers are gatekeepers for liquid dietary supplements, double portions at meal times and/or bedtime snacks. These items have value in the jail or prison "black market" and increase the work for security, dietary and medical staff. Before ordering, consider these issues and document medical necessity based upon both subjective and objective information which may be as basic as confirming weight loss or "low blood sugar." Many facilities have criteria related to body mass index and availability of additional food. Liquid supplements are generally restricted to persons with issues related to mastication such as those recovering from mandible fracture reduction.

Food allergies present issues in the correctional environment including the over-diagnosis which can result in significant food service operational challenges. Medical providers should make distinctions between food allergy and food intolerance and provide education on avoidance. Another article published by Dr. Jeffrey Keller in June 2012 (www.jailmedicine.com) offers practical advice by in addressing these differences follows. The information is offered not as an official endorsement but as an insight into the intricacies of correctional healthcare.

"I Can't Eat That!" Introduction to Food Allergies in Corrections

In my previous incarnation as an emergency physician (before I discovered "The Way" of correctional medicine), I saw a lot of cases of acute allergic reactions. It is a very common emergency complaint; I have probably seen hundreds in my career. But when I began my jail medicine career, I was still unprepared for the sheer volume of food allergies claimed by inmates. Who knew so many inmates had so many food allergies?

Of course, most of them don't. Most just don't want to eat something on the jail menu. Inmates believe that if they claim an allergy to a food they dislike, you cannot serve it to them. They will claim allergies to tomatoes, onions, mayo, etc., when really, they just don't like these foods. Tuna casserole doesn't seem very popular, for some reason.

However, some inmates truly are allergic to some foods and we can potentially harm them by ignoring their complaint. How do we correctional medical staff sort out the truly allergic from the "I don't like it" crowd? It is an important question because we certainly don't want anyone in our care to have a sudden anaphylactic reaction!

To answer this question, we need to understand the mechanism of food allergies, the overall incidence of food allergies as well as the incident of death, how to accurately diagnose a true food allergy and what steps to take once we find one. All of this is important to make accurate risk assessments.

The incidence and causes of food allergies vary markedly with age. For the most part, food allergies are a problem of childhood. In children, the most common food allergies are milk, eggs, wheat and nuts. However, most of these allergies abate with time. So a child who is allergic to eggs most likely will be able to eat eggs as an adult. One important exception to this rule is peanuts and tree nuts (like almonds, cashews, etc.). Those allergies tend to persist into adulthood. The most common adult food allergies are peanuts, tree nuts, shellfish and fish.

True food allergies come in two types. The first are called IgE Mediated Allergic reactions because the IgE antibody is essential to the reaction. The second type of allergic reactions does not involve IgE and so, of course, are called non-IgE mediated food allergies. The best example of this is celiac disease in which patients are allergic to gluten found in grains. Non-IgE mediated allergic reactions are typically indolent and chronic and may not be discovered for several years.

IgE is an antibody that is created by the body to react to a specific antigen substance. This substance can be ragweed pollen, of course, but it also can be food proteins. Later on, if the person eats the same food to which IgE was created, the protein locks onto the IgE which causes the release a bunch of inflammatory chemicals, such as histamine, cytokinens, prostaglandins and leukotrienes.

The most common symptom caused by these inflammatory chemicals is hives, the itchy splotchy rash we have all seen. The second most common symptom is angioedema, which is swelling of the face. Angioedema most commonly occurs around the eyes but also rarely can cause the tongue to swell. Third and less frequently, the allergic reaction can cause bronchospasm in the lungs, so the patient wheezes as if having an asthma attack. Finally, the patient can suffer anaphylaxis, which consists of acute vasodilation leading to hypotension, shock and possibly death.

All of these allergic symptoms occur within minutes of eating. Allergic hives occurring several hours after eating are probably NOT due to the food.

Of these four allergic symptoms, by far the most common are hives and angioedema. However, most of the time hives and andioedema are nuisances rather than life threatening emergencies. On the other hand, anaphylaxis is an acute medical emergency. Anaphylaxis is the allergic reaction we should fear the most and work to prevent.

The CDC estimates that approximately 100 deaths from food allergies occur in the US

per year. Almost all of these deaths occurred in teenagers or young adults who knew that they were allergic to the food they ate. By far, the most common culprit foods are peanuts and tree nuts (85%) with shell fish coming in second. In contrast, 400 deaths due to allergic reactions to penicillin occur every year, most of those occur in people who have no idea that they are allergic.

Now let's summarize some of the more important points presented so far.

1. *Allergies tend to occur in childhood and abate with time.*
2. *If you were allergic to something as a child, most likely, you will not be allergic as an adult.*
3. *The important exceptions to this are peanuts, tree nuts, and shellfish. These allergies commonly do persist into adulthood.*
4. *The older you are, the less likely you are to have a severe anaphylactic reaction.*
5. *The food allergens most likely to produce anaphylaxis are peanuts, tree nuts and shell fish.*
6. *Most deaths due to an acute allergic reaction to food have had a previous severe allergic reaction.*

You can use these principles to do a risk assessment for individual patients. Patients at higher risk of an anaphylactic allergic reaction are those who are younger (late teens, early 20s) who state an allergy to peanuts, tree nuts or shellfish, and who have had a previous documented allergic reaction. Patients with a lower risk are older patients who state an allergy to a low risk food (say onions or peppers) and cannot document a previous severe allergic reaction. Someone who has had a severe allergic reaction to a food in the past should be able to tell you about an ER visit, allergy testing, EpiPen prescriptions and how they avoid the food in restaurants and while shopping.

However, there are other tests that also can help you sort out the confusing cases. The first is called a CapRAST test. This is a blood test that measures the levels of IgE to a certain specific allergen, say peanuts. We then draw blood for a CapRAST for peanuts. A positive result is peanut specific IgE of greater than 2.0 Ku/L. If the test comes back at, say, 0.35 Ku/L, then the patient is not allergic. The test is quite sensitive but not specific. That means that you can believe a negative result, but patients with positive results might still NOT be allergic. The main problem with a CapRast test is that it is expensive—around $45.00! However, that is probably less expensive than the cost in time and energy putting out a special diet.

A second test is the skin prick test. In this test, the patient's skin is pricked with a small instrument and a drop of allergen extract is placed on the site. If a patient is truly allergic, she will form an itchy wheal at the site within 5-15 minutes. The advantage of this test is that it is cheap and easy to do and the results are immediate. The disadvantage is that you have to order and store the extracts and be trained in the procedure, usually by an allergist.

"Food Challenge" tests probably should not be done in a correctional setting. This is where you simply feed the food to the patient and wait to see what happens. If this is done in a double blinded fashion, it is the most accurate test of all. Sometimes, patients

will have done their own food challenge without knowing it. For example, a patient might say he is allergic to eggs but admits to eating pasta and mayonnaise, both of which are made with eggs. He is likely not truly allergic.

Of course the easiest way to deal with the foods most likely to cause severe allergic reactions is not to serve them at all. Most jails do not serve shellfish to inmates (if your jail does, write me; I would like to know about it!) If your facility uses tree nuts in cookies, consider eliminating them from the menu. Then you won't have to worry about it. That just leaves peanuts as the food served in most prisons and jails that has the greatest potential to cause allergic reactions.

Once you have discovered that a patient has a positive CapRAST test to peanuts, what should you do then? It may not be enough to simply order a peanut free diet. Since allergic reactions can be triggered by even a small amount of allergen contact, you should consider these other factors:

1. *You probably have peanut-containing items on your commissary. Should this inmate have a commissary restriction?*
2. *Should this inmate be allowed to work in the kitchen, preparing peanut butter sandwiches?*
3. *Should this inmate be housed with other inmates who may be eating peanut butter sandwiches right next to him?*
4. *What about an Epi-pen? Where should it be kept?*

Hopefully, this information will make you a little more confident the next time an inmate says she is allergic to, say, "all vegetables" (as one patient told me once). You can also use these principles of risk assessment, history and testing to write a Policy and Procedure for the clinical assessment of food allergies. If you need help, email me and I will send you mine.

1. *Adkinson: Middleton's Allergy: Principles and Practice, 7th ed.*
2. *Essential Evidence: Food Allergy. https://www.essentialevidenceplus.com/content/eee/4*
3. *Food allergy: a practice parameter. ANNALS OF ALLERGY, ASTHMA & IMMUNOLOGY, VOLUME 96, MARCH, 2006.*
4. *Food Allergy: Diagnosis and Management, Atkins, Prim Care Clin Office Pract 35 (2008) 119–140.*

"Wants" vs. Medical Needs Summary

The information in this section is intended to provide you with general knowledge and understanding of the common "wants" of persons incarcerated and how to effectively handle. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Are there common themes to requests from patients that I should be aware of? How are these addressed by healthcare staff?
- Where is the Diet Manual, how are special diets handled, are there any special dietary issues such as patient requests for Ensure at this facility?
- Is there a significant problem with bottom bunk issues at this facility?

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Chapter 17: Telehealth

Overview

Telehealth is the delivery of health-related services through telecommunication technologies. Telehealth is an expansion of telemedicine and includes mental health services as well as healthcare staff video-conferencing and training opportunities. Telehealth enables treatment staff to provide care at a distance. It eliminates travel and access-to-care barriers while supporting transmission of medical, imaging, bio-signals, and other healthcare information across hundreds of miles. Rapid advances in technology have made telehealth highly reliable, with visual and auditory fidelity that is essentially indistinguishable from "in person" service delivery. Sophisticated equipment now goes well beyond cameras, microphones and cables. Telehealth routinely includes advanced diagnostic and service delivery tools for specialty care and HIPAA-compliant encryption and transmission of personal health information, including the transmission and delivery of telehealth services themselves.

The use of telehealth has expanded rapidly as more agencies have learned that the services being provided with the use of technology are equivalent in quality and outcome to those provided in person. With the use of technology, people in remote communities are now receiving improved access to specialty providers. They no longer have to travel long distances in order to receive care. Correctional facilities are often found in very remote parts of a state. In many instances, these are ideal locations for the provision of telehealth services. The ability to use technology to provide medical and mental health services assists in improving patient access to care; enhances public safety by reducing off-site travel; and helps manage costs related to the provision of healthcare, including the diversion of correctional officers to escort patients to off-site healthcare appointments.

Our telehealth program is not a "one size fits all" product. We design and tailor each telehealth program individually to meet the technological and operational needs of the correctional system. Our approach involves ongoing collaboration with our client and a thorough analysis of the requirements for each program. We assess each stakeholder's requirements and evaluate any technology already in place to ensure required services can be provided as needed in a manner that is consistent with the community standard of care, national telehealth guidelines, and state and local regulations and standards. We also ensure that telehealth services are provided in a confidential, HIPAA-compliant manner. To achieve these goals, each telehealth program must be designed to meet the unique needs of the correctional system.

Implementation of a telehealth program is not a one step process of installing equipment and communication lines. Although the technology is essential and an important part of this process, established protocols, training and ongoing monitoring ensures the success of the programs. Using information acquired from established American Telemedicine Association guidelines for the provision of healthcare as a reference, we work directly with our clients and individual programs to develop individualized policies and protocols identifying the clinical applications, guidelines for staff credentialing, HIPAA compliance, training requirements for staff on the use of telehealth services, and ongoing quality improvement studies.

We have used telehealth to facilitate clinical case conferences, physician mentoring and re-entry initiatives. Participation in a weekly video conference among all healthcare partners in one contract assisted in improving continuity and quality of care for the patients. Medical Directors have used the telehealth technology to provide face-to-face supervision and mentoring without the need to travel long distances. We have also designed a system to allow the Medical Director to consult with the nurse practitioner at a remote site for more immediate delivery of services for patients requiring this higher level of consultation without incurring the costs associated with travel to the remote site.

Telemedicine

As a medical provider practicing in a correctional environment, you will encounter growing use of telemedicine. Our medical providers can be ensured that protocols have been established to ensure compliance with national telehealth standards, state professional boards, and local regulations and policies. Training and ongoing support in telemedicine are provided for all staff.

With the appropriate peripherals on the video-conferencing equipment, medical care at a distance is possible. We invest in technology to ensure that our networks for telemedicine facilitate quality transmission of video, audio and other health-related information. Currently, telemedicine is primarily used to provide specialty consultations for patients. The types of specialty consultations are limited only by the availability of specialists with telemedicine capabilities, and telehealth specialists continue to grow.

The process of selecting and receiving approval for a specialist consultation uses the same utilization management criteria that are required for in person visits. Since the provision of telemedicine services at facilities with a telemedicine unit is coordinated centrally, specialist appointments can be scheduled with the goal of decreasing inmate waiting times and maximizing the efficiency of specialty provider clinics. Our programs rely on the use of telemedicine for specialty consults as much as is clinically feasible to improve access to specialists and reduce off-site transportation. The need to transport patients to off-site locations for services can be disruptive to the patient, disruptive to the specialty providers and disruptive to security staff.

Based on the approval of our clients, we implement telemedicine capabilities in as many facilities as possible to permit current medical providers to provide coverage at other facilities for medical provider absences related to vacations and illness. This process facilitates continuity of care and ongoing access to care delivered by providers skilled in correctional healthcare.

Telemental Health Experience

While our telemedicine services are still growing, we already have extensive experience with the delivery of telemental health. Telemental health includes telepsychiatry as well as other mental health services delivered at a distance. We provide thousands of individual telepsychiatry contacts annually. Like our telemedicine services, our telemental health services are expanding rapidly.
Across the United States, use of telepsychiatry has significantly expanded in correctional environments. Telepsychiatry has enabled contractors and correctional systems to

improve the provision of psychiatric services in very remote facilities. The benefits of telepsychiatry include:

- Improved access to care
- Flexibility in psychiatric coverage
- Improved ability to recruit psychiatric staff
- Efficiency in care

Telepsychiatry provides an advantage in recruiting and flexibility in staffing remote facilities. Telepsychiatry can be used as the primary source of psychiatric coverage or to augment coverage at sites with the video-conferencing technology.

Telemental health has been used to provide face-to-face staff supervision and inter-facility treatment planning conferences. Additionally, the use of telemental health in the re-entry process is gaining use allowing us to facilitate interaction between the soon-to-be released inmate with serious mental illness and the community mental health center from which they will receive ongoing treatment prior to leaving prison. Research supports that this visual contact will improve compliance with mental health treatment upon re-entry, which will ultimately reduce costs for all. This initiative can be readily adapted for medical services when patients have complex chronic healthcare conditions and/or acute medical needs and require close monitoring and collaboration upon release to the community.

In the span of a few short years, we have come a long way in the delivery of telemental health services. The growth of telemental health services was initially driven by demand, as there was simply no alternative to deliver services at remote sites using traditional in-person clinics. However, as psychiatric staff grew more comfortable with the use of technology for the provision of psychiatric services and saw the capability allowed for comparable levels of service; the perception changed and has allowed for continued growth.

We have completed two large scale patient satisfaction surveys to explore whether patients are as satisfied with services provided through telepsychiatry as with those services provided on-site. Results from both studies revealed that patients are as satisfied with telepsychiatry services as they are with psychiatric services received in person. This is an important finding, because we know that patient satisfaction correlates with compliance with treatment. Ongoing studies concerning satisfaction are pursued in all programs providing services through telehealth.

We have also conducted a psychiatric provider satisfaction survey which produced results supporting the continued use of telepsychiatry. Our providers overwhelmingly supported the use of telepsychiatry and have appreciated the flexibility this additional means of providing services has provided as well as the ability to respond more immediately to patient treatment needs.

Telehealth Summary

The information in this section is intended to provide general knowledge and understanding of the growing use of telehealth within correctional settings. The following

space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- Is telehealth used at this facility?
- If telehealth is used, what services are provided through telehealth?
- Are case conferences/training provided through telehealth?
- Where are telehealth services provided?
- What are the policies for providing telehealth services?

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Chapter 18: Mental Health and Physical Health Collaboration

Overview

The information in this chapter is presented to heighten awareness to the significance of the impact of patients with serious mental illness in the correctional environment and to reinforce the need for strong integration and collaboration between medical and mental health professionals in addressing the needs of this population.

A 2006 Special Report of the Bureau of Justice estimated that 705,600 mentally ill adults were incarcerated in State prisons, 78,800 in Federal prisons and 479,900 in local jails. These numbers have continued to rise as mental health care in our communities has continued to lag behind the need for care.

In 2010, it was estimated that 40% of all individuals with serious mental illness had been incarcerated, and about 16% of all inmates suffer from serious mental illness. In county jails, research indicates that about 31% of female detainees and 14.5% of male detainees suffer from serious mental illness. In prisons, roughly 20% male inmates and 40% to 50% of female inmates are receiving psychotropic medications at any given time.

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Psychotropic medications used to treat schizophrenia and bipolar disorders can have side effects that can exacerbate already high levels of medical comorbidities and cardiovascular risk factors. This coupled with the accelerated aging rates of incarcerated individuals and the incidence of age-related dementia contributes to the "perfect storm" that correctional healthcare professionals face.

In our experience, the foundation of any effective clinical relationship is open communication and a culture that supports and encourages exchange of information. It is important for medical providers to collaborate with psychiatric staff and other members of the mental health team when:

- Facing unexplained changes in patients with chronic medical and serious mental health diagnoses
- Evaluating or "clearing" patients for admission to acute mental health units with significant chronic co-morbidities
- Caring for patients who require a team approach including "hunger strikes" and end-of-life care
- Ensuring continuity, safety and efficacy of medications that may have serious side-effects but must be balanced against benefits

One of the most effective means to support collaboration is regularly-scheduled case conferences devoted to the review of seriously ill dual-diagnosed patients and other patients identified who may have special needs.

The following articles are intended to encourage exchange of information and ideas and do not necessarily represent a comprehensive review of this topic and should not take the place of clinical judgment.

An article written by members of our Clinical Operations team, Dr. Sharen Barboza and Dr. John Wilson, provides an overview of the importance of multidisciplinary collaboration between medical and behavioral health staff and an introduction to the concept of integrated care. The 2013 article, published in *CorrDocs, Volume 17*, Issue 5, is entitled *Your patient is my patient: The need for integrated medical-mental health care for inmates with serious mental illness*.

From emergency intervention and acute care to chronic care and end-of-life services, coordination and integration of medical and mental health care are essential. Within correctional populations, coordinated and integrated preventive and chronic care services are most needed for inmates with comorbid mental and medical illnesses. Roughly 11% of the inmate population suffers from both serious mental illness and chronic medical disease, a figure that is likely to rise as the inmate population ages. These inmates belong to a high-risk group with an associated life expectancy that is up to 25 years shorter than that of individuals without serious mental illness.

Mental Illnesses Are Bad for Your Health

Individuals with serious mental illness have more medical illnesses, significantly shorter life expectancies and higher standardized mortality ratios than the general population.

Compared to individuals without serious mental illness, individuals with serious mental illness have double to triple the risk of early death due to medical disease.

Suicide has received the most attention as a cause of premature death among those with mental illness. However, chronic medical disease, not suicide, is responsible for 60% of the excess mortality and 75%-87% of the years lost due to premature death among these individuals. On average, individuals with serious mental illness live 10 to 25 years less than those without serious mental illness. This mortality gap may be widening. Similarly, individuals with personality disorders live 17 to 19 years less than those without these disorders.

Many individuals with serious mental illness are living and sometimes dying inside our jails and prisons. Rates of serious mental illness are two to four times greater in jails and prisons than they are in the general public, and the overall prevalence of serious mental illness in jails and prisons is estimated to be 16%. Approximately 60%-70% of individuals with serious mental illness also suffer from a chronic medical condition; nearly half of these individuals suffer from two chronic medical conditions. Comorbidity of serious mental illness and chronic medical conditions may be even higher among populations with significant substance use disorders.[24]

Taken together, these figures suggest that 1 out of every 9 inmates suffers from both serious mental illness and chronic medical illness. For inmates with serious mental illness, comorbidity of medical and mental illness is the rule, not the exception. Moreover, the inmate population is aging faster than the national population, resulting in increased need for both health and mental health services. With increasing age comes the increasing likelihood of comorbidity and more severe, more complicated disease.

Challenges to Integrated Services

Given the high rates of comorbid medical conditions and decreased life expectancy from preventable and/or treatable medical conditions, the need for integrated medical and mental treatment is clear. Researchers and policy-makers who study the elevated mortality rates among patients with serious mental illness consistently call for integrated delivery of medical and mental health services. Instead of integration of services, fragmentation of services is common.

Primary care providers in the community are often confronted with the need to diagnosis and treat patients with serious mental illness. More often than not, their training in the diagnosis and treatment of serious mental illness is limited. Additionally, many primary and general medical providers have limited experience working with seriously mentally ill patients. As such, providers may be limited in their ability to conduct a differential diagnosis which rules out psychiatric symptoms, provide adequate education in the context of the mental illness and provide support for treatment adherence. General medical providers in the community have reported that the primary barriers to seeking psychiatric services for their patients include poor referral resources and poor follow-through on referrals by patients.

Theoretically, service delivery in correctional facilities should avoid many of the challenges to integrated and effective treatment found in the community. Correctional systems possess unique advantages for integrated service delivery. Treatment staff are able to screen the entire population and provide primary medical services and psychiatric services to all patients who require them. Medical infirmaries and inpatient mental health units are often co-located; chronic care clinics for medical and mental health services often occur in the same offices. Referrals to psychiatric or other mental health providers are relatively easy and there are no issues related to insurance coverage to confront. Referred patients are often scheduled automatically through a centralized system and are seen within stringent timelines set by NCCHC standards. At least in theory, treatment non-adherence and substance abuse can be quickly identified, thereby limiting two of the most challenging obstacles to effective chronic care in the community.

Despite these potential advantages, medical and mental health services in most correctional systems are far from integrated. Figure 1 illustrates the typical organizational structures for medical and mental health services in a prison or jail. Each service is organized vertically and separately. Horizontal integration, in terms of routine communication and collaboration between medical and mental health providers, is generally limited or absent below the level of senior managers and administrators.

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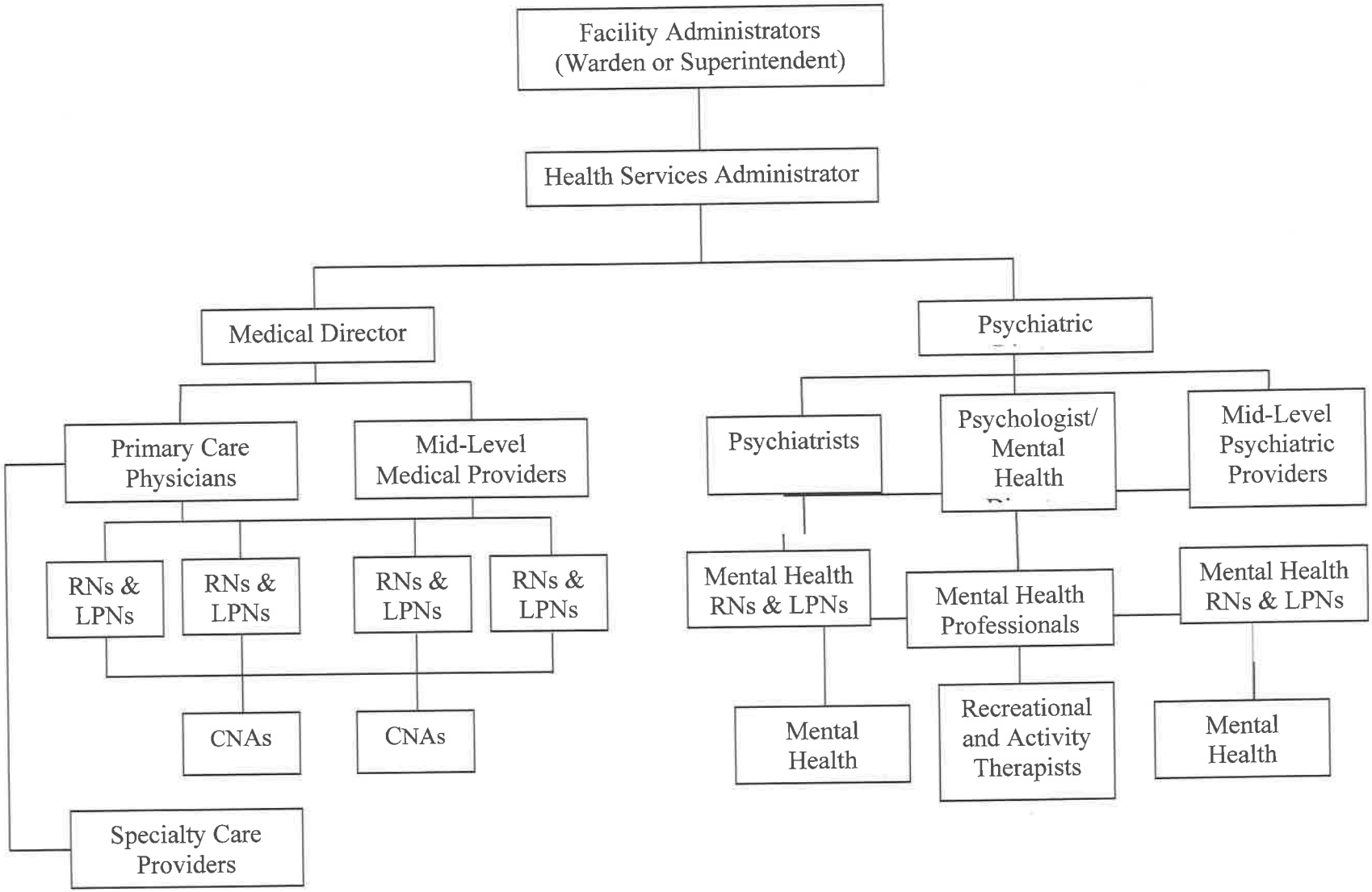
Figure 1: Traditional Vertical Organization of Healthcare Services in Correctional Institutions



Typically, by the time senior managers or administrators become involved in the care of an inmate, a bad outcome has already occurred. Collaboration is after-the-fact, through a post-incident failure analysis, root cause analysis, or morbidity and mortality review. At their best, these processes result in improved service delivery through the implementation of new safeguards and procedures. Even then, the result may not be integration of medical and mental health services. Think about your system. Despite the close proximity of medical and mental health providers within your institution, how frequently do joint medical-mental health *treatment* meetings occur? How often do an inmate's primary medical provider and primary psychiatric provider sit in room and discuss the coordination of care for that individual?

In order to move towards a more integrated service delivery model, medical and psychiatric providers need to assume joint responsibility for the patient with comorbid medical and mental illnesses. To do that, providers need to be aware of the pitfalls that interfere with detection, monitoring and treatment of comorbid conditions and service delivery models that have resulted in successful integration of medical and mental health services.

Pitfalls in Detection, Monitoring and Treatment

What of the link between excess medical comorbidity and excess mortality among the seriously mentally ill? Researchers who study the treatment of chronic medical conditions in individuals with serious mental illness almost universally point to under-detection, under-monitoring and under-treatment of medical conditions compared to the same services in the general population. Problems in health care have been estimated to contribute to 10%-15% of premature deaths nationwide and to 25% of premature deaths among individuals with serious mental illness. It is critical to recognize challenges in service delivery for individuals with serious mental illness. Understanding and overcoming these challenges is all the more important in the context of incarceration, where inmates have a constitutional right to necessary healthcare.

Fear and Stigma

Beyond patient availability and cooperation, at least three factors may contribute to under-detection, under-monitoring and under-treatment of medical conditions among inmates with serious mental illness. The first potential factor is fear of individuals with serious mental illness and resulting stigma and discrimination. Researchers have suggested that healthcare providers perceive individuals with serious mental illness to be dangerous and/or possess diminished capacity to understand and follow treatment. These biases contribute to decreased delivery of healthcare services. In the context of jails and prisons, experience confirms that each correctional system typically has a number of high profile inmates with serious mental illness, serious medical illness, dangerous behaviors and poor levels of cooperation with treatment. Provider experiences with these inmates can lead to the perception that other inmates with comorbid medical and mental illnesses will be difficult and problematic. Prejudgment may lead to a generalized reluctance to provide adequate treatment to inmates in need of services who have both serious medical and mental health conditions.

While this hypothesis remains under-researched, evidence consistent with provider biases can be found in patient perceptions. In a recent survey conducted by the National Alliance for the Mentally Ill, patients with serious mental illness reported that their psychiatric diagnosis impeded appropriate attention to physical health concerns.

Nearly half of the patients surveyed said that doctors took their medical problems less seriously once the doctors learned of their psychiatric diagnosis. Thirty-nine percent said their psychiatric diagnosis made it more difficult to obtain access to physical healthcare.

Diagnostic Bias

The second potential factor reflects not fear and social bias, but diagnostic biases, including what has come to be known as "diagnostic overshadowing." Although the term "diagnostic overshadowing" originally referred to the tendency for a diagnosis of intellectual disability to "overshadow" or eclipse consideration of comorbid mental illness, the term has since generalized to refer to the tendency for one diagnosis to eclipse consideration of potential comorbidities. Researchers have suggested that diagnostic overshadowing may be common in the context of treating individuals with serious mental illness.

According to this hypothesis, serious mental illness frequently overshadows consideration of serious medical illness, resulting in under-detection and under-treatment of the medical illness. Diagnostic biases may be most consequential in emergency care, when serious medical conditions such as hypoxia, delirium, metabolic abnormalities, or central nervous system infections are misdiagnosed as psychiatric illness because the patient is already known to suffer from serious mental illness. The diagnostic overshadowing hypothesis is consistent with patients' reports that their psychiatric diagnosis made it more difficult to obtain medical care. It is also consistent with findings that physicians underestimate the probability of medical disease and obtain fewer appropriate tests when a hypothetical patient has a history of mental illness.

Think about the practices within your own system. How often does a psychiatric illness "trump" consideration of a medical condition? Do you know of occasions when diagnostic testing for a medical condition has been delayed or omitted once the presence of psychiatric symptoms is discovered?

Segmentation/Fragmentation of Services

When medical and mental health care are provided in a segmented or fragmented service delivery system, shared professional responsibility for comorbidity is difficult if not impossible to achieve and maintain. There is no doubt that medical and mental health providers in corrections are stretched, typically beyond capacity, by large caseloads of seriously ill inmates. Under these conditions, diffusion of responsibility and failures to communicate and coordinate can readily occur.

Consider your system and the multiple points of contact that are required between medical and mental health providers. Which profession is responsible for routine monitoring of serum glucose and lipids for inmates receiving second generation antipsychotic medications? When significant metabolic abnormalities develop in the context of treatment with antipsychotics, which discipline is responsible for treatment of the abnormalities? Who obtains and reads baseline electrocardiograms for inmates receiving tricyclic antidepressants? When an inmate has a significant change in mental status while housed in mental health unit, who is responsible for ruling out medical causes? When an inmate with serious mental illness requires outside medical care, how are the inmate's medical and mental health treatment needs coordinated to ensure continuity and consistency across locations? If an inmate refuses necessary medical

treatment and impaired decision-making capacity is suspected, who conducts the capacity evaluation? Which profession is responsible for the treatment and management of inmates with dementia?

Integrated Service Delivery

Although the list of areas in which coordination between medical and mental health services is potentially endless, an integrated care model of service delivery provides a straightforward solution to potential challenges in the medical-mental health interface. The integrated care model has a simple goal: care coordination.

Coordination of care for inmates with serious mental illness is best achieved when dedicated treatment coordinators or "care managers" are built into correctional mental health staffing models. In the integrated service delivery model, responsibility for the coordination of all healthcare needs of inmates with serious mental illness rests with the care manager. Structured opportunities for interdisciplinary treatment planning and consultation among the care manager, medical and psychiatric providers are built into the work week. Optimally, providers are co-located and scheduled proximately to facilitate the inmate's access to care and the coordination of care across disciplines. Organizational and service delivery infrastructure can be redesigned to support integration of care so that medical screening, monitoring and treatment are inclusive of the mental health care manager, who also consults with the psychiatric provider.

Under this model, the care manager is able to integrate all current needs and interventions into a single treatment plan. In turn, the treatment plan reflects coordination of *all* healthcare services, not just mental health services or just medical services. The mental health care manager is also responsible for the critical task of providing self-management skills training to the inmate to address both medical and mental illnesses. These skills, which take into account limitations of both physical and psychiatric symptoms as well as the individual strengths of the inmate, support treatment adherence and improve treatment outcomes.

Figure 2 illustrates the integrated care service delivery structure. As can be seen, service delivery is coordinated by the care manager. The inmate with serious mental illness also takes a central role in this process. Involvement of the inmate as a central stakeholder rather than a passive service recipient is critical to integrated healthcare and consistent with the recovery model.

Figure 2 is not an organization chart and does not reflect traditional lines of formal supervision. While job descriptions and performance expectations need to be redefined and expanded under an integrated service delivery model, supervisory hierarchies can remain largely unchanged.

Implementation of integrated service delivery for inmates with serious mental illness requires significant changes in culture and healthcare delivery models. The introduction of care managers into the mental health staffing matrix and provision of structured time for medical and mental health staff to collaborate can be associated with additional upfront costs to the correctional system. To offset these costs, improved service delivery, increased treatment adherence, timely and positive medical outcomes and reduction in preventable hospitalizations can be realized, resulting in cost savings over time. Programs using integrated care models for service delivery for individuals with

serious mental illness have demonstrated success in Medicaid and Medicare patient-centered homes, the Veteran's Administration, and SAMSHA projects involving community mental health centers. For individuals with serious mental illness, integrated service delivery either does not increase overall healthcare costs or realizes cost savings that off-set initial cost increases.

There can be little doubt that inmates with serious mental illness require external and ongoing support to receive the medical and mental health care they need. It is challenging enough for medical and mental health professionals to sort out which symptoms are psychiatric and which are medical; expecting inmates with serious mental illness to be able to do so and to advocate for themselves effectively is not realistic. Impairments in functioning, insight, self-care, communication and behavior associated with serious mental illness make this a particularly vulnerable population. Support in accessing necessary medical and mental health services is needed. Both medical and mental health needs must be considered during assessments and treatment interventions. This is where a care manager is needed. At the center of an integrated care model is the care manager and the inmate.

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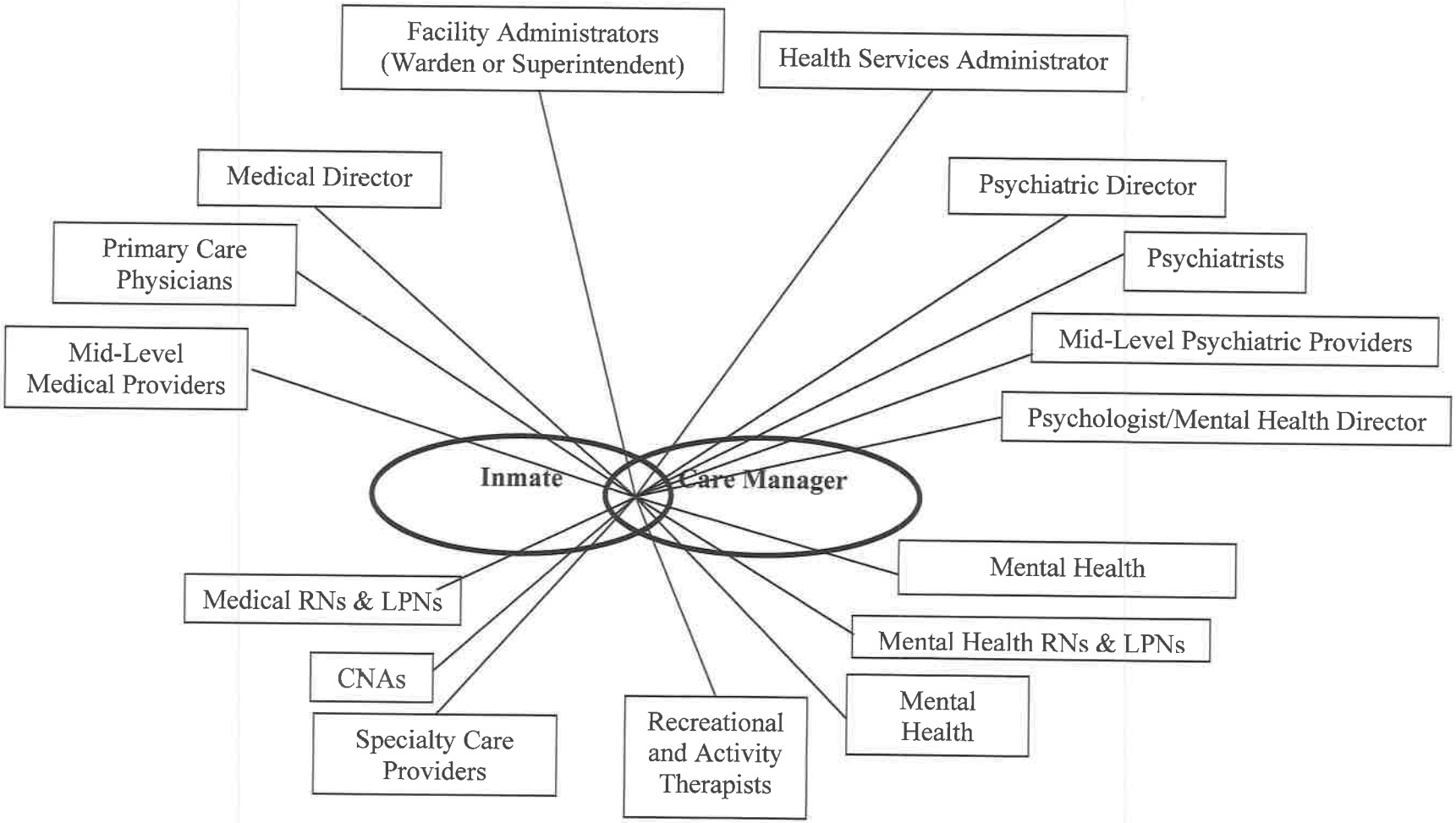
Figure 2: Integrated Service Delivery for Inmates with Serious Mental Illness



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Health and wellness are achieved not only through the delivery of health and mental health services once diagnoses have been made, but also through preventive care, including psychoeducation and behavioral interventions to improve inmate self-care and treatment adherence behaviors. Nearly 40% of premature mortality may be due directly to patient behavior, and at least some proportion of the genetic contributions to premature death may only be activated in the presence of lifestyle behaviors that are modifiable. Care managers can help inmates by supporting behavior and lifestyle changes that address current and predictable health concerns. For example, research has reliably demonstrated a link between cardiovascular disease and serious mental illness. Patients suffering from their first psychotic episode may not yet be at elevated risk for cardiovascular disease and primary prevention efforts at this stage may be particularly important. Through the integrated medical and mental health services facilitated by a care manager, preventative, health-promoting behaviors can be supported. Integrated health care services help bring about integrated health behaviors in the inmate population.

Conclusion

Overall health and wellness are dependent upon access to healthcare, including early detection and preventive care; trust in the healthcare system; enhanced knowledge regarding self-care and healthcare; psychosocial support; improved diet, exercise and weight management; and lower rates of smoking. Inmates with serious mental illness need support to access healthcare and attain optimal health. It is only through integrated health service delivery that this can be achieved. The days of practicing fragmented healthcare are coming to an end, both in the community and in corrections. All healthcare professionals are responsible for supporting systems of integrated care. He is not your patient. She is not my patient. They are our patients.

This article appeared in *CorrDocs* Volume 17/Issue 5/Winter 2013. *CorrDocs* is the newsletter of the American College of Correctional Physicians (ACCP) newsletter, previously the Society of Correctional Physicians. For more information about the ACCP, go to the website, http://accpmed.org.

Psychiatric Issues in Medical Management:

Information presented March, 2013 representing current practices at Bridgewater State Hospital, Bridgewater MA

When patients present with acute symptoms or abnormal lab results, please consider as part of the differential diagnosis the possibility that their psychiatric medications may either be causing their symptoms, or may need to be adjusted or discontinued. The following summary is intended as an overview of some of the more common issues caused by, or related to the psychotropic medications most typically used at the Bridgewater State Hospital.

Clozaril-Related Concerns:

- Patients on Clozaril are at risk for neutropenia, infection, orthostasis, sialorrhea, and aspiration pneumonia.

- If a patient presents with a decreased WBC or ANC, please consult the policy on Clozaril Prescribing/Monitoring. WBC levels below 3500, or ANC levels below 2000 REQUIRE an alteration in the administration/monitoring of the medication.

- Patients who present with a fever or sore throat while taking Clozaril should be worked up for neutropenia even if they've had a recent CBC which was normal.

- Fever of 101.5 or higher REQUIRES transfer of the patient to the nearest emergency room for a stat workup to exclude neutropenia.

- Because of the potent CNS sedation which this medication can cause, Clozaril should not be routinely combined with other CNS sedatives (anti-histamines, benzodiazepines, opiates, barbiturates). If a patient on Clozaril presents with a change in mental status, or increased sedation/lethargy, consider adjusting/eliminating concomitant sedatives, and consider obtaining a serum level of clozapine (levels in excess of 600ng/ml may be contributing to the changes in mental status).

- Clozaril-related sialorrhea (hypersalivation) has been associated with aspiration pneumonia.

- Clozaril has been associated with fatal cases of acute myocarditis. 90% of cases occur in the first 8 weeks of treatment. In most of the reported cases there are serum elevations of troponin levels. Clinical suspicion of myocarditis in a Clozaril-treated patient is a medical emergency. In patients recently started on Clozaril, clinicians should maintain a high degree of suspicion for myocarditis. This is especially true if patients present with tachycardia, dyspnea, fatigue, chest pain, EKG changes, hypotension, or excessive fatigue. In these instances, an EKG, CPK-MB, and troponin level should be ordered, and consideration of transferring the patient to an emergency room should occur.

Lithium-Related Concerns:

- Patients can present with signs of toxicity which include nausea, vomiting, diarrhea, altered mental status, abdominal cramping, tremor, muscle weakness, and seizures.

- Suspicion of toxicity should be confirmed with a stat serum level.

- The Lithium Prescribing/Monitoring Policy REQUIRES that patients with a serum level >1.5mEQ/L be transferred to an emergency room for evaluation.

- Medications know to increase serum lithium levels are ACE Inhibitors, diuretics, and NSAIDS. Serum lithium level elevation can cause renal insufficiency, BUT can also be a manifestation of renal insufficiency.

- Lithium should be held until normal serum levels and renal function can be confirmed.

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Antipsychotic Medication-Related Concerns:

- As a class these medications can cause hypotension/orthostasis, cardiac conduction abnormalities, and EPS (including akathisia, acute dystonia, tremor, and Parkinsonism).
- Orthostasis is common with Risperdal.

Neuroleptic Malignant Syndrome (NMS)

- NMS can occur with any antipsychotic medication and is a life-threatening condition!
- It is most common with the older neuroleptic medications.
- Symptoms include diaphoresis, muscle rigidity, autonomic instability, changes in mental status, and hyperpyrexia.
- Risk factors for developing NMS include: Administration of high-potency neuroleptics, high doses or rapid dosage escalation, parenteral administration, dehydration, patients in restraints, impaired thermoregulation, or concomitant infection.
- An elevated CPK is typically present.
- This condition can be fatal and should be managed aggressively.
- Strong consideration of transfer to an emergency room in suspected cases is prudent.
- Patients on antipsychotics who present with a fever >101.5 MUST be transferred to the Infirmary and worked up for NMS, unless they're being transferred to an outside facility.
- If NMS is suspected, the offending agent(s) should be discontinued pending the workup and subsequent review by the Director of Medicine.

Hyponatremia-Related Concerns:

- Hyponatremia occurs frequently in chronically psychotic patients and this condition should be considered for any abrupt change in mental status or diminished level of consciousness.
- Patients with Na<130mmol/L MUST be transferred to the Infirmary on fluid restriction and sodium level monitoring.
- Patients with Na<124mmol/L MUST be transferred to an emergency room for acute evaluation.

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Mental Disorders Secondary to General Medical Conditions

Linda Chuang, MD, Chief Editor: Iqbal Ahmed, MBBS, FRCPsych (UK)

Updated: Mar 15, 2012

Overview

The psychiatric presentation of a medical disorder can be defined as "the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition," according to the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*). Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of the utmost importance.

However, evaluation of patients who present to hospitals or physicians with altered behavior and/or mentation can be time-consuming and difficult and may lead to symptoms being quickly and prematurely dismissed as psychiatric in nature. Nonetheless, the failure to identify the medical cause of psychiatric symptoms can be potentially dangerous because serious, and frequently reversible, diseases can be overlooked. Proper diagnosis of a psychiatric illness necessitates investigation of all appropriate medical causes of the symptoms.

The following features suggest a medical origin for psychiatric symptoms:

- Late onset of initial presentation
- Known underlying medical condition
- Atypical presentation of a specific psychiatric diagnosis
- Absence of personal and family history of psychiatric illnesses
- Illicit substance use
- Medication use
- Treatment resistance or unusual response to treatment
- Sudden onset of mental symptoms
- Abnormal vital signs
- Waxing and waning mental status

Medical Disorders That Can Induce Psychiatric Symptoms*

Medical and Toxic Effects	Central Nervous System	Infectious	Metabolic/Endocrine	Cardiopulmonary	Other
• Alcohol • Cocaine • Marijuana • Phencyclidine (PCP) • Lysergic acid diethylamide (LSD) • Heroin • Amphetamines • Jimson weed • Gamma-hydroxybutyrate (GHB) • Benzodiazepines • Prescription drugs	• Subdural hematoma • Tumor • Aneurysm • Severe hypertension • Meningitis • Encephalitis • Normal-pressure hydrocephalus • Seizure disorder • Multiple sclerosis	• Pneumonia • Urinary tract infection • Sepsis • Malaria • Legionnaire disease • Syphilis • Typhoid • Diphtheria • Human immunodeficiency virus (HIV) • Rheumatic fever • Herpes	• Thyroid disorder • Adrenal disorder • Renal disorder • Hepatic disorder • Wilson disease • Hyperglycemia • Hypoglycemia • Vitamin deficiency • Electrolyte imbalances • Porphyria	• Myocardial infarction • Congestive heart failure • Hypoxia • Hypercarbia	• Systemic lupus erythematosus • Anemia • Vasculitis

*Adapted from Williams ER, Shepherd SM. Medical clearance of psychiatric patients. *Emerg Med Clin North Am.* May 2000;18(2):185-98.[2]

This article in its entirety is available on http://emedicine.medscape.com/article/294131-overview. If you are not already a registered Medscape user, you may go to the Medscape web site and register.

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Mental Health and Physical Health Collaboration Summary

The information in this section is intended to provide general knowledge and understanding of the importance of collaboration between mental and physical healthcare teams. The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics you may want to discuss include:

- What mental health services are provided at this facility?
- How many patients at this facility receive mental health services?
- How many patients at this facility are diagnosed with a serious mental illness?
- Who are the psychiatric providers at this facility and when are they on-site?
- What multidisciplinary meetings do medical staff have with the mental health team?

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Chapter 19: Correctional Organizations and Resources

American Correctional Association

FOUNDED 1870

American Correctional Association (ACA) is the oldest and largest international correctional association in the world. ACA serves all disciplines with the corrections profession and is dedicated to excellence in every aspect of the field. From professional development and certification; standards and accreditation; networking, consulting, research and publications; and conferences ACA is a resource. The ACA is committed to its mission of improving practices in correctional systems by helping agencies provide correctional populations with safe and effective health service delivery. ACA is the leader in setting international and national standards for the quality of life and safety of correctional systems.

https://www.aca.org/

National Commission on Correctional Health Care

"NCCHC's origins date to the early 1970's, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in the early 1980's became the National Commission on Correctional Health Care, an independent, not-for-profit 501(c)(3) organization whose early mission was to evaluate and develop policy and programs for a field clearly in need of assistance.

Today, NCCHC's leadership in setting standards for health services in correctional facilities is widely recognized. Established by the health, legal and corrections professions, NCCHC's *Standards* are recommendations for the management of a correctional health services system. Written in separate volumes for prisons, jails and juvenile confinement facilities, plus a manual for mental health services and another for opioid treatment programs, the *Standards* cover the areas of care and treatment, health records, administration, personnel and medical-legal issues. These essential resources have helped correctional and detention facilities improve the health of their inmates and the communities to which they return, increase the efficiency of health services delivery, strengthen organizational effectiveness and reduce the risk of adverse legal judgments.

Building on that foundation, NCCHC offers a broad array of services and resources to help correctional health care systems provide efficient, high-quality care."

http://www.ncchc.org/

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American College of Correctional Physicians

The American College of Correctional Physicians (ACCP), formerly the Society of Correctional Physicians (SCP), is dedicated to the professional development of physicians in the specialty of correctional medicine.

ACCP members are united through the goal of improving public health by examining issues specific to the incarcerated and identifying solutions for medical professionals.

ACCP meets the needs of correctional physicians through education, advocacy, networking, and avenues of communication.

The ACCP supports and provides leadership to our members challenged with the internal and external obstacles to the care of the incarcerated.

A conferences and educational offerings occur annually in conjunction with the NCCHC Fall Conferences, with additional opportunities and conference during the year.

http://accpmed.org

Academy of Correctional Health Professionals

"The Academy of Correctional Health Professionals is the nation's community for correctional health care. Through publications, educational activities and special events, the Academy works to connect you with peers from across the country. The Academy provides you with the latest information and knowledge specifically designed to help you, the correctional health professional."

http://www.correctionalhealth.org/about/about.html

CorrectCare

"As the official voice of the preeminent organization in correctional health care, *CorrectCare* is a popular magazine in this unique field. It features news, articles and commentary on timely and important topics of interest to correctional health care professionals. Wide-ranging coverage addresses clinical and administrative practices for health services delivery, medical updates, governmental and other agencies that influence correctional facilities, law and ethics, professional development and much more. Each issue also shares news from NCCHC and its supporting organizations.

Published quarterly, *CorrectCare* has a controlled circulation consisting of members of the Academy of Correctional Health Professionals, NCCHC-accredited facilities and other qualified professionals. It is also posted in its entirety online."

http://www.ncchc.org/correctcare

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Correctional Health Care Information Offered by Centers for Disease Control and Prevention

http://www.cdc.gov/correctionalhealth/default.htm

State Resource Map Includes chronic and infectious disease information, links to corrections and public health departments, and correctional system overview

Data on Common Health Problems Find the latest statistics on the medical problems and other conditions reported by prison inmates

Scientific Reports and MMWRs Find corrections-related journal articles by CDC authors from 2000 to the present disease topics include HIV, MRSA, TB and Hepatitis

Interim Guidance for Correctional and Detention Facilities on Novel Influenza A (H1N1) Virus Released in May 2009, this document provides guidance for correctional facilities during the outbreak of novel influenza A (H1N1) virus

Recommendations and Guidelines Find CDC's guidance on the prevention, care, and treatment of infectious diseases found in correctional settings

Health Education Materials Find brochures and facts sheets on infectious diseases and Traumatic Brain Injury for patients and professionals

- Research Regulations
- Federal Links
- Corrections Links

Academic Consortium on Criminal Justice Health

The Academic Consortium on Criminal Justice Health (ACCJH) is a member organization with a mission to advance the science and practice of health care for individuals and populations within the criminal justice system. As the academic home for its members, ACCJH advances health research, training and care for justice involved populations

ACCJH members benefit from the resources of an academic community that conducts breakthrough research in correctional health care, and develops and promotes a broader and more critical view of the relationships between community and inmate health care.

https://www.accjh.org

International Corrections and Prison Association

The International Corrections and Prisons Association (ICPA) is an innovative, learning platform which enhances international and inter-agency co-operation. ICPA actively promote policies and standards for humane and effective correctional policies and

practices, assisting in their development and implementation. ICPA believes that imprisonment is a last resort and supports the development of alternative sanctions and community corrections. ICPA believes in integrity and professionalism, the sharing of ideas and partnerships. ICPA believes in the capacity for positive change in individuals, their dignity and the duty to protect their rights.

https://icpa.org

Worldwide Prison Health Research and Engagement Network

Worldwide Prison Health Research & Engagement Network (WEPHREN), an open access collaborative forum for everyone interested in prison health globally, aiming to improve the health of people in prison through the equitable development of the evidence base and through capacity building initiatives for health.

https://wephren.tghn.org

NOTES:

Medical Provider Orientation Workbook

centurion™

How to Use this Orientation Workbook

This workbook is intended to help you locate orientation resources, ask contract and site specific questions and create a working reference guide as you transition into your new role.

The workbook is organized to follow the order of the topics reviewed from the Provider Orientation Checklist.

Correctional Environment – Chapter 1 Medical Provider Reference Manual

This following space is for your notes and questions. Include information that you need to discuss with the Medical Director, DON, and the Health Services Administrator.

Topics to discuss include:

- Does this system or facility have any active Consent Decrees? If so, what is medical's involvement?

- How do healthcare staff address inmates and what is the expected way inmates address healthcare staff?

- Are there "access to healthcare" issues at this site?

- Where do inmates report for medications and scheduled/non-scheduled healthcare appointments?

- Will I need to go see inmates in areas outside the healthcare unit?

- What are examples of inmate health information that might be shared, who can it be shared with, and why might the information be shared?

- How and who is responsible for providing information requested by security or administration staff?

- What is the process for obtaining medical records at the facility?

- When are consents for health services used at the facility?

ADDITONAL NOTES:

PREA and Forensic Health Information - Supplemental

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics to discuss include:

- How many PREA Reports are received by the institution?

- How many inmates receive examination and testing at community facilities and are test reports automatically sent to the facility? What role does the site medical practitioner take in follow up for inmates after a reported incident has occurred?

- What is the reporting process or chain of command if there is a suspected incident?

- Do medical staff receive directives for court-ordered healthcare? If so, where are the correctional system's administrative directives or policies and procedures maintained?

- What involvement do medical staff have in court ordered directives?

- What is the medical provider's responsibility in the PREA process?

ADDITIONAL NOTES:

Security Overview and Awareness – Chapter 2 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and the Health Services Administrator.

Topics to discuss include:

- What are the titles of facility administrative staff and what is the suggested way to address them?

- What are the proper titles for security staff and what is the suggested way to address them?

- What is the process for entering your facility?

- What items are you allowed to be brought into the facility with you?

- Are you required to carry keys while in the facility? If yes, how are keys obtained?

- What is considered contraband and/or sharps in the facility?
  (Note: Make a request for a written contraband list, if available)

- What is your responsibility for controlling access to contraband?

- What are the requirements for security staff escorts when working in the healthcare unit?

- What are the requirements for security staff escorts when moving within the correctional facility?

ADDITIONAL NOTES:

Inmate "Wants" vs. Medical Needs – Chapter 16 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and the Health Services Administrator.

Topics to discuss include:

- Are there common themes to inmate special requests that I should be aware of?

- How are these addressed by healthcare staff?

- Is there a Diet Manual of listing of special medical diets? How are special medical diets handled? What are the requirements for requesting/ordering dietary supplements, such as Ensure?

- What is the process for managing special medical requests (i.e., bottom bunks, special shoes, and special blankets)? How is medical necessity determined for requests for these items?

ADDITIONAL NOTES:

Sick Call – Chapter 8 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and the Director of Nursing.

Topics to discuss include:

- How is the sick call process managed at the facility for inmates in general population and for inmates in specialized housing units?

- What are the contract-specific guidelines for common healthcare problems (also referred to as nurse protocols)?

- What nursing staff can perform nurse sick call? What are nursing/nursing extender staff responsibilities in the sick call process?

- What training do nursing staff receive before conducting sick call?

- How are inmates scheduled and/or referred to be seen by the on-site medical provider?

- Are there specific documentation/templates used to document encounters completed by the medical provider and/or nurse?

ADDITIONAL NOTES:

Disease Management/Chronic Care Clinics – Chapter 10 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and Chronic Care Coordinator.

Topics to discuss include:

- What are the more routine chronic diseases treated at the facility? What resources are there available for consultation for chronic disease care (i.e., infectious disease specialists)?

- What is the average number of inmates in each chronic care clinic?

- How are the chronic care clinics and associated diagnostic testing scheduled?

- Who coordinates and assists with the clinics?

- Are there special forms required for documenting chronic care clinics?

- Are Disease Management Summary treatment guidelines readily available?

- Are there multidisciplinary team meetings available for discussion of treatment for complex care patients?

ADDITIONAL NOTES:

Special Needs Inmates – Chapter 15 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and Director of Nursing.

Topics to discuss include:

- What types of "special needs" inmates are housed at the facility? Where are they housed?

- What is a provider's responsibility for classification determinations and communications with security?

- What types of "special needs" inmates can the facility not manage? Where and how are these inmates transferred to a facility that can manage those needs?

- Are there templates for documenting treatment plans for "special needs" inmates or is the plan documented in the Plan section of a SOAP note?

ADDITIONAL NOTES:

Medication Management – Chapter 9 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and the Medication Room Coordinator/Designee.

Topics to discuss include:

- Where can I find a copy of the most recent Formulary?

- What is the process and forms required to be completed by the provider when requesting a non-formulary medication? How are the requests handled?

- What are the medication administration times for this facility?

- What medications are allowed to be KOP? What medication are NOT allowed to be KOP?

- What OTC medications are available in the commissary and should inmate purchasing be encouraged?

- Are medications ordered through e-prescribing? If yes, what training will be provided and when will training be provided?

- How is the medication order refill process handled?

- How are controlled substances managed? What is the philosophy on use and ordering of controlled substances?

ADDITIONAL NOTES:

On-Site Emergency Care, Emergency Department Services, Hospitalizations and Infirmary Care – Chapter 12 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics to discuss include:

- Are infirmary services offered at this facility?

- If infirmary services are offered at this facility, what is the capacity of the infirmary, nursing skills provided, staffing levels, typical diagnosis, and typical length of stay?

- If infirmary services are not offered at this facility, where are inmates transferred for infirmary level of care?

- How often do emergency "man-down" calls occur in the facility? Are there any recurring issues?

- What is the typical response time of the ambulance? Are there any issues in emergency services accessing inmates?

- What emergency department is used by this facility?

- Does the emergency department routinely send discharge notes including copies of lab and other studies for inmates released from the emergency department?

- How many hospitalizations does this facility average monthly?

- Do inmates return to this or another facility when discharged from a hospitalization? When returning from an Emergency room visit or hospitalization, when will the provider be contacted and/or see the inmate for follow up care?

ADDITIONAL NOTES:

Laboratory and Other On-Site Testing – Chapter 13 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Director of Nursing and/or the Health Services Administrator.

Topics to discuss include:

- What testing is available on-site?

- Where are testing results recorded?

- How is testing ordered and scheduled?

- What is the typical turn-around time? Routine tests versus Stat tests?

- How are the results delivered to the provider for review? What documentation is required by the provider at the time review?

- How are critical values reported to the site and to the provider?

- What happens if an inmate does not get scheduled test? Is it rescheduled? Is provider notified?

- Is there a laboratory formulary? If not, are laboratory preferred testing groupings used?

- Who is the laboratory vendor(s)? If more If more than one vendor, what testing is performed by each vendor (i.e., state laboratory performs HIV testing only)?

ADDITIONAL NOTES:

Specialty Care and Off-Site Services – Chapter 11 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator, and the specialty appointment tracking staff

Topics to discuss include:

- What paperwork or electronic information must be generated to request a specialist referral? How and who will provide training on required process and required paperwork/systems?

- How will the referring provider know that the specialist appointment was completed? How will the provider know if the inmate refused the appointment or there are delays in scheduling the inmate for a specialty appointment?

- Will inmates returning from specialist appointments be automatically scheduled for an appointment to see an on-site provider? What is the referring provider's responsibility for review of the specialist information and documentation regarding ongoing plan of care?

- Who schedules appointments?

- Who are the medical specialists used?

ADDITIONAL NOTES:

Telehealth – Chapter 17 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Regional Telehealth staff, the Director of Nursing and/or the Health Services Administrator.

Topics to discuss include:

- Is telehealth used at this facility?
- If telehealth is used, what services are provided through telehealth?
- Are case conferences/training provided through telehealth?
- Where are telehealth services provided?
- What are the policies for providing telehealth services?

ADDITIONAL NOTES:

Utilization Management Overview - Supplemental

Chapter 11, Specialty Care and Off-Site Services, the Medical Provider Reference Manual presents an overview of the Centurion Medical Management/Utilization Management program. The following is offered to expand on the goals of the program and expectations for your role in implementing evidence-based healthcare services.

The guiding principles of Centurion's Utilization Management program include:

- Inmates have a constitutional right to medically necessary healthcare services.
- Healthcare services are provided by a physician-driven system of care.
- Healthcare services are provided at the appropriate time within a progression of illness and in the best and most secure setting.
- Utilization management program is the coordinated review of the interventional strategy and services provided to the inmate population for inpatient and outpatient services.
- Utilization management process is conducted by utilization management nurses and ancillary staff supported by a strong physician team.
- Utilization management program is clinically focused and patient-centric.
- Utilization management guidelines are consistent with nationally recognized evidence-based practices that are within the expected standard of care and provide the clinical foundation for consistency of medical practice.
- Utilization management review process does not interfere or create a delay in providing medically necessary care.
- Utilization management program facilitates timely access to healthcare by pre-service review of healthcare service requests. Process includes multi-level evaluation, determination of medical appropriateness and timing of intervention.
- Alternative treatment planning is a component of the utilization management review process when a specialty services request is not found to be medically indicated after application of evidence-based guidelines for standard of care.
- The utilization management program is metric driven. Information obtained from the utilization management program is analyzed to improve management of inmate medical care by use of designated metrics and dashboards.

Utilization management is part of a dynamic healthcare management process. Evidence confirms that the most effective and efficient approach to quality correctional healthcare is to consistently manage wellness, chronic medical illness, support aggressive acute care intervention, and maximize services provided by on-site healthcare staff.

Centurion has developed Clinical Guidelines to assist on-site providers in determining when a referral for specialty diagnostic procedures and interventions should be made. The Clinical Guidelines are based on current research and professional standards as well as "best practices" in correctional healthcare.

The Centurion utilization management program uses three types of reviews: prospective, concurrent and retrospective. Our process conducts prospective review of requested specialty services as well as concurrent and retrospective review of inpatient and outpatient services to determine medical necessity based on McKesson Health Solutions, LLC's InterQual® guidelines. InterQual® provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. We

use InterQual® criteria in determining medical necessity and place of service for specialty referrals, outpatient and ancillary services as well as determining level of care and continued appropriateness of inpatient care.

Prospective Reviews:

The Centurion utilization management program is supported by a proprietary product, *TruCare*™. *TruCare*™ is a patient-centric integrated disease, care and utilization management product that offers clinical appropriateness tools based on evidence-based criteria, customized assessments and care plans for inmates, stratification of risk, and tracking/reporting/improvement data.

TruCare™ receives requests for specialty services and permits prospective and concurrent clinical review using InterQual® criteria as well as practice statements. In completing prospective reviews, Centurion offers both a nursing review and physician multi-level review as needed. The goal is to have the clinical team work together to promote appropriate, timely, quality care for the inmate.

Initiation of the prospective utilization management review process:

- Prior authorization is required for outpatient specialty services/diagnostics and planned inpatient services. The request for these services is initiated by an on-site provider on a standardized *TruCare*™ Prior Authorization form. The form must be completed in its entirety to indicate if the referral requires urgent or routine processing.
- Additional clinical information is submitted with the Prior Authorization form to provide the information required to apply evidence-based guidelines and ensure informed medical necessity decision-making.
- Requests for specialty services completed by a physician assistant or nurse practitioner may require review/written approval by the Site Medical Director or supervising physician prior to submitting for authorization.
- The Prior Authorization form and supporting documentation are faxed directly into Centurion's automated *TruCare*™ system.
- Utilization management staff receive the Prior Authorization and supporting clinical documentation for the requested services through *TruCare*™. The requests are processed from an electronic queue to streamline the coordination of referrals. *TruCare*™ supports the transfer of requests from the utilization management nurses and physicians when needed.

Initial Utilization Management Clinical Review

Initial clinical review is conducted by the utilization management nurses. If the request does not include sufficient information to conduct the clinical review, the requesting provider will be notified and asked to submit additional information.

The clinical review consists of the evaluation of presenting new onset, acute event or episodic chronic clinical data, possible diagnosis, co-morbid conditions, failed prior therapies if previously treated, diagnostics completed, current status of condition, and requested medical, surgical, or diagnostic intervention.

With any request, the following information is considered:

- Review of the submitted information
- Determine the type of service being requested
- Identify critical information for application of evidence-based criteria/guidelines
- Apply the evidence-based criteria/guidelines
- Review outcome determination
- Determination of setting of care
- Review of potential safety concerns

If the request can be approved based on the utilization management nurse's clinical review, the specialty service is authorized in the *TruCare*™ system. The provider requesting the specialty service is notified and the inmate is scheduled for the service.

If the utilization management nurse is unable to approve the request based on the established criteria, the request will be sent for a physician advisory review. Requests will not be denied based on a utilization management nurse's review.

Physician Advisory Review

When the clinical review conducted by the utilization management nurse cannot approve a request, the Statewide Medical Director or designee reviews the clinical information to make a determination. If unable to make a determination based on the available information, the Statewide Medical Director will contact the requesting provider for a peer-to-peer discussion of the referral. The Statewide Medical Director has the option to consult with the Department and specialty medical experts available through Advanced Medical Review (AMR) for contracted specialty advisor review on difficult and complex cases.

The physician advisory review and determination is documented in *TruCare*™. If the request is approved, the specialty service is authorized in the *TruCare*™ system. The provider requesting the specialty service is notified, and the inmate is scheduled for the service. If the request is not authorized, an alternative treatment plan is documented and the requesting provider notified.

Appeal Process

Referring on-site providers have the opportunity to appeal the utilization review determination and recommendations for alternate treatment to the Statewide Medical Director. The appeal process includes submission of the original request and additional medical history and data that may be pertinent to the appeals review. The appeal review process for the Statewide Medical Director will include case discussion with the requesting provider and the on-site Medical Director. Consensus is preferred, and the Statewide Medical Director will work with the requesting provider to ensure that the provider is comfortable with the recommendations and treatment planning final determination is agreed upon and documented.

Concurrent and Retrospective Review of Emergency Care

Utilization management prior authorization is not required for emergency services. For unplanned Emergency Department visits or hospitalizations, the utilization management staff receives notification from on-site healthcare staff of the sending facility. Upon notification of emergency inpatient hospitalizations, the utilization management staff initiate concurrent review. Utilization management staff contact the receiving hospital to obtain information and provide input regarding ongoing treatment needs. Transfer to another inpatient facility with the capacity to provide the required level of care may be indicated.

For all hospitalizations, utilization management staff begin discharge planning at the time of admission. Appropriate access to care includes the timely and appropriate use of off-site services as well as on-site infirmary, skilled nursing beds, and transitional care beds within the correctional system. The goal of the inpatient utilization management program is to ensure an inmate requiring inpatient care receives the appropriate follow-up care at a facility with the capacity to manage his/her medical condition.

Follow-Up When Inmate Returns from Off-Site Specialty Service or Hospitalization

When an inmate returns to a correctional facility from a specialist appointment or hospitalization, the inmate is brought to the medical clinic. A consult report or discharge summary should accompany the inmate. Healthcare staff review any paperwork received and a provider is contacted if orders are needed immediately. An on-site provider reviews the results and recommendations from the off-site services to determine if the recommendations are clinically appropriate and medically necessary. The on-site provider documents the review of the off-site records and his/her recommendation for treatment in the medical record. The plan for treatment should be reviewed with the inmate in a face-to-face encounter.

If recommendations from a consultant are modified, the reviewing provider must document justification for the change in the treatment plan. If the provider accepts recommendations for further off-site services, he/she must initiate a referral for the utilization management process.

Tips for Initiating a Specialty Services Referral

In initiating a referral request for specialty services that can be processed in a timely manner, the following tips are offered:

- Understand the steps in the referral process. This typically requires completion of a Centurion Fax Prior Authorization form, completion of a clinical summary outlining the reasons for the referral and supporting medical documentation such a laboratory testing and other diagnostic results.
- Prior to initiating a referral, review the Centurion Guidelines and consider the following related to the referral:
    - How will this intervention impact the ability of the inmate to perform activities of daily living?

- How will this intervention impact the ability to stay safe in the prison environment?
- When is the appropriate time for this intervention within this continuum of illness?
- How will this intervention impact any comorbid conditions?
- What is the outcome that you are anticipating from this intervention?
- Are there any barriers to follow-up care or barriers to provision of this intervention at this time?

- If you are referring an inmate for multiple specialty services, complete the referral process for each service being requested.
- When completing the Centurion Fax Prior Authorization form, ensure all information is legibly entered in the required information boxes as designated by the contract. Indicate that the referral is "routine" except when the intervention is "urgent" and needs immediate attention.
- When completing the Clinical Summary, provide sufficient information to permit a review of clinical appropriateness and medical necessity. Also provide any relevant supporting documentation.
- When the referral is completed, ensure that the information is faxed to the Utilization Management Department. Inform staff who manage the facility's off-site services process of the new referral to facilitate tracking at the site level.

Communication, Communication, Communication

An effective utilization management program requires the coordination of many members of the healthcare staff. It is essential that you know which staff are responsible for submitting referrals, tracking the referral and scheduling process, scheduling inmate transportation for scheduled appointments, and follow-up for inmates who do not attend scheduled appointments. Coordinating these elements is complex and your support may be needed. Effective communication among the on-site healthcare team and with the Utilization Management Department and security is essential.

If the utilization management nurses request additional information to permit review of one of your referrals based on evidence-based criteria, submit the information as quickly as possible to permit timely clinical review. If utilization management determination is delayed, you should request an update on the status of the process.

If an inmate is unable or refuses to attend an off-site appointment, the team will need your input in determining if the appointment requires rescheduling. If an inmate's medical condition changes while awaiting an original scheduled non-urgent appointment, the team will need your support in determining if the original referral is still clinically appropriate or if the urgency of the request has changed.

When an inmate returns from a specialty service, you will need to determine if the consultant's recommendations for further care is clinically appropriate and initiate new referrals as needed. Utilization management staff may consult with you when considering an inmate's discharge from a hospital to your facility.

Communication is essential for a successful utilization management program!

Utilization Management - Supplemental

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and Corporate Utilization Management staff.

Topics to discuss include:

- Who are the staff in the Utilization Management Department of the contract? Have their individual roles been explained? What is your role in the process?

- Which healthcare staff at your site have responsibilities in the utilization management program? The utilization management program includes many functions including tracking specialty referral process, scheduling of appointments, receipt of specialist information, etc. What are the specific roles of these staff members?

- What electronic applications/processes are used in your contract to complete prospective, concurrent and retrospective utilization management reviews?

- Have you received a copy of the current Centurion Clinical Guidelines?

- Have you received a copy of the current Centurion Business Rules?

- What is the referral process and associated timelines for completion of referral process for specialty services in the contract?

- What guidelines are used by the Utilization Management Department to make a prior authorization decision for requested specialty services?

- What documentation is required for a specialty services referral? Have the requirements for completing the Centurion Fax Prior Authorization form been explained?

- How do you determine if a referral for specialty services should be designated as "urgent" or "routine?" What is the timeline for review of a request and the actual appointment based on designation?

- If you are a physician assistant or nurse practitioner, does the contract require review/written approval by the Site Medical Director or supervising physician of your referrals for specialty services prior to submitting to the Utilization Management Department?

- What are the expectations for your involvement in the utilization management process after you have submitted a referral?

- What is the process that occurs when the Statewide Medical Director or designee does not authorize one of your specialty service referrals?

- What is the process that occurs when an inmate returns from an off-site specialty visit, emergency room visit or hospitalization? What are your responsibilities when an inmate is returned to the site after a specialty service visit or hospitalization?

- Who are you to contact for questions about the utilization management process?

- Who are you to contact for questions related to the status of a specific referral for specialty services? Who are you to contact for questions specific to an appointment for an approved referral?

- Why are coordination and communication essential for the utilization management process in the contract?

ADDITIONAL NOTES:

Your Role in Quality Healthcare- Chapter 14 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and the Health Services Administrator.

Topics to discuss include:

- Is there an outline or process to follow for mortality reviews? What is the provider's responsibility in the Morbidity and Mortality review and process?

- Who performs my peer review? When are peer reviews performed? Is there a standard format for peer reviews?

- What meetings site and regional, is the provider required to attend?

- What types and how many grievances do healthcare services in this facility receive each month? How are the grievances specific to healthcare handled?

ADDITIONAL NOTES:

Risk Management – Chapter 7 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Director of Nursing and Corporate Risk Manager.

Topics to discuss include:

- Questions or clarifications on the Incident Reporting Policy?

- What form or forms are used to request medical information from a source outside the correctional system? Who obtains the inmate's signature for the request?

- How long does it typically take to get the information and how will you know it has been received?

- Are there Administrative Directives or Department of Corrections Policies and Procedures regarding sharing of inmate health information?

- What information and how is information shared with security staff?

- How is information shared with security staff?

ADDITIONAL NOTES:

Mental Health and Physical Health Collaboration- Chapter 18 Medical Provider Reference Manual

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director, the Director of Nursing and/or the Health Services Administrator.

Topics to discuss include:

- What mental health services are provided at this facility?

- How many inmates at this facility receive mental health services?

- How many inmates at this facility are diagnosed with a serious mental illness?

- Who are the psychiatric providers at this facility and when are they on-site? Who is responsible and/or on-call for after hour psychiatric issues and emergencies? Are there mental health emergencies that the site medical provider is responsible for?

- What multidisciplinary meetings do medical staffs have with the mental health team?

ADDITIONAL NOTES:

Correctional Healthcare Documentation - Supplemental

Appropriate documentation of services promotes communication and continuity in the overall healthcare delivery system. We provide training to our healthcare staff on preparing documentation that reflects the assessment and/or intervention conducted as well as an inmate's response to his/her treatment plan. We reinforce that the medical record is a legal document in which each staff member has a professional responsibility to document legibly, thoroughly and accurately.

While the fundamentals of appropriate documentation will not be reviewed in this handout, potential documentation issues in correctional healthcare are offered for your consideration.

- Since healthcare is provided 24 hours a day, 7 days a week in correctional facilities, documentation needs to ensure that healthcare staff reviewing the record understand what has happened with the inmate and the inmate's treatment plan when medical staff are not on-site. Documentation is regularly reviewed by our CQI program to ensure compliance with standards and that care and treatment expectations are met.

- Avoid negative comments or judgments such as "faking" or "malingering" when completing inmate-specific documentation. It is important not to engage in negative documentation such as using other departments or staff member names to place blame or argue about an inmate's care. Disagreements in inmate care should be discussed with supervisory/administrative staff for resolution rather than noted in the inmate's medical record

- Correctional systems are moving to electronic medical records; however, many systems still rely on paper medical records. Some systems have a hybrid of electronic medical records and paper medical records.

- In systems with paper medical records, it is critical that documentation is legible, date and timed, and signed with your name and title. Some systems provide stamps with your name and title to facilitate this process. In systems with paper medical records, it is also important to have the record available when conducting an inmate encounter. This can be a challenge since records are often used by many disciplines and may not be readily available at the time of the encounter. When encounters occur without a record, there can be gaps in documentation or loose/lost progress notes. Conducting an evaluation or providing treatment to an inmate without first reviewing the record should be avoided as your decisions may be based on incomplete information.
- In systems with electronic medical records, it is critical that you receive adequate training to be comfortable with using the system. Request assistance when you are unsure of how to use various templates and sections of the electronic medical record.

- Correctional healthcare systems may use many standardized forms to ensure consistent documentation of specific assessments or encounters. Healthcare staff are expected to fill out forms completely and leave no blanks. Partially completed forms compromise continuity of care and will be questioned by auditors. Although forms are the most common form of documentation, you will also be required to write narrative notes of your encounters. When documentation is provided through progress notes, the structure of progress notes must comply with the system's requirements. Most correctional systems require healthcare documentation in the SOAP format. You should discuss and review the specific forms and documentation requirements for the contract based on the type of encounter.

- Certain procedures and treatment require documented inmate consent or refusal for care. Obtain consent and document on designated consent form(s) to confirm the process if the proposed intervention is beyond that implied by the general consent to treat form signed by the inmate when received by the system.

- Documentation of inmate services must be completed on the day the service was performed and prior to leaving the facility. The caveat that "if an encounter is not documented, there is no proof that it occurred" is true in corrections. If you must make a late entry, properly document it with the date, the date of the late entry and "late entry" clearly indicated.

- Although inmates are a "captive population" in corrections, there are "no shows" for scheduled appointments. A "no show" occurs when an inmate does not attend his/her scheduled appointment either due to choosing not to attend or due to a security situation (lock down, lack of security escort, inmate at court). Security staff may assist in ensuring that an inmate shows for an appointment. It is important to document in the inmate's medical record when he/she is a "no show," the reason for the missed appointment and the rescheduling of the appointment as clinically indicated.

- Telephone consultations and orders when you are "on-call" will be documented by the on-site staff. Telephone orders will need to co-signed by a provider in the time frame required by the system. In some systems, orders may be co-signed by a provider other than the provider who issued the order.

- Laboratory, radiology, and other diagnostic reports require your review. Review of the information requires your signature, date and time on the document reviewed. Review should include documentation in the progress notes and orders for abnormal findings that require orders and/or follow-up with the inmate.

- Specialist reports, hospitalization and emergency room discharge reports require your signature, date and time on the document reviewed. Review should include documentation in the progress notes and orders for follow-up and continued plan of care for the inmate.

SOAP Documentation Guidelines - Supplemental

S: Subjective

The subjective elements of the patient encounter (that which is expressed by the patient) should be documented in this section (e.g., patient reports of nausea, pain, tingling). Information that may be reported and included as part of this section include information specific to:

- Presenting complaint and associated functional inquiry, including the severity and duration of symptoms
- Whether this is a new concern or an ongoing/recurring problem
- Changes in the patient's progress or health status since the last visit
- Review of medications, if appropriate
- Review of allergies, if applicable
- Past medical history of the patient and his/her family, where relevant to the presenting problem
- Patient risk factors, if appropriate
- Salient negative responses

O: Objective

The measurable elements of the patient encounter and any relevant physical findings from the patient exam or tests previously conducted are documented in this section and might/should include:

- Physical examination appropriate to the presenting complaint
- Positive physical findings
- Significant negative physical findings as they relate to the problem
- Vital signs
- Review of consultation reports, if available
- Review of laboratory and procedure results, if available

A: Assessment

This section will contain the physician's impression of the patient's health issue including diagnosis or differential diagnosis.

P: Plan

The physician's plan for managing the patient's condition is described in this section and can include:

- Discussion of management options
- Tests or procedures ordered and explanation of significant complications, if relevant
- Specialty consultation reports review and ongoing plan of care, if relevant
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects
- Patient education (e.g., diet or exercise instructions, contraceptive advice)
- Follow-up and future considerations
- Specific concerns regarding the patient, including any decision by the patient not to follow the physician's recommendations

Documentation - Supplemental

The following space is for your notes and questions. Include information that you need to discuss with the Medical Director and Medical Records staff.

Topics to discuss include:

- Does this system use an electronic medical record, paper medical record or a hybrid of electronic medical records and paper medical records?

- If the system uses a paper medical record, how is access to the records ensured for scheduled inmate encounters? What is expected when an inmate's medical record is not available?

- If the system uses a paper medical record, what are the standardized templates for healthcare assessments/evaluations/interventions?

- If the system uses a paper medical record, what is the format expected for progress note documentation?

- If the system uses a paper medical record, is there a stamp provided for your signature and title?

- If the system uses an electronic medical record, have you been trained in using the templates in the electronic medical record?

- If the system uses an electronic medical record, who do you contact when you have questions about the documentation/input requirements?

- If the system uses a hybrid, what documentation is expected in the electronic medical record and what documentation is expected in the paper medical record?

- When are inmate consents or refusals for care required for a proposed intervention?

- What are the expectations for documenting inmate "no shows" in the inmate's medical record and facility tracking?

- What are the expectations for co-signing orders provided during telephone consultations?

- Who should be alerted if you do not agree with the intervention/treatment plan proposed by other staff or department for a specific inmate?

ADDITONAL NOTES:

Attorneys Eyes Only

Attorneys Eyes Only

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