


ADULT CROSS WALK HEALTH CARE DIRECTIVES

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6.01A	3.15A	Infirmity Manual
2.18A	3.16A	Restraints in General Medical Usage
2.01A	3.17A	Organ Donation
4.01A	4.01A	ARS
4.02A	4.02A	Therapeutic Restraint
4.03A	4.03A	Mental Health Services
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1.37A	5.01A	Transitional Health Care
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			HEALTH CARE SERVICES DIRECTIVE-ADULT Manual of Policies and Procedures		

Title HEALTH CARE SERVICES DIRECTIVES FOR ADULT SERVICES
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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Health Standards
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I. PURPOSE:

This document describes Health Care Services Directives (HCSDs) applicable within facilities housing incarcerated individuals. These directives present information and procedures to both Health Care Services and other staff in the Department, regarding matters of concern in the provision of Health Care Services to staff and IDP's.

This directive describes the way the Health Care Services Directives the way policies, procedures and directives are developed, distributed and maintained, and implemented.

II. GUIDELINES:

A. Policy

Within the Department the term, "Policy," is a statement of executive intent and is normally used in conjunction with administrative procedures, both of which come from Central Office.

Formal direction from Central Office to the facilities may come in the form of Executive Directives, Administrative Procedures, and Division Directives. The Division of Health Services generally provides its direction to the facilities in the form of Health Care Service Directives.

Executive Directives are used by the Executive Staff and will not be addressed in this HCSD.

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B. Development of HCSD

HCSDs shall be developed by the Division of Health Services Executive Directors, CMO and/or Directors, in conjunction with the Health Services staff and shall cover topics relevant to the health and welfare of staff and incarcerated individuals within the Department.

Upon learning of the need for a HCSD, the Executive Directors shall consult with appropriate staff and seek their input in its development and regarding its potential impact. The appropriate Executive Director shall have the HCSD developed and prepared as described in this document.

Prior to issuance, HCSD drafts shall be forwarded to the Department Policy Manager for review. The Department Policy Manager shall ensure consistency of format and compliance with related policies or directives. Following the Department Policy Manager's review, the Department Policy Manager shall have it reviewed by appropriate Central Office personnel who shall advise regarding its approval.

Upon the completion of necessary reviews and approvals, the Department Policy Manager shall prepare an Executive Directive for signature. The HCSD shall be distributed under cover of an Executive Directive to all facilities and appropriate divisions.

C. Format of HCSDs

HCSDs shall follow a format similar to that demonstrated in this document. Each HCSD shall be numbered, dated, and titled.

Each HCSD shall have a permanent number assigned to it. This number shall not change when the HCSD is revised. Each number shall consist of one digit before and two digits following a decimal point, e.g., 1.01, 2.03, and so on. In a general sense, each digit shall include similar types of HCSDs as follows:

1.00	Administrative
2.00	Practice Guidelines
3.00	Physical Health
4.00	Behavioral Health
5.00	Transitional Health
6.00	Oral Health

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HCSDs shall be written in narrative form and shall include as general headings:

- Identifying caption
- Title
- Purpose – a brief description of the reason that the HCSD is issued,
- Guidelines – the information or direction
- Site Specific Needs – direction to individual facilities regarding making the HCSD applicable to individual sites, and
- Applicability
- Signature or record of approval by the Chief Medical Officer (CMO)

Headings may be subdivided.

Each page shall be numbered and identified by HCSD name and number.

D. Review of HCSDs

HCSD shall be reviewed annually for relevance and updates. The Division's Executive Directors shall review all HCSDs and Healthcare Policies annually and report to the CMO. The Department Policy Manager will be notified of the completed review by the Health Services Operations Administrator.

Any HCSDs found to be inaccurate or out-of-date shall be revised or rescinded by the Department as quickly as possible. Revisions shall be circulated as new HCSDs superseding old ones, and not as corrections in separate memoranda. Facility, division staff, and Health Services Vendor shall be notified by the Department Policy Manager in writing when HCSDs are rescinded.

E. Maintenance of HCSDs

Wardens or designee shall ensure that copies of all HCSDs are maintained for use by facility administrative staff and other required staff. Additionally, copies of HCSDs shall be maintained by the Health Services staff in Health Services areas for day-to-day use by staff.

HCSDs are designated as public information but there is no requirement

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that they, as internal working documents, be filed in the facility law libraries. Should an incarcerated individual or a member of the public request to review or a copy of an HCSD, staff shall make the HCSD available. Copies shall be provided in accordance with Department procedures governing the release of information. If an HCSD is determined to be confidential/restricted, at the time of distribution the facility shall be notified in the covering Executive Directive and the HCSD shall be so marked.

The Department Policy Manager shall maintain master copies of all HCSDs.

F. Implementation

Wardens are responsible for local implementation of HCSDs and shall work closely with Health Care Administrators to accomplish this. When requested or appropriate, technical assistance shall be provided by Central Office Health Services staff.

Although some Policies, Procedures, and HCSDs are sufficiently precise to permit implementation, others require additional local directives for proper implementation. The local directive is called a “Facility Directive” and is described in Policy and Administrative Procedure 00-04-101, “The Development, Approval, and Implementation of Policy.” When site specific Directives are necessary, they are subject to Central Office review prior to implementation and to annual review at the local level.

Compliance with HCSDs is mandatory. If local compliance appears to be problematic, the Warden shall submit a completed State Form 48584, “Request for Exemption from Policy,” describing the difficulty, suggesting solution(s), and requesting permission to act other than as required by the HCSD, to the Department Policy Manager. The Department Policy Manager shall cause this request to be reviewed by appropriate Health Services Executive Directors and appropriate Division Executive Directors. After this review, the Department Policy Manager shall submit State Form 48584 to the CMO for final approval/denial. After receiving the approval or denial, the Department Policy Manager shall forward the State Form 48584 to the Warden and Facility Policy Manager. The Health Services Operations Administrator and the Department Policy Manager shall maintain these responses with the involved directives in their master files.

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III. FACILITY SPECIFIC REQUIREMENTS:

Each facility shall establish locations in which manuals including up-to-date copies of HCSDs shall be maintained. These locations shall be sufficient to permit Health Services staff to become familiar with HCSD content and to facilitate consultation of the HCSDs as jobs are performed. No facility directive is required for this HCSD.

Each facility must maintain compiled manuals including

- Department Policies directly relevant to health service provision,
- All HCSDs and attachments
- Approved guidelines and protocols
- Approved manuals
- The site-specific materials which are necessary for health service provision.

These manuals must be readily available to personnel who need to use them, in areas such as infirmaries, outpatient clinics, and administrative offices.

At facilities, all manuals shall be kept current so that personnel can rely upon their contents.


IV. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
HEALTH CARE SERVICES PROGRAM ORGANIZATION AND MANAGEMENT

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Health Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the organizational structure and assignment of responsibilities within the Department's facility health care services programs.

II. PROCEDURE:

- A. Provision of Health Services to incarcerated individual encompasses physical health, behavioral health, and transitional health services provided in locations within correctional facility confines, and outside agencies. In order for health services to be provided in an effective and efficient manner, organizational structure is required. Each facility's Health Services staff shall report to a single Responsible Health Authority. At the facility level the Responsible Health Authority is the Health Services Administrator (HSA). HSAs may be assigned to single or multiple facilities if the complexities of the assignment remain reasonable.
- B. The Responsible Health Authority is authorized and responsible for making decisions regarding the deployment of health resources and the day-to-day operations of the Health Services program.
- C. Each facility shall have a designated HSA. For smaller facilities (those without 24 hours / 7 days per week nursing coverage), the HSA shall be on site weekly, at a minimum.

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- D. As the Responsible Health Authority, the HSA arranges for all level of health services and assures quality, accessibility, and timely health services for patients.
- E. The HSA is the chief administrative officer (at the local level) for the Health Services delivery system serving the facility incarcerated populations. The HSA has responsibilities to the Warden, to Central Office, and to the Health Services Vendor company. The HSA ensures that facility directives and controls are established, implemented, and reviewed at least annually.

The major areas of responsibility for the HSA include:

- Implementing and monitoring compliance with HCSDs and otherwise ensuring that proper Health Services are provided.;
- Employing qualified facility personnel in sufficient quantities to support the clinical and management objectives of the Department's Health Services Division and the facility.;
- Forecasting and planning for the needs of the facility as set forth by the Health Services Division;
- Ensuring compliance with applicable laws and regulations.;
- Protecting the assets of the Department, including the controlling of purchases, maintenance, and distribution of equipment.;
- Implementing fiscal controls, including but not limited to:
 1. Authorization and record keeping procedures to provide accounting controls over all Health Services properties (compliance consistent with State Board of Accounts and Department procedures as applicable).;
 2. Monitoring of and accounting for services to patients by contractual providers within the facility and services provided to patients who are transferred outside the facility; and,
 3. Verification of the accuracy of billing at the facility level for services provided either to the Health Services Division or individual patients.
- Establishing communication and reporting processes consistent with Department procedure and designed to promote the orderly flow of information within the organization.;
- Establishing and enforcing lines of authority and accountability that

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- provide for appropriate supervision of Health Services personnel.;
- Establishing and enforcing Department controls relating to the custody of official/confidential records/documents located in the Health Services program area; and,
- Establishing and maintaining current the Health Services organizational chart.

F. The HSA's job description shall also include the following responsibilities:

- Establish a site-specific mission statement which defines the scope of Health Services;
- Develop mechanisms, including written agreements, when necessary, to assure that the scope of services are provided and properly monitored;
- Develop the facility's operational Health Services policies and procedures in conjunction with the Warden, Health Services Vendor Staff and the appropriate Executive Directors or Designee;
- Identify the type of Health Services providers needed to provide the determined scope of services;
- Establish systems for the coordination of care among multi-disciplinary Health Services providers; and,
- Develop a quality management program in cooperation with Medical Vendor Staff and HCSD 2.25, "Continuous Quality Improvement."

G. HSAs will have a strong administration background. A facility physician shall be designated as the Site Medical Director. The Medical Director shall serve as the facility's Responsible Physician. The Responsible Physician shall have final judgment (subject to other physician supervisors) regarding primary care issues. Similarly, the final authority regarding clinical dental decisions lies with the facility's Dental Director, the final authority regarding clinical mental health decisions with the Lead Psychologist subject to medical autonomy on the part of the psychiatrist, who has final authority regarding psychiatric care.

H. All facility Health Services programs that have more than one (1) professional staff member shall identify clinical and administrative reporting relationships for the Health Services staff on an organizational chart. The organizational chart shall include all Health Services staff and indicate both direct administrative reporting relationships and indirect responsibilities.

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While some of the facilities may not have all disciplines represented on site, each facility does provide some level of health services or provides a mechanism to refer the patient for services at another facility/location.

- I. Statistical reports as established by the Health Services Division, Executive Directors and CMO in conjunction with the contracted medical vendor describing the services provided by facility Health Services Vendor staff and certain key issues shall be maintained. Areas covered shall include, but not be limited to, the number of patients receiving health services by category of care, operative procedures, referrals to specialists, serious infectious diseases, off-site hospital admissions, emergency services provided to patients, the results of tuberculosis surveillance, medication errors, Clinical Critical Incident reviews, backlogs, and vacancies. These records shall be submitted to Health Services Division staff monthly, or as otherwise directed, on forms approved by the Department's Health Services Operations Administrator.

- III. SITE SPECIFIC NEEDS:

Each facility shall establish a Facility Directive outlining the organizational structure and a separate Facility Directive describing the facility's committees and meeting structure.


- IV. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title HEALTH SERVICES STAFFING LEVELS AND POSITION DESCRIPTIONS
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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Health Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) requires that Health Services units utilize plans to provide staffing that are adequate to carry out health services responsibilities.

II. GUIDELINES:

- A. There must be a sufficient number of on-site Health Services staff of varying types to provide patients with adequate and timely evaluation and treatment consistent with providing the highest quality of care.
- B. Health Services personnel duties and responsibilities are governed by written job descriptions that are approved by the Health Services Administrator (HSA). Verification of current credentials and job descriptions are on file in the facility.
- C. HSAs shall maintain a written staffing plan, developed from a staffing analysis, describing the numbers and types of personnel in each Health Services area. The numbers and types of employees shall be adequate to provide the necessary services without undue delays. This plan shall be agreed upon, approved by the Health Services Division as outlined contractually, and reviewed annually.
- D. Each position included on the staffing plan shall have a written position description associated with it. Job descriptions shall include qualifications and specific duties and responsibilities. The position descriptions shall be reviewed annually by the employee and the employee's supervisor for adequacy, accuracy, and completeness.

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- E. HSAs shall keep an updated staffing control document electronically that tracks vacancies and shall work to control turnover rates in accordance with established guidelines as set forth in the Health Services contract.

III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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1.04A

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Title

CREDENTIALING OF EMPLOYEES

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 01-02-106	National Correctional Health Care Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the requirements for credentialing of Health Services employees providing health services to incarcerated adults.

II. GUIDELINES:

- A. All qualified health care professionals employed by the Department must be licensed, certified, and/or registered. Limitations on these credentials that restrict practice to “corrections only” are not acceptable.
- B. All professionals such as MD, DO, DDS, PsyD, PhD, and APNs must be credentialed by the Contracted Medical Vendor and approved by the Chief Medical Officer (CMO) or designee.
- C. The Health Services Administrator (HSA) or designee ensures that prospective new hires undergo a credentialing verification process that confirms the employee has a current Indiana license, certification, or registration. Documentation of proper credentials shall be obtained in advance of start of employment.
- D. The credentialing process includes inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB).
- E. It is the responsibility of the individual professional to maintain all credentials as current. It is the HSA’s responsibility to maintain copies of these credentials on site, and to alert the individual professional if there are

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missing or outdated credentials on file. No Health Services employee may continue to provide care in the absence of current credentials.

- F. Health care professionals must not perform tasks beyond those permitted by their credentials or according to State laws and regulations governing their practices.


 - H. In the event that students or interns are present in any Department facility, these individuals shall only be permitted to provide services commensurate with their training and education, and under the direct supervision of fully qualified and credentialed personnel. A letter from the student/intern's training program stating that the student/intern is in good standing must be on file. If a medical student, medical intern, or medical resident are formally rotating in the Department, a letter of good standing and proof of malpractice insurance is required prior to the individual beginning the assignment. A Memorandum of Understanding (MOU) shall be established between the training program/school and the contracted Medical vendor. **Students or interns agree in writing to abide by all facility policies, including those relating to the security and confidentiality of information.**

 - I. Specialists providing onsite or tele-health care services have appropriate licenses and certifications on file.
- III. APPLICABILITY:
- This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
ORIENTATION FOR HEALTH SERVICES PERSONNEL

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Health Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) requires the orientation of Health Services personnel to their facilities and responsibilities.

II. DEFINITION:

CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.

II. GUIDELINES:

- A. All employees, both part and full time, shall receive on the job orientation including orientation to the facility to which assignment has been made
- B. All new fulltime employees must complete a formalized 40-hour orientation program before undertaking their assignments. At a minimum the orientation program shall include instruction in the following:
 - The purpose, goals, policies, and procedures for the facility and parent agency
 - Security and contraband regulations
 - Key control
 - Appropriate conduct with incarcerated individuals
 - Responsibilities and rights of employees
 - Universal precautions
 - Occupational exposure
 - Personal protective equipment
 - Biohazardous waste disposal
 - An overview of the correctional field
 - Aspects of sexual abuse and harassment

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- Procedures for the Suicide Prevention Plan
- Recognizing signs and symptoms of mental illness
- Introduction to the equipment and supplies that will be utilized in the performance of duties
- Tools and sharps control
- Controlled substance management
- Incarcerated individual classifications including transfers and security levels
- Discussions of performance evaluations and expectations
- Confidentiality of health records
- Infection control
- Disaster and Emergency Response Plan
- Legal issues
- Case Plan Credit Time including how Health Services personnel contribute to Case Plan goals and credit time reviews
- Sustainable and environmentally responsible practices

- C. All parttime staff and contract personnel shall receive formal orientation, on-boarding and on-the-job (OJT) training appropriate to their assignments and additional training as needed. This training will include New Employee Training Process (NETP) as described in Policy and Administrative Procedure 01-05-101, “ Staff Development and Training.”
- D. Employees transferring from one facility to another shall, if they have a prior completion of the general correctional orientation (whether full or part time), shall be provided with local on the job orientation. Repetition of the general correctional orientation shall not be necessary.
- E. Orientation shall be fully documented and available for review by the Department, including the Health Services Division.
- F. Failure to successfully complete NETP may result in unsatisfactory performance and separation from employment.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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<p>Title HEALTH-RELATED TRAINING FOR CORRECTIONAL STAFF</p>
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<p>Legal References (includes but is not limited to)</p> <p>IC 11-8-2-5 IC 34-4-12.6</p>	<p>Related Policies/Procedures (includes but is not limited to)</p> <p>01-02-101 01-02-106</p>	<p>Other References (includes but is not limited to)</p> <p>National Correctional Health Care Standards</p>
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes the health-related training provided to Correctional staff.

II. GUIDELINES:

- A. All correctional staff working with incarcerated individuals must receive health-related training annually.
- B. Correctional and Health Services staff shall be appropriately trained to respond to health-related situations/emergencies within a four (4) minute response time.
- C. Health-related training for Correctional staff, established by the Health Services Administrator, the Health Services Vendor and the Health Services Division includes:
 1. Recognition of signs and symptoms, and knowledge of action that is required in potential emergency situations;
 2. Administration of basic first aid;
 3. Certification in cardiopulmonary (CPR) in accordance with the recommendations of the Department's certifying health organization;
 4. Methods of obtaining assistance;

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5. Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal;
6. Procedures for patient transfers to appropriate medical facilities or health care providers;
7. Suicide prevention and intervention;
8. Participation in the facility disaster drill(s);
9. Recognizing the acute manifestations of certain chronic illnesses, such as seizures, cardiac episodes, dental emergencies, etc., and certain adverse reactions to medication;
10. Use of naloxone for overdose reversal;
11. Precautions and procedures with respect to bloodborne pathogens and serious communicable diseases, including HIV, hepatitis, and tuberculosis; and,
12. Maintaining patient confidentiality.

All training shall be documented and available for review upon request.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CONTINUING EDUCATION FOR HEALTH SERVICES EMPLOYEES
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidance on required continuing education (CE) and development.

II. GUIDELINES:

- A. All Health Services staff with incarcerated individual contact must receive forty (40) hours of training and continuing education in addition to orientation during the first year of employment and forty (40) hours of training and continuing education each subsequent year. Professional training hours may count towards this forty (40) but will not preclude the need to receive mandatory corrections related training. Part-time Health Services staff prorate their continuing education hours based on full time equivalency.
- B. If additional hours are required for continuing licensure or certification, these hours shall be obtained. It is the employee's responsibility to obtain necessary hours.
- C. All training must be reviewed annually, by the Quality Assurance Manager (QAM) to ensure that Health Services staff are receiving adequate continuing education.
- D. When gaps in education or training (whether for individuals or groups) are identified, supervisory staff shall arrange for educational and training interventions to remedy the identified deficiencies. A plan of action shall be provided to the Quality Assurance Manager (QAM) and followed until the required training is completed.

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Title CONTINUING EDUCATION FOR HEALTH SERVICES EMPLOYEES			

III. TRAINING REQUIREMENTS:

Specific training and documentation requirements for Health Services staff shall be in compliance with Policy and Administrative Procedure 01-05-101, “Staff Development and Training.”


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

	State of Indiana Indiana Department of Correction	Effective Date	Page 1 of	Number
The HEALTH CARE SERVICES DIRECTIVE-ADULT Manual of Policies and Procedures		4/1/2022	3	1.08A

Title
ADMINISTRATIVE MEETINGS AND REPORTS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Health Care Standards

I. PURPOSE:

This Health Care Services Directive (HCSA) describes the meetings and reports that are minimally required of each facility.

II. GUIDELINES:

. Multidisciplinary Team Meetings (MDTM)

Health Services Administrators (HSAs) and Wardens shall meet monthly to review and discuss Health Services delivered at their facilities. These meetings shall be made available virtually in case of circumstances that do not allow for in-person meetings. These meetings shall include staff persons representative of multiple clinical, administrative, and operational divisions. This includes, but not limited to:

1. Health Service Administrator (HSA);
2. Director of Nursing (DON);
3. Lead Psychologist or designee;
4. Addiction Recovery Director or designee;
5. Deputy Warden of Operations or designee;
6. Deputy Warden of Re-Entry or designee;
7. Unit Manager(s) or designee;
8. Office of Investigation and Intelligence or designee;
9. Classification Supervisor or designee; and,
10. Transitional Health Care

Discussion points are as follows:

1. Complex Physical Health cases;

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2. Complex Behavioral Health (Mental Health and Addiction Recovery) cases;
3. Backlogs and vacancies;
4. Custody concerns (including difficult to manage patients);
5. Case Management and Re-Entry needs; and,
6. Transitional Health Care special needs release occurring within the next 90 days.

Minutes (or other summaries) of these meetings shall be taken and distributed to attendees and shall be retained for reference in accordance with the Department's Records Retention Schedule.

A. Health Services Meetings

Monthly the facilities' Health Services departments shall conduct a staff meeting to review administrative concerns, share information, and problem solve. This meeting shall include representatives of all disciplines working in the facility's Health Services and additional staff as necessary.

Minutes (or other summaries) of these meetings shall be taken and distributed to attendees and shall be maintained for reference in accordance with the Department's Retention Schedule.

B. Continuous Quality Improvement(CQI)

Each facility shall schedule a CQI meeting monthly. Depending upon facility size and activity, these meetings may be held in conjunction with other meetings or even grouped with other facilities when a single HSA manages multiple facilities. No matter how the meetings are managed, minutes (or other summaries) shall be recorded and distributed to attendees, and shall be maintained for reference in accordance with the Department's Record Retention Schedule.

C. Statistical Reports :

Each facility shall provide monthly a health services statistical report (HSR) including, but not limited to:

1. The number of patients receiving services by category of care;
2. Referrals to specialists;
3. Deaths;
4. Serious infectious diseases (e.g., hepatitis, HIV, STDs, TC);
5. Emergency services provided to patients;

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6. Access, timeliness of health services (backlogs) including follow up;
7. Incidence of certain illness (e.g., cancer, chronic illnesses);
8. Missed appointments;
9. Dental procedures performed; and,
10. Grievances.

The HSA shall also provide the required national accrediting organization's outcome measures to the appropriate facility staff.

E. Weekly Reports

The Health Services vendor shall provide a vacancy report and a backlog report on a weekly basis to the Executive Directors and CMO of the Health Services Division. These two (2) reports shall include the number and vacancies and backlogs at each site for all disciplines.

F. Reporting to Department Health Services Division

Copies of minutes and reports shall be forwarded to the Quality Assurance Managers, the medical administrative assistant and other offices as requested.

G. Other

When requested, Health Services personnel shall attend meetings at the facility or Central Office locations.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title EXTERNAL PEER REVIEW PROGRAM
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Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Health Care Standards
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I. PURPOSE:

This Health Care Services Directive establishes the requirement that the clinical performance enhancement of clinicians be monitored on a regular basis.

II. DEFINITION:

For the purpose of this Health Care Services Directive, the following definition is presented.

- A. CLINICIANS: For the purposes of this directive, clinicians are licensed practitioners providing care in the facility including physicians, dentists, advanced practitioners, and psychologists.
- B. COLLABORATIVE PHYSICIAN: Provides patient care through partnership with APNs to review the patient's medical records on a regular basis to ensure patients receive the care and treatment needed.
- C. EXTERNAL PEER REVIEW: Process of having a health professional's clinical work reviewed by another professional of at least equal training in the same general discipline, such as the review of the facility's physician by the responsible physician.
- D. INDEPENDENT REVIEW: The assessment of a health professional's compliance with discipline-specific and community standards. The review includes an analysis of trends in a practitioner's clinical practice.

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Title EXTERNAL PEER REVIEW PROGRAM			

III. GUIDELINES:

- A. A documented external peer review program for clinicians is conducted annually or more often if determined necessary by the Health Services vendor.
- B. APN licensure requires the collaborative physician to make sure that a 5% random sampling of records documenting the care provided by the APN is reviewed at least once every seven (7) days. This sampling must not be performed by the APN.
- B. The review shall be conducted by another professional of at least equal training in the same general discipline who has not been previously involved in the care of the patients reviewed.
- C. Reviews shall be maintained confidentially and shall incorporate, at least, the following elements:
 1. The name of the individual being reviewed.;
 2. The date of the review.;
 3. The name and credentials of the reviewer.;
 4. Confirmation that the review was shared with the clinician; and,
 5. A summary of the findings and corrective action, if any, to be stored confidentially in the Health Services vendor's regional office and made available to the Department's Health Services Division leadership upon request.
- D. A written record providing the name of the reviewer, the name of the clinician being reviewed, signatures of both indicating they have discussed the review and the dates of the review, shall be available to the facilities for the accreditation files.
- E. The Health Services Administrator shall request an independent review whenever there is serious concern about any clinician's competence.
- F. The Health Services Administrator, in collaboration with the Health Services vendor's medical director, implements procedures to improve a clinician's competence when such action is necessary and must be maintained and stored confidentially.
- G. The Health Services vendor shall confidentially notify the Chief Medical Officer and appropriate Health Services Division Executive Director when the need to provide skilled competency training for a clinician arises.

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Title EXTERNAL PEER REVIEW PROGRAM			


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title MEDICAL AUTONOMY

Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Health Services Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) ensures clinical decisions are made for clinical purposes without interference from other personnel.

II. DEFINITION:

CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.

III. GUIDELINES:

A. Health Services Division

Clinical decisions are the sole province of the responsible clinician and are not countermanded by non-clinicians. This responsibility is subordinate to no other Department responsibilities, although it is not superior to custodial needs. Appropriate Health Services cannot be provided in a vacuum; decisions regarding delivery of Health Services interact and interrelate with other decisions regarding management of correctional facilities.

The provision of Health Services is a joint effort of Facility Administrators and Health Services Staff and can be achieved only through mutual trust and cooperation. The Health Services Administrator (HSA) arranges for the availability of health services; the responsible clinician determines what services are needed; the facility's operations staff provide the administrative and Custody support for making the services accessible to incarcerated individuals and the Unit Team staff work collaboratively with

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clinicians to hold incarcerated individuals accountable for identified treatment goals through the Case Plan Credit Time process;

B. Health Services and Operations

Clinical decisions and their implementation must be completed in an effective and safe manner. Decisions regarding delivery of health services must be coordinated with operations and administrative staff. However, determining patient needs, access to Health Services, diagnostic requirements, and treatments/interventions to be provided remain within the province of authority of Health Services staff. Personnel who are not health care professionals employed within Health Services are not permitted to make decisions regarding incarcerated individual's health services management and may not deliver or order health care interventions. This decision making is reserved to licensed Health Services staff.

It is the responsibility of the HSA assigned to each facility to ensure that proper coordination is maintained between the Health Services unit and the Custody staff assigned to moving patients to and from Health Services and other treatment areas. Custody and Unit Team staff must support the implementation of clinical decisions. Custody, Unit Team and Health Services staff shall work together, recognizing that the interests of the patients and the facility are well served when health care is delivered in a professional and appropriate fashion.

The Department has determined that it will comply with Health Services standards established by the national correctional accrediting organization. In accordance with these standards and with various federal court requirements, security restrictions that would interfere with provision of necessary health services shall not be placed on staff physicians or other qualified health care professionals providing services within Department facilities. At the same time, Health Services staff is subject to the same security regulations as other facility employees. Operations and Health Services personnel are expected to resolve conflicts when they arise.

C. Conflicts Between Health Services and Operations

If a physician or other qualified health professional provides an order that is in direct conflict with a security directive, the Health Services employee shall be requested to review both the order and the directive. When possible and appropriate, the Health Services employee is expected to modify their order in a way that will comply with the security directive but will not negatively impact the patient's health. If this is not possible, the Health Services employee shall consult directly with the local Health Services and

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Operations administrative staff and attempt to work out a mutually acceptable treatment plan.

If this cannot be accomplished, consultation with the Chief Medical Officer (CMO), the Health Services Division's appropriate Executive Directors , as well as other appropriate parties shall be sought. If delay of the ordered service will result in a significant negative impact upon the patient's health, the physician or qualified health care professional's order must be followed without undue delay even if this precedes the previously described consultation. This will ensure the delivery of needed Health Services and also the cooperation that is required within all facilities.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing health services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title FIRST AID KITS				
Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards		

I. PURPOSE:

This HCSD establishes guidelines for the provision of first aid kits in Department facilities.

II. GUIDELINES:

- A. First aid kits shall be available in designated areas of the facility based on need and automatic external defibrillators (AED) are available for use at the facility.
- B. The Health Services Administrator (HSA) shall assist the Warden in determining the number of and the locations where first aid kits will be placed. The Health Services staff shall supply and re-supply the first aid kits and monitor their usage.
- C. The Safety-Hazard Manager is responsible for inspecting first aid kits and reporting depleted inventories to the HSA and inspecting all AEDs on a monthly basis to ensure functionality.
- D. First aid certification is required for new employees. All employees with patient contact are required to receive the required training periodically to maintain certification.
- E. First aid kit contents are designed to provide first aid supplies, the use of which is included in the training. Additionally, items of general use (such as adhesive bandages and supplies for Universal Precautions) but not emergency drugs may also be included. The contents of the kits must be approved by the HSA and the Warden.

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Title MORTALITY REVIEWS-ADULT			


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CLINIC SPACE, EQUIPMENT, AND SUPPLIES

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) addresses the need to ensure that sufficient and suitable space, equipment, and supplies are available for each facility's Physical, Behavioral and Transitional health care services.

II. GUIDELINES:

- A. Examination, treatment rooms, and group rooms for Physical, Behavioral, and Transitional health care must be large enough to accommodate the necessary equipment, supplies, and fixtures and to permit privacy during clinical encounters. Facilities must identify specific space for use in delivering health services. This space must have adequate light, ventilation, floor space, equipment, and hand washing facilities. The amount of space and the configuration of the room(s) needed for the care and treatment of patients may vary with the size of the facility and the kinds of services provided on site.
- B. Pharmaceutical, medical supplies, and mobile emergency equipment must be available and checked regularly. Inventories must be adequate to cover expected usage. Sharps and other dangerous items must be always maintained under careful control and must be inventoried daily (every shift when multiple shifts utilize the same supplies) to ensure that unnoticed loss does not occur; even back up supplies must be inventoried at least weekly.
- C. There must be adequate office space with administrative files, secure storage of paper health records, and sufficient space to accommodate the computers needed for the electronic medical record.
- D. Space must be provided to accommodate both individual and group treatment as well as desks, chairs, lockable file space, and relevant testing material.

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Title CLINIC SPACE, EQUIPMENT, AND SUPPLIES			

- E. When laboratory, radiological, or other ancillary services are provided on site, the designated area is adequate to hold equipment and records.
- F. An appropriate basic library of health reference material must be maintained at each health care unit and made accessible to staff either physically or electronically.
- G. When patients are placed in a waiting area for more than a brief period, the waiting area has seats and access to drinking water and toilets. The waiting area must be adequately sized and supervised.
- H. Each facility must have at a minimum, the following equipment, supplies, and materials for the physical examination and treatment of patients:
 - 1. Hand-washing facilities or appropriate alternate means of hand sanitization;
 - 2. Examination table;
 - 3. A light capable of providing direct illumination;
 - 4. Scales;
 - 5. Thermometer;
 - 6. Blood pressure monitoring equipment;
 - 7. Stethoscope;
 - 8. Ophthalmoscope;
 - 9. Otoscope;
 - 10. EKG machine;
 - 11. Pulse oximeter;
 - 12. Sterilizer;
 - 13. AED;
 - 14. Oxygen;
 - 15. PPE;
 - 16. Transportation equipment (e.g., wheelchair, stretcher);
 - 17. Trash container for biohazardous material and sharps;
 - 18. Emergency response bag;
 - 19. In female facilities, equipment and supplies for pelvic examinations; and,
 - 20. In any facility housing pregnant patients, a fetal heart monitor.
- I. Basic equipment for on-site dental examinations includes at a minimum:
 - 1. Hand-washing facilities or appropriate alternate means of hand sanitization;
 - 2. Dental examination chair;
 - 3. Examination light;
 - 4. Sterilizer;
 - 5. Instruments;

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Title CLINIC SPACE, EQUIPMENT, AND SUPPLIES			

6. PPE;
7. Trash containers for biohazardous materials and sharps; and,
8. A dentist's stool.

- J. Facilities with full-time Health Services staff must have multiple-test dipstick urinalysis, finger-stick blood glucose tests, PEAK flow meters (hand-held or other), stool blood testing material, urine drug screens, and pregnancy test kits (female facilities only).

III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



**HEALTH CARE SERVICES
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Title

HEALTHCARE EQUIPMENT MAINTENANCE

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	Nation Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to require each facility to implement a preventive maintenance program to support all equipment used in the diagnosis and treatment of patients.

II. PROCEDURE:

- A. Each facility shall maintain an equipment inventory log listing all equipment assigned to its Health Services program and a copy given to the Facility's Asset Coordinator. A copy of this log shall be maintained in the facility's Health Services program. This list shall be supplemented with a schedule for preventive maintenance for each piece of equipment requiring periodic inspections. Each item requiring a preventive maintenance check shall be recorded as set forth in this HCSD and in accordance with Policy and Administrative Procedure 04-01-101, "Asset and Inventory Management."

The preventive maintenance inspection interval selected for each piece of equipment shall be consistent with the manufacturer's specifications, when such exist, health care industry standards, where such exist, and, finally, government agencies and/or Department guidelines, if applicable. When there are preventive maintenance standards issued by more than one reputable source, the standard with the most frequent inspections (the most stringent standard) shall be followed.

- B. The development of a preventive maintenance program shall be completed in cooperation with the facility's Physical Plant Director, or other designated staff, and in accordance with Policy and Administrative Procedure 04-02-101, "The Establishment of Standards for the Maintenance of Correctional Facilities."

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Title PREVENTIVE MAINTENANCE PROGRAM			

Each facility/program is to have a written facility directive which shall include the following for each piece of health equipment or non-clinical equipment located in the Health Services area or building:

1. Any special precautions to be implemented when the care of a patient requires the use of any type of electrical or mechanical device used for direct patient care which is directly involved in monitoring, measuring, or some other manner in the diagnosis or treatment of a patient.
2. Methods and frequency of testing and verification of performance and use specifications based upon established safety requirements, performance criteria and manufacturer's claims.
3. Requirements for written records of all inspections performed on electrical and electronic systems and equipment including any action(s) taken and/or recommendations for subsequent action.
4. A testing interval for each device consistent with the manufacturer's recommendations and/or standards promulgated by recognized technical organizations (see above).

III. SITE SPECIFIC NEEDS:

Each facility shall develop a facility directive to accomplish the requirements of this HCSD, including maintenance of the preventive maintenance plan itself.


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title HEALTH RECORDS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCS D) describes the Department's health record system and creates a consistent standard for content, maintenance, and confidentiality of patient health records, in accordance with State and federal rules and regulations and applicable correctional standards.

II. DEFINITIONS:

- A. CASE PLAN CREDIT TIME PROGRAM (CPCT): An earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time, as allowed by law.
- B. ELECTRONIC MEDICAL RECORD (EMR): A longitudinal electronic record of patient health information generated by Health Services staff, using a designated application, established templates and free text to document the delivery of health care and patient encounters.

III. GUIDELINES:

A. The Health Record

The patient health record is a combination of paper chart and electronic documentation. It is the legal record of the care provided to patients by Health Services staff. Documentation in the EMR includes, but is not limited to patient demographics, allergies, progress notes, chronic problem list, past medical history, drug orders, vital signs, intake and transfer screens, immunizations, and laboratory data.

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HEALTH RECORDS			

Access to the health record, including the EMR, shall be limited to those Health Services staff having a need to use the health record in the performance of their duties. Paper health records shall be stored in a secure location under the authority of the Health Services Administrator (HSA).

Incarcerated individuals shall not be used in the processing, storing, or destroying of medical record information under any circumstances.

Chronology is essential to the maintenance of the health record. All documentation in the health record must include the patient's name and IDOC number.

The paper health record must be stored in a jacket separately from the facility packet, although information which is necessary for the classification, security, and control of incarcerated individuals must be shared with the appropriate Correctional personnel.

Access to the EMR shall be granted in accordance with the facility access procedures and IDOC User Agreements. Staff who access the EMR must have a unique user ID and password.

Computer passwords for the EMR are confidential and shall not be shared with or used by any other person. Health Services employees must use their individually assigned logon information to access and document in the EMR.

At no time may an employee use another person's logon identity to access the electronic health record.

Health Services staff must properly secure the workstation for the EMR from unauthorized access.

Health Services staff documenting in the EMR must adhere to verification requirements to ensure information is entered in the correct encounter record for the correct patient.

Electronic dental records are maintained separately from the physical, behavioral, and transitional health records. The HSA shall establish a process which ensures that pertinent information is shared between all providers and clinicians.

All health record documentation must be made as soon as possible after the patient is assessed or care is provided.

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Each facility shall develop and implement procedures to preserve health record information and ensure the proper documentation of care during those times when the EMR is unavailable. Documentation during this time shall be scanned into the EMR as soon as possible upon the EMR's availability.

The paper chart must contain original reports when used, if possible.

Releases of the health record shall be managed in accordance with signed authorization of the patient in accordance with applicable Indiana laws and federal rules and regulations. Health records must be released, without the patient written authorization, in response to a subpoena or court order. Health records of a deceased incarcerated individual may be released to the coroner upon request.

B. Content of the Health Record; Paper and Electronic

All clinical contacts between providers and patient, and decisions and correspondence affecting or relating to the health care delivered to a patient (even if no direct contact occurred) shall be documented in the health record. The health record must contain the following:

- Patient identification on each form or printed sheet
- A problem list of medical and mental health diagnoses
- Known allergies
- Completed receiving screening and health appraisal data forms
- Health care request forms
- Progress notes/reports of all findings, diagnoses, treatments, and dispositions
- A record of immunizations
- Tuberculosis screening
- Provider orders for prescribed medication and medication administration records
- Individualized treatment plan, when applicable
- Reports of laboratory, x-ray and diagnostic studies
- Health service reports (e.g., emergency department, dental, behavioral health, telemedicine, or other consultations)
- Flow sheets
- Consent and refusal forms
- Release of information forms
- Clinical Review Forms establishing treatment goals and documented progress reviews for patients participating in the Case Plan Credit Time process

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- Results of specialty consultation and off-site referrals
- Discharge summaries of hospitalizations, inpatient stays, and other Health Services termination summaries
- Place, date and time of each clinical encounter
- Legible signature (electronic or written) and title of each provider (may use ink, type, or stamp under the signature)

C. Confidentiality of the Health Record

1. Health records shall be maintained securely, and in a confidential manner at all times. Extreme care shall be exercised to ensure that the health record remains secure and intact. All active paper health records are maintained securely in file cabinets or open shelf files in the Health Services Unit unless there is no Health Services Unit in the facility. When not under direct supervision, health records shall be locked securely in cabinets and/or rooms.
2. Designated workstations for the EMR must be appropriately secured to prevent unauthorized access and loss of data.
3. At the inception of mental health treatment, patients shall be fully informed regarding the limits of confidentiality, including information that may be necessary in order to protect the health, safety, and welfare of others.
4. The Substance Abuse Management System (SAMS) is not part of the health record, and is not confidential, therefore documentation is limited to administrative notes only.
5. The Electronic Dental Record's (EDR) confidentiality and security shall be maintained in the same manner and importance as the EMR.
6. Sex Offender Management and Monitoring Program (SOMM) documentation is not a part of the health record. . As a condition of participation each participant agrees that information generated in the program may be shared as necessary, without written authorization or consent, under the provision of continuity of care. This does not, however, authorize release of this information for general review by the public.

D. Health Record Storage

All inactive health records are retained in the appropriate storage location for a period of not less than ten (10) years following discharge of the

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incarcerated individual. Paper health records shall be placed with the incarcerated individual's facility record and stored in accordance with Policy and Administrative Procedure 01-04-104, "Offender Records." Paper records shall be maintained in a designated Department records storage facility where they shall be held until eligible for destruction

All loose filing relating to a released patient shall be filed in the paper health record as soon as possible after the patient's release so the complete record may be transferred to the Department's Records Warehouse.

In the event of a return to incarceration, the health record shall be forwarded to the appropriate facility for reactivation.

E. Access to Health Records

The HSA controls access to the health records. Health information which is necessary to address the special medical needs of a patient regarding housing, program placement, security, and transportation shall be provided to the appropriate Department staff.

All staff persons who have a need, in the course of their assigned duties, to use information found in a patient's health record (including physical, behavioral, and transitional health entries) shall have access to them. Special consideration shall also be given to information related to mental health, HIV infection, substance abuse, and all employees using health records must be aware of specific prohibitions under State and federal statutes and regulations regarding release of such information.

Incarcerated individuals shall be allowed to access and review their health records. If copies are requested, the facility shall charge the incarcerated individual the current Indiana Department of Administration (IDOA) copy rate, regardless of the indigent/non-indigent status. There shall be no unreasonable delays in providing these copies. The incarcerated individual shall be required to sign a release indicating that they understand that the Department accepts no responsibility for the documents once the incarcerated individual obtains them.

F. Information Release

Copies of health records shall be processed via the appropriate channels and under all State and federal law. No patient's health record shall be removed from Department premises unless there is a court order.

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Health record information may be shared with other health care agencies such as the Indiana Department of Health, Family of Social Services Administration or the Occupational Health and Safety Administration, as authorized by statute. However, no photocopying of health records by these agencies may be performed. Access to the EMR by staff from a non-Department of Correction agency shall be provided, with the Department's Legal Division's approval, through a unique logon when necessary or the requested material shall be exported or scanned and e-mailed with notification that the material is confidential and protected. The material provided to outside agencies shall be the minimum necessary to meet the request.

Health Services providers also have an obligation to divulge information under certain circumstances. These include:

1. Information relating to the neglect or abuse of a child or endangered adult;
2. Information which describes or clearly suggests the presence of a future threat to the welfare of a person.

G. Clinical Critical Incident Reviews

Clinical Critical Incident Reviews (CCI) are performed after every identified CCI event. However, the CCI review records are strictly confidential and maintained only by the designated Continuous Quality Improvement (CQI) staff. Copies shall not be stored in the health records and may not be released to any party.

H. Availability and Use of Health Records

A patient's health record shall be available for documentation and reference during each health care encounter. "Shadow" health records (secondary files containing partial documentation for the convenience of a provider or type of provider) shall not be established. If identified, shadow health records shall be destroyed.

Except in emergency circumstances, a patient's health record must be made available to those delivering on-site clinical services to them. Documentation shall be accurate, legible, complete, and timely.

I. Transfer of Health Records

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To enhance continuity of care, it is imperative that a patient's paper health record accompany them upon transfer to another facility (intrasystem). When an incarcerated individual is transferred from one facility to another, the paper health record shall be securely and confidentially packaged and transported at the same time as the incarcerated individual. Loose filing shall be incorporated into the patient's health record prior to the incarcerated individual's transfer. If loose filing or other reports relating to a transferred incarcerated individual are found, these shall be forwarded to the incarcerated individual's current facility as soon as possible.

Health Services staff at receiving facilities must review all incoming incarcerated individuals with their health records within the parameters established in HCSD 2.07A, "Transfer Screening."

Health records may not be transferred to non-Department facilities, although full copies may be transferred when appropriate in order to ensure continuity of care. For purposes of this HCSD, contract facilities which receive incarcerated individuals, manage them, and return them to Department control are considered Department facilities.

If an incarcerated individual is transported to an off-site health care consultant or clinical setting for care, the original health record may not be sent along. However, a written form including pertinent information must be sent to the off-site providers so that care may be provided in a continuous fashion. The forms used must make it simple for the off-site provider to return pertinent information, so that care may be provided in a continuous fashion.

III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

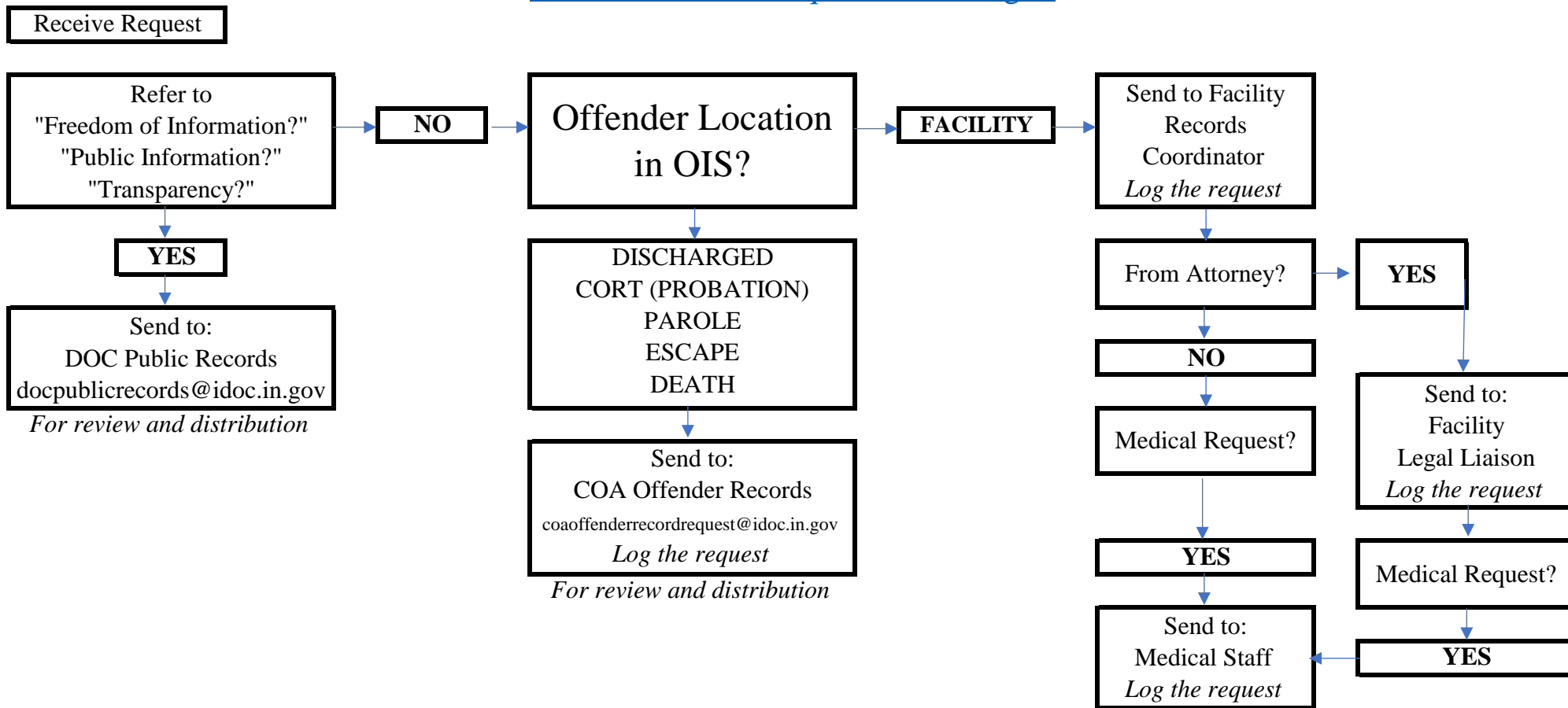
signature on file

Kristen Dauss, MD
Chief Medical Officer

Date


OFFENDER RECORD REQUEST PROCESS

coaoffenderrecordrequest@idoc.in.gov



* Internal/external medical to medical record requests for current patient care should be handled by medical - *Log the request*

* Requests forwarded to Legal Liaisons should be coordinated by that office to ensure proper release authorization and documentation has been obtained

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Title PRIVACY OF CARE

Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) outlines the privacy that shall be afforded to patients without jeopardizing the safety and security of the facility, staff, or incarcerated individuals.

II. GUIDELINES:

- A. Health care encounters, including physical, behavioral and transitional health interviews, examinations, and procedures, shall be conducted in a setting that respects the patient's privacy.
- B. Within correctional settings, privacy requirements and security requirements may conflict when health care activities are being performed. It is necessary to provide respect and privacy when that can be accomplished without placing the provider or others at risk. **Security remains paramount.**
- C. At all security levels, personal safety requires that employees not be isolated simultaneously by sight and sound. All patients and personnel must be aware at all times that such isolation is administratively prohibited.

Concurrently, patient's shall not be interviewed or examined in settings that fail to provide privacy from each other except in settings such as emergency rooms and multiple occupancy inpatient rooms. In the latter settings staff shall endeavor to provide whatever privacy can be provided (e.g., portable curtains, partitions, and to limit sensitive discussions and activities when possible).

- D. Custody staff are permitted to remain with patients, even in examination rooms, when necessary to maintain safety and security. Although Custody

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staff have been instructed regarding confidentiality, it is useful to remind Custody staff of confidentiality practices when they are privy to sensitive information or circumstances. When Custody staff and Health Services staff are working in the same rooms, Custody staff shall follow privacy requirements and **provider's instruction** regarding confidential health information.

- E. In circumstances where Custody and Health Services personnel share the same work area, all Custody staff members shall be instructed regarding the confidentiality of the health information they may learn.
- F. All Health Services staff member's workstations shall be logged out, locked, and secured when not in use.
- G. All staff members are required to uphold all Health Insurance Portability and Accountability Act (HIPPA) laws, rules, and regulations.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title MEDICAL RESEARCH

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 00-04-201	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) restricts the use of incarcerated individuals as subjects in medical, pharmaceutical, or cosmetic research / experiments.

II. GUIDELINES:

- A. The use of incarcerated individuals for medical, pharmaceutical, or cosmetic experiments is prohibited. This does not preclude individual treatment of an-incarcerated individuals based on their need for a specific medical procedure that is not generally available. Clinical research aimed at improving the care of the incarcerated individuals is not prohibited and shall be in compliance with all State and federal guidelines.
- B. Any participation of an incarcerated individual as a subject in a treatment research protocol must be reviewed and approved in advance by the Chief Legal Counsel, the Chief Medical Officer, Chief Digital Officer, and the Commissioner.
- C. Any formal medical or pharmaceutical research either based in the Department, or including incarcerated individuals, must be reviewed and approved in advance by the Chief Legal Counsel, the CMO, the Chief Digital Officer, and the Commissioner.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

Signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title FORENSIC INFORMATION

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes Department practices regarding collection of forensic information. Health Services personnel are prohibited from participating in the collection of forensic information. Health Services personnel shall avoid, whenever possible, participating in collection of information or evidence that is subsequently used in adversarial proceedings.

II. DEFINITIONS:

For the purposes of this HCSD, the following definitions are provided:

- A. **ADVERSARIAL PROCEEDING:** A determination or process that may result in subsequent abridgment of liberty rights or loss of privileges.
- B. **FORENSIC EVALUATION:** An evaluation carried out for the purpose of generating information to be used in an adversarial determination, such as collecting blood or urine specimens for non-clinical drug analysis.

III. GUIDELINES:

A. Sexual Assault

In the event of a sexual assault, information obtained shall be provided to appropriate authorities and may be used for subsequent prosecution or misconduct hearing. Patients being treated for sexual assaults must be informed of this.

B. Information Relating to Escape, Assault, or Other Threat to Facility Security

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In the event that any employee learns of a planned escape, assault (whether on staff, an incarcerated individual, or other person), or other security threat, the employee must inform the appropriate authorities of the plan. Incarcerated individuals must be informed of this limitation on confidentiality. Ongoing security threats must also be reported immediately.

- C. Information Relating to Abuse of an Individual Under 18 Years Old (other than an emancipated minor), or of an Endangered Adult (among others, any individual over 60 years old).

If an employee learns of abuse of a minor (not an emancipated minor) or of an endangered adult (including any adult over the age of 60), past, present, or planned, appropriate protective authorities must be informed. Incarcerated individuals must be informed of this limitation on confidentiality.

- D. Dangerous objects noted or found inadvertently during clinical examinations shall be turned over to appropriate authorities. This may result in loss of privileges or liberty. Incarcerated individuals must be informed of this limitation on confidentiality.
- E. Psychological evaluations for the purpose of determining competency to stand trial, competency to be executed, or similar purposes, shall not be performed by Health Services staff employed at Department facilities. Information regarding mental status that may be helpful to other staff in understanding events that may have occurred may be shared by Health Services personnel.
- F. Court ordered laboratory tests or similar court ordered examinations shall be performed with the consent of the incarcerated individual. If an incarcerated individual refuses consent, the Executive Director of Physical Health shall be informed and, if consent cannot be obtained and the examination requires a health care professional, the Executive Director of Physical Health shall identify a health care professional who does not work at the involved facility and does not have a current patient-professional relationship with the incarcerated individual to perform the required activity.
- G. Samples for DNA determination for forensic databases may be obtained by Health Services employee if there is no therapeutic relationship between the Health Services employee and the incarcerated individual and the incarcerated individual is willing to provide it. These conditions are met (for

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example) when the Health Services staff member involved is a phlebotomist who has no pre-existing relationship with the incarcerated individual.

- H. Health Services employees' involvement in body cavity searches is covered in Policy and Administrative Procedure 02-03-101, "Shakedowns." It must be recognized that an incarcerated individual with a foreign object secreted in a body cavity who decides that they wish assistance in removing it and decides to cooperate with this removal is not being subjected to a body cavity search. Rather, Health Services staff removing a foreign body are acting as the agents of the patient and carrying out a health care procedure.


IV. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title INCARCERATED WORKERS

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 02-01-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. **PURPOSE:**

Incarcerated individuals assigned to work in Health Services areas must be trained appropriately and supervised closely.

II. **GUIDELINES:**

A. Incarcerated individuals, under staff supervision, may perform the following duties:

1. Delivery and retrieval of food and associated supplies and equipment;
2. Janitorial services;
3. Delivery of supplies and equipment provided the materials are not considered contraband or prohibited property under facility procedures.;
4. Peer Support and education.;
5. Hospice activities.;
6. Assisting impaired patients on a one-on-one basis with activities of daily living; and,
7. Suicide companion, if qualified and trained in a Department-approved program.

B. Supervision shall be the responsibility of unit Correctional Officers. At no time shall an incarcerated individual, or group of incarcerated individuals, be given control or authority over other incarcerated individuals.

C. Incarcerated workers performing authorized services shall not be permitted to be present without direct supervision near the following:

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1. Medications.;
2. Sharps/Tool/Medical Instruments.;
3. Offender Records/Medical Records.;
4. Scheduling materials.;
5. Personal possessions; and/or,
6. Other materials which may be dangerous contraband/prohibited property if in possession of the offender.

D. Incarcerated workers shall not:

1. Perform direct patient care services.;
2. Distribute or collect health care request forms.;
3. Schedule appointments.;
4. Determine access of other patients to health care services.;
5. Handling or having access to any medical records, paper or electronic.;
6. Handling or having access to any medications, sharps, or medical instruments; nor,
7. Operate diagnostic or therapeutic equipment except under direct supervision by specially trained staff, in a vocational training program.

E. Incarcerated workers shall not be a substitute for regular program staff but may be involved in appropriate peer health-related programs.

F. Medical Surveillance of IDP Workers

Contracted medical vendor shall keep a running list of all incarcerated workers. Incarcerated workers shall have an initial medical screening for contraindications to a work program, based on job risk factors and patient condition that is conducted prior to initiation of work that is handling biohazardous waste. Any incarcerated worker that handles biohazardous waste shall be offered a physical exam annually, as requested, and post exposure. Contracted medical vendor shall ensure all incarcerated workers working with biohazardous materials are vaccinated appropriately according to OSHA standards and CDC guidelines such as tetanus, Hepatitis A, and Hepatitis B vaccinations, etc. Contracted medical vendor shall offer behavioral health services for incarcerated workers that are exposed to biohazardous waste, compassionate care workers, infirmity aides, or suicide companions, pre assignment, post exposure, or as requested by the incarcerated worker, as they are made aware. Contracted medical vendor shall also ensure that any reported injuries or incidents related to incarcerated workers work assignments have appropriate medical follow up.

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- G. For safety and security reasons, incarcerated workers shall not be permitted to remain in their positions more than 180 days. Suicide companions are exempt from this time limit.

III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



**HEALTH CARE SERVICES
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Manual of Policies and Procedures**

Title

EMERGENCY PLAN

Legal References

(includes but is not limited to)

IC 11-8-2-5 IC 34-4-12.6

Related Policies/Procedures

(includes but is not limited to)

01-02-101

Other References

(includes but is not limited to)

National Correctional Healthcare
Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) requires all facility Health Services units be prepared to provide services in the event of a facility emergency or disaster.

II. GUIDELINES:

- A. The Health Services Administrator shall establish and maintain a flexible emergency plan that addresses preparedness to provide necessary health services during emergencies ranging from individual patient emergencies through mass casualty incidents. The plan shall make reference to any identifiable local risks.

This plan shall be written and published for use by staff, shall be implemented upon approval by the Warden, and shall be coordinated with local health services outside the facility (ambulances, hospitals, fire department, police). This plan shall be in compliance with the *Department Emergency Manual*. The Health Services Division Quality Assurance Managers shall review this plan annually to confirm it is up-to-date. In accordance with Policy and Administrative Procedure 01-05-101, "Staff Development and Training," all Health Services staff shall be trained in the implementation of the facility's emergency plans.

- B. The following topics shall be included in the plan:

- ◆ Preparation for emergency care delivery (obtaining necessary medication, supplies, and equipment, training staff in advance of need, etc.)
- ◆ Determination of the nature of the emergency
- ◆ Notification and mobilization of on-site Health Services and Operations staff

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- ◆ Notification of off-site resources as appropriate
- ◆ Preparation of the facility as necessary
- ◆ Identification of the deceased and planning for a temporary morgue
- ◆ Triage, treatment, and/or transfer of the injured
- ◆ Report on the results if the plan is implemented
- ◆ Management of public information
- ◆ Disaster drills

C. All Health Services staff, including, Providers and Mental Health Professionals, shall participate in at least one (1) disaster drill annually, and records of participation shall be maintained.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title NOTIFICATION IN EMERGENCIES

Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Replaces: National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCS D) describes the process through which next-of-kin are notified regarding health-related emergencies.

II. GUIDELINES:

- A. Next-of-kin, as designated in the incarcerated individual's facility packet, shall be notified in the event of an incarcerated individual's admittance to a critical care unit or placed on imminent death status. The person calling shall be provided with appropriate information prior to making a call. Only the following information may be communicated to next-of-kin when calling regarding a critically ill incarcerated individual:

1. Identification of the caller;
2. Incarcerated individual name and number; and,
3. Diagnosis including any other relevant clinical information.

- B. Contact with next-of-kin should be made by the Warden or designee in the case of any death.

The Warden is encouraged to permit visitation when the incarcerated individual is on imminent death status, unless there is a security concern that precludes this. If visitation is permitted, the Warden or designee shall provide the following information:

1. Name and number of the individual;
2. Reason for the call;
3. Name of hospital; and,
4. Telephone and room number of the hospital.

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- C. If direct notification has been successful, a letter confirming the information provided shall be sent from the Warden's or Deputy Warden's office to confirm.
- D. If telephone notification to next-of-kin fails, the Office of Investigations and Intelligence, local or State police may be contacted for assistance. If this also fails, a mailgram containing the information described in "B" shall be sent to the next-of-kin of record.
- E. If requests for information are received by the facility or by hospital personnel, the requests shall be referred to the Warden's office. This office shall provide only the information as described above in "B."


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title GRIEVANCE PROCESS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 00-02-301	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the required adherence to the Department's Grievance Process.

II. GUIDELINES:

- A. The Department's grievance process is described in detail in Policy and Administrative Procedure 00-02-301, "The Offender Grievance Process." Health Services personnel shall adhere to the policy and administrative procedure.
- B. When a Health Services staff member receives a concern from an incarcerated individual or any other individual, the Health Services Administrator, or designee, is expected to review the concern and address significant issues even if the grievance process is not initiated.
- C. The Health Services Administrator shall maintain a log of grievances received and respond to the Grievance Specialist within five (5) business days of receiving a grievance.
- D. Grievances shall be reviewed by the facility's Quality Assurance Committee.
- E. Health Services staff shall respond to attempts at informally resolving grievances in a timely manner.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

 Kristen Dauss, MD
 Chief Medical Officer

 Date

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Title ACCESS TO HEALTH CARE

Legal References (includes but is not limited to) IC 11-10-3-5	Related Policies/Procedures (includes but is not limited to) 01-02-101 04-01-104	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes the Department's obligation to provide patients with health care services necessary for the treatment of serious health conditions, as guaranteed by the Constitution of the United States.

II. DEFINITIONS:

For the purpose of this HCSD, the following definitions are presented:

- A. **CONVENIENCE CARE:** A trivial condition for which health care services are desired that does not rise to the level of a serious health need requiring treatment; it is not necessary to provide this type of treatment to patients.
- B. **CO-PAY:** A program through which a patient pays a nominal amount of money associated with certain services, the purpose of which is to reduce unnecessary and excessive use of the health care services system.
- C. **HCRF:** A health care request form used to request health care services. State Form 45913, "Request for Health Care," shall be used for this purpose.
- D. **MEDICAL OR HEALTH EMERGENCY:** A serious health problem, usually presenting unexpectedly, which can lead immediately to loss of life or limb, or other serious morbidity; no delay in provision of services is acceptable.
- E. **MEDICAL OR HEALTH NECESSITY-ROUTINE:** A serious health problem that can be addressed days or weeks in the future; a delay in response does not affect eventual outcome.

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- F. **MEDICAL OR HEALTH URGENCY:** A serious health problem, usually presenting unexpectedly, which can lead to loss of life or limb if not quickly addressed; generally, a delay of hours is acceptable in an urgent situation.
- G. **PRACTITIONER:** An individual licensed and certified to practice medicine, as an independent, dependent, or collaborative practitioner. When dependent or collaborative practitioners are utilized, proper physician supervision must be demonstrated.
- H. **PRACTITIONER APPOINTMENT:** A scheduled opportunity for a patient to meet with a practitioner.
- I. **QUALIFIED HEALTH CARE PROFESSIONAL:** Means physicians, nurses, advanced practice nurses, dentists, dental assistants, mental health professionals and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients.
- J. **UNIMPEDED ACCESS:** This means that there are no unreasonable barriers to stop a patient from accessing health care services.
- K. **SICK CALL:** The evaluation and treatment of an ambulatory patient in a clinical setting by a qualified health care professional.
- L. **TRIAGE:** The sorting and classifying of patients' health requests to determine priority of need and the proper place for health care to be rendered.

III. GENERAL CONSIDERATIONS:

Incarcerated individuals have a constitutional right to receive necessary health care services for serious health problems. In order to meet this need, the Health Services Division must enable unimpeded access to care while maintaining clear control over the health care delivery process. Access to care must be timely, there must be a process in every facility for all incarcerated individuals to initiate requests for health services on a daily basis, and the patients must be seen by qualified health care personnel who provide a professional clinical evaluation. Care that is ordered must be provided unless another authorized Health Services staff member modifies the order.

Access to health care services shall be free of major barriers and shall not come under the control of employees who are not part of the health care delivery team. A priority system must be used to schedule clinical services to ensure emergency services are provided emergently, urgent services are provided urgently, and routine services are provided routinely.

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Unimpeded access does not mean that a patient has a right to receive whatever services might be demanded, or to dictate when and in what manner the services will be provided. Appropriately trained health care personnel may control access to care for appropriate health reasons. Examples of unreasonable barriers include, but are not limited to:

- Non- Health Services staff approve or disapprove requests for access to health care services
- HCRFs repeatedly returned to incarcerated individuals asking for additional or clarifying information
- Prolonged waits for sick call appointments, off site referrals, diagnostic tests, and prescribed medications and treatments
- Failure to honor prescriptions or provide services in a timely manner

Health care services must be provided in a timely manner and in a clinic setting by qualified health care professionals. Incarcerated individuals must have the opportunity daily to request health care, and the frequency and duration of sick call must be sufficient to meet the health needs of the facility's population. Clinical services must be available to patients in a clinical setting at least 5 days a week in facilities without 24/7 nursing coverage and 7 days a week in facilities with 24/7 nursing coverage.

Outpatient services must be provided in an acceptable professional environment. In order to provide proper screening and treatment services, the clinical setting shall provide:

- Adequate security (no isolation by both sight and sound, and, in high security settings, the presence of Custodial staff);
- Adequate space and equipment;
- Adequate light;
- Hand washing facilities or a satisfactory substitute; and,
- Easy access to health records.

Incarcerated individuals regardless of housing assignment or lock down status, must have access to regularly scheduled sick call. If a patient requires an escort to the clinical setting and cannot be brought over because of staff availability, the health care provider shall be notified immediately of the problem. The health care provider may indicate whether the care may be deferred. If the care cannot be deferred, the health care provider shall work with Operations staff to ensure that the care is provided. If the care can be deferred, a new appointment can be made.

Provision of health care services to patients shall be considered one of the highest facility priorities. Inordinate delays in patient movement are not acceptable. Professional Health Services staff should be able to work efficiently and rapidly. It is

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inappropriate for other scheduled activities routinely to "bump" health care activities. Coordination and cooperation in the local administration can almost always prevent conflicts in scheduling service delivery.

In all facilities it is possible to continue to see patients even during count times – provided proper planning is completed. Each facility shall examine its incarcerated population and facility characteristics and take steps to ensure that “down time” does not occur during count periods. With some populations (for example, protective custody) it may be especially desirable to see patients during count periods.

Incarcerated individuals who repeatedly request unnecessary services do not need to be scheduled repeatedly for the same assessment in the absence of changed circumstances. Refusing to schedule a patient for convenience care, for services already provided, or for services that are not authorized by the Department’s Health Services system, is acceptable. When no appointment is provided, the patient shall be informed of the decision, the reasoning behind it, and documentation must reflect that the appropriate assessments or reviews were completed by properly trained Health Services staff. Care must be taken in order to avoid excluding from evaluation new problems when they develop.

Patients do not have the right to specify which type of provider or which staff member they see. If a patient refuses to be seen by the staff member to whom they are scheduled, it shall be processed as a refusal to receive health care services and documented as such. All patients refusing health care services shall be offered a release of responsibility to sign.

IV. CO-PAY

Procedures for co-pay for Health Services are found in Policy and Administrative Procedure 04-01-104, “Offender Trust Fund.”

V. ROUTINE SERVICES

Patient initiated request, through an HCRF or routine request initiated by staff or through other means must be triaged within 24 hours. A standardized HCRF (State Form 45913) shall be used in all facilities. The form includes three major sections:

- The first section is for use by the patient and includes identification information, a check-off area in which the general category of the inquiry or request may be indicated, an area for a narrative description of their concern, and a space for a signature and date. Patients shall also include their current housing assignments when completing these forms.
- The second section is for use by health care providers; it includes an area in

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which the reviewer can write a few words or lines to indicate what response is being made (e.g., an appointment, return of some information, advice to go to the commissary, etc.) and an area for the provider to place a signature and date.

- The third section is for communication regarding co-payments.

Blank HCRFs shall be maintained in all housing areas and made available upon request. Health Services staff must arrange for assistance in completing HCRFs to be offered to illiterate patients.

Each facility must establish and maintain secure drop boxes to receive completed HCRFs. Drop boxes must be available so that HCRFs may be placed directly into them without first giving them to staff members. Health Services staff shall retrieve HCRFs from each drop box at least daily. In restrictive status housing settings, HCRFs shall be handed directly to nursing staff while they are performing restrictive status housing unit rounds.

Health Services staff shall review all HCRFs daily. Forms without identification data adequate to identify the author must be thrown away. Forms lacking adequate information shall be returned for resubmission, provided the information already presented does not suggest an urgent or emergent health care need. (The repeated return of forms to patients shall not unduly delay the provision of necessary care.) Occasionally, when the HCRF indicates the patient is requesting clarifying information from a recent sick call visit, the results of recent diagnostic tests or requesting refills of medication, the Health Services staff may indicate on the return section of the form what action will be taken and shall forward the return section of the form to the patient. Health Services staff shall not provide counseling, educational information regarding self-care measures, or referrals to the commissary via the HCRF in the absence of a recent appropriate clinical evaluation.

HCRFs must be collected daily by qualified health care professionals and triaged within 24 hours. A HCRF log shall be maintained to indicate what HCRFs have been received. As HCRFs often contain incomplete information, it is frequently necessary to conduct a face-to-face interview and nursing assessment before establishing a priority for subsequent evaluation. A nursing assessment must be completed when the HCRF describes a clinical symptom(s) within 24 hours of form collection. Depending upon the number of staff available and the time and circumstances of the HCRF review, a two-step triage process whereby one Health Services staff, typically a nurse, reviews the information, and schedules the patient to be evaluated by another nurse in the clinic area within a few hours, may be necessary.

Nursing triage must be conducted by a registered nurse (RN) applying principles of the nursing process. Licensed practical nurses (LPNs) may participate in nursing triage, but Indiana Code 25-23-1 and 848 IAC 2-3-1 limit the involvement of LPNs

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in assessments to a contributory or collaborative role, at the direction of or in conjunction with other members of the health care team. Nurse sick call conducted by LPNs shall be under direction of the RN and / or clinician at the facility. All nurse sick calls are subject to a review process by a supervising RN.

Nursing staff shall not schedule practitioner appointments in the absence of an appropriate clinical assessment. Practitioners who receive scheduled patients when a nursing assessment has not been conducted may refer the patient back to the nurse if not urgent or emergent in nature.

In facilities without 7 day/week nursing staff, a trained correctional officer may review HCRFs and, by consulting with a nurse or higher level provider, facilitate appropriate immediate care or deferral of care.

Each facility must devise an appointment system that schedules patients to be seen by appropriate types of staff members. The scheduling shall provide service to the most urgent patients first, on a "first come first served" basis. Appointments need not be scheduled "immediately" unless the problem warrants it. Each facility must devise an appointment system that schedules patients to be seen by appropriate types of staff members. Patients shall be scheduled in a manner that promotes short waits. However, it is inappropriate to space patients far enough apart to avoid any wait at all; as this causes the provider to have to wait between patients. Causing patients to wait is preferable to causing the providers to wait.

Appointments shall be handled as mandatory "call outs," with patients who do not arrive on time being considered "out of place." In general, patients retain the right to refuse care and must not be subject to disciplinary action for refusing care. However, patients may not refuse to report to the Health Services department. It is inappropriate for facility staff other than health care professionals to accept the refusal to be seen, and it is impossible to obtain a proper "informed refusal" unless the patient is seen by Health Services staff.

Health Services staff shall not accept a patient "no show" for a scheduled appointment as a refusal of care. Health Services staff shall evaluate the purpose of the health care visit and the reason for which the "no show" occurred and determine, based upon health need, whether to reschedule it. The rescheduling decision shall be documented in the health record.

HCRFs shall be permanently filed in health records. Individual facilities may determine whether the form is filed in the appropriate health record section after initial review or only after the problem has been addressed. HCRF forms shall be scanned into the electronic medical record.

VI. URGENT OR EMERGENT SERVICES:

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In addition to the use of written HCRFs for routine services, the Department's access process permits immediate access when health emergencies and urgencies occur. When health services staff learn of a health emergency or urgency by whatever communication route (for example, from an officer, from a family member, from an attorney, from a news reporter), services must be provided immediately.

Urgent and emergent health problems may develop and present at any time. All Department facilities must be prepared to respond to these problems, either utilizing Department facilities or local off site services, 24 hours a day, 7 days a week.

Health Services staff shall assess the situation, as well as may be possible, using all available information, including (when possible) the patient's health record, and plan their response accordingly. In the extreme or unclear cases, emergency care shall be provided immediately.

When a physician or other practitioner determines that off-site emergency travel is required, orders for that travel must include direction regarding the type of transport vehicle to be utilized.

Information regarding health emergencies and urgencies shall be used no matter how it is received. Examples of possible routes include:

- A. HCRF received routinely describes a problem which is actually urgent or emergent,
- B. A verbal report from a patient (either the one who is ill or one who observed him or her) describes what may be an urgent or emergent situation,
- C. A verbal report from any staff member who has received information from other staff members or from patients that is consistent with an urgent or emergent situation; and,
- D. A report based upon information received from a non-prison source, such as a family member or attorney.

The response to a possible emergent or urgent situation must depend upon the patient's condition and not upon the manner in which the information is received. The locus at which care is delivered must depend upon patient needs and not upon staff convenience.

On occasion a disruptive patient may be demanding emergent care unnecessarily or creating unnecessary concern among others. In order to preserve facility security and stability, it may occasionally be prudent to respond as if a situation is urgent even if it

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is clear to Health Services staff that it is not. After such occurrences, involved personnel shall receive information and/or training as necessary in order to minimize the likelihood of future problems. Health Services staff shall not discount patient reports of health care problems simply because independent corroboration is lacking (for example, un-witnessed vomiting).

VI. CONVENIENCE CARE:

Convenience care includes cosmetic services, hygiene items, cold preparations, and many other items which shall not be provided by Health Services staff. Health Services staff shall determine which services are convenience care and which items are medically indicated treatment. This information shall be conveyed to the patient or concerned staff member(s).

In inpatient settings, it is crucial that all medications being used by patients, including legend and over-the-counter preparations are strictly controlled. In inpatient settings, it is acceptable to provide over-the-counter hygiene items that would not be provided in outpatient settings. Cosmetic and similar care shall not be provided in inpatient settings.

Health Services staff have the ability to review commissary orders so that a complete perspective regarding clinical decision making and a patients individualized treatment plan can be determined.

VII. FREQUENCIES, HEALTH CARE DOCUMENTATION, POINT OF ENTRY AND CONSENT:

A. Access to care must be timely. The following frequencies and timelines shall be followed in Department facilities:

1. HCRF review: Daily by nurse or appropriately trained Department employee and triaged to the correct department.
2. Sick call: Review and evaluation by nurse for routine services, within 24 hours of HCRF review in facilities with 24/7 nursing coverage and on all business days in facilities without 24/7 nursing coverage.
3. Practitioner appointment: Review and evaluation by practitioner for routine care, within one 7 days
4. Dental review of HCRFs: HCRF must be screened by Dental staff or a nurse within 24 hours. Nursing staff shall see all patients for any reports of a physical complaint and then referred to Dentist. The evaluation by Dental staff must occur within 14 days for routine

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exams. A process must be put in place for emergent/urgent dental needs.

5. Dentist appointment: For routine services (non-urgent), within six (6) weeks of dental staff review (for urgent services, immediately)
6. Mental health professional review of HCRF: For routine services on all business days
7. Mental health professional appointment: For routine services including all levels of professionals, within seven (7) days.

B. Documentation

All health care services, including sick call and related triage services, shall be documented in the EMR. To facilitate this, the EMR shall be available to those staff seeing patients. Even in restrictive status housing settings, it is possible to create a process that permits contemporaneous charting in a convenient manner. It is not possible to be confident about the appropriateness of a health intervention unless the existing health record data is considered.

C. Point of Entry

Upon entry to a facility, all patients must be informed (verbally and in writing) regarding access to health services, both routinely and emergently, and co-pay procedures. Signs shall be posted in Intake areas, providing brief instruction regarding this, and facility handbooks shall provide detailed instruction. Illiterate patients will need assistance in requesting health care services. Those identified as illiterate shall have access individualized. Some may need assistance in completing HCRFs and others may need to have periodic inquiry made of them by Health Services staff.

Facilities shall identify those patients in their care who will require translation services to permit adequate service delivery and individualize their responses to ensure that necessary health care services can be delivered.

VIII. SITE SPECIFIC NEEDS:

Each facility must establish a written facility directive describing access to routine care through the HCRF process, the scheduling and delivery of sick call and primary care services, the provision of care to restrictive status housing patients, the provision of emergent and urgent services, and the provision of secondary services (Dental, Mental Health, Optometry, and so on). Some facilities may find it useful to expand upon other areas in this HCSD.

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IX. APPLICABILITY:

This Health Care Services Directive is applicable to all Department facilities that provide health care services to incarcerated adults.

signature on file

Kristin Dauss, MD
Chief Medical Officer

Date

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Title RECEPTION SCREENING

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the general health reception screening services offered when incarcerated individuals are received by the Department at one of its facilities.

II. GUIDELINES:

- A. Screening at the beginning of incarceration serves the Department by determining which health care services should be provided to new incarcerated individuals, providing guidance regarding placement, identifying activity restrictions, reducing potential liability related to existing conditions, initiating goal planning related to treatment needs for incarcerated individuals participating in the Case Plan Credit Time process, offering an opportunity to initiate discharge planning , and ensuring that health services are provided in an organized, efficient, and continuous fashion.

The Department primarily receives new and returning incarcerated individuals at the:

- Rockville Correctional Facility (adult female),
- Reception and Diagnostic Center (adult male), and
- Indiana State Prison (males sentenced to death).

Intake screening commences upon the incarcerated individual's arrival at the facility. The Department must maintain a consistent program:

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- To screen for the presence of the following:
 1. Acute or urgent medical needs;
 2. Any history of serious infectious or communicable illness and any treatment or symptoms (e.g., chronic cough, hemoptysis, lethargy, weakness, weight loss, loss of appetite, fever, night sweats that are suggestive of such illness;
 3. Current medications;
 4. Allergies;
 5. Height and weight;
 6. Current illness and health problems including communicable disease (e.g., tuberculosis and sexually transmitted diseases).;
 7. Dental problems;
 8. Use of alcohol and other drug including type(s) of drug used, mode of use, amounts used, frequency used, date or time of last use and history of any problems that may have occurred after ceasing use (e.g., convulsions);
 9. Current or prior history of withdrawal symptoms;
 10. Past or Current mental illness to include past hospitalizations;
 11. Suicidal ideation or self-injurious behavior attempts;
 12. For women, pregnancy or the possibility of pregnancy and history of gynecologic problems or other problems designated by the physician;
 13. Serious physical handicap or disability; and,
 14. Other special needs.
- To observe for the following:
 1. Behavior, including state of consciousness, mental status, appearance, conduct, tremor, and sweating;
 2. Breathing pattern e.g., normal breathing pattern, persistent cough;
 2. Body deformity, ease of movement; and,
 3. Condition of the skin, including trauma marking such as bruises, lesions, jaundice, rashes, and infestations, recent tattoos and needle marks or other indications of drug abuse.
- To determine the medical disposition of the patient:
 1. To General Population;
 2. To General Population with prompt referral to appropriate health services; and,

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3. Referral to appropriate health services for emergency treatment.

- B. The following discussion is applicable to all incoming incarcerated individuals, committed or otherwise, ordered to the Department. While it is intended primarily for use at the Intake facilities, this directive is to be applied to incarcerated individuals who arrive from outside agencies at other Department facilities as parole violators or as safe keepers (those arriving from a county jail that have not yet been sentenced to the Department).

When incarcerated individuals are housed only transiently at reception facilities, provision or initiation of some services may appropriately be deferred until the arrival at the assigned facility. Staff in the reception center must not be expected and should not attempt to address all patient needs prior to transfer to other settings, even if the needs have been identified in the reception screening process. Treatment for routine health conditions which can wait until the patient is transferred to their parent facility should be deferred.

C. Reception Process

Arriving incarcerated individuals range from healthy through seriously ill to moribund. In order for Department staff to address urgent and emergent needs, arriving incarcerated individuals must be screened at the time of arrival. Incarcerated individuals who are unconscious, semiconscious, bleeding, or otherwise obviously in need of immediate medical attention are immediately referred to the health services staff. When a patient is referred to an emergency department, the patient's admission or return to the facility is predicated on written medical clearance.

Because it is unwieldy and sometimes impossible to provide full screening at the point of entry, the intake screening process is phased, searching for urgent needs first and for others in a timely but more leisurely fashion. It is generally simplest to divide the intake process into three phases, each of which must occur within a specific time frame.

In this HCSD the three phases are called "point of entry screening" (POE), "arrival health screening" (AHS), and "intake health appraisal" (IHA).

1. The Point of Entry Screening (POE), State Form 45998, is carried out, literally, at the point of entry into incarceration, within the first minutes of arrival at a receiving facility at the time the Department accepts custody of the incarcerated individual at one of its facilities. This process

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searches for critical and immediate health care problems and it is usually completed by a properly trained correctional officer and reviewed by qualified health care staff. The POE includes a brief written history obtained from the incarcerated individual, observations by the Intake staff completing the POE, a conclusion regarding the need for referral (with or without health care staff participation), and a written disposition. Whenever possible, completion of the POE should include information obtained directly from the officer(s) who brought the patients to the facility. Staff carrying out the POE must indicate whether or not such information has been received from the sending facility or from the officers escorting the patient to Department custody. Patients who are identified as having urgent or emergent medical needs on the POE shall be referred to the health services staff for an expedited assessment.

2. The Arrival Health Screening (AHS) is carried out within 24 hours of arrival and searches for important and urgent health care problems including any history of mental illness and suicide risk in accordance with Health Care Services Directive 4.03A, "Adult Mental Health Services." The AHS is the first screening phase that requires contact with a health care professional. When the AHS is completed by a licensed practical nurse (LPN) it must be reviewed and initialed by a RN or higher-level health care professional. This screening shall be documented in the EMR. Access to Care shall be explained during this screening. State Form 45999, "Offender Health History," may be utilized during this AHS or completed prior to the screen. Health care staff shall ensure the patient has the capacity to complete the screening form autonomously. During this AHS, medications that are reported by the patient or brought in with the patient must be reviewed by a clinician. All decisions regarding medications must be documented in the EMR.

In addition to the AHS, the nurse shall:

- a. Identify other health care concerns requiring early intervention such as continuation of medication and initiate services to ensure continuity of care;
- b. Provide patients with information regarding access to health care services;

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- c. Conduct the syphilis risk assessment and refer those patients who answer “yes” to any risk factors for syphilis serology laboratory testing. The referral for syphilis serology laboratory testing should be noted in the electronic health record;
 - d. IDOH testing (HIV, HCV, Gonorrhea for all women and if clinically indicated men);
 - e. Pregnancy testing for all women;
 - f. PAP smears if age 21 or if history of previous abnormal screen or clinically indicated;
 - g. Perform screening and testing as described in the Department’s Pandemic Preparedness Plan, if applicable;
 - h. Bring vaccinations up to date, if necessary; and,
 - i. Perform tuberculosis screening.
3. The Intake Health Appraisal (IHA) is the intake physical and shall be completed by a clinician within seven (7) days of a patient’s arrival. The IHA is a deliberate, uniform, and directed screening evaluation designed to establish a patient’s health status and to take note of serious health conditions that may be present. The clinician must conduct a chronic disease case review to confirm existing historical problems and to identify serious health problems of which the patient may not be aware. The IHA shall be documented in the EMR to include a problem and diagnosis list, initial treatment plan, and any activity limitations. Diagnostic and laboratory testing shall be included for each problem as clinically indicated during IHA. Any past medical records shall be reviewed or obtained during the IHA to maintain continuity of care. Medical and Disability Codes shall be assigned during the IHA in accordance with HCSDs 2.04A, “Physical Health Status Classification for Assignments,” and 2.05A, “Disability Status Classification Assignments.”

Intake Health Appraisal data collection and recording includes the following:

- a. A uniform process as determined by the Chief Medical

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- Officer;
- b. Documentation of review of the earlier receiving screening;
 - c. Recording of height, weight, pulse, blood pressure, and temperature by qualified Health Services personnel;
 - d. Collection of additional data to complete the physical health, dental health, mental health, and immunization histories by qualified Health Services personnel;
 - e. Medical examination, including review of mental and dental status by qualified Health Services personnel;
 - f. laboratory and/or diagnostic tests to detect communicable disease, including venereal disease and tuberculosis;
 - g. Other tests and examinations as appropriate;
 - h. development and implementation of treatment plan, including recommendations concerning housing, job assignment, and program participation;
 - i. Initiation of therapy, when appropriate; and,
 - j. Review of the results of the medical examination, tests, and identification of problems by a physician or nurse practitioner.

After completion of the IHA, the nurse practitioner or physician must write a summary progress note in the electronic medical record including a brief listing of identified problems, initial treatment plans, and activity limitations (if any). Problem lists and treatment plans shall be initiated or reviewed and updated.

- D. Dental services must be initiated during the receiving screening process. Urgent problems may be identified at any phase during the screening and treatment must then be initiated. In addition to the general inclusion of dental concerns in the POE and AHS, a dentist or other health services employee trained by a dentist must perform a formal dental screening exam within 7 days of arrival. This screening process must include instruction regarding oral hygiene practices and oral disease education. The dental exam will be recorded in the electronic dental record. Preventative care by dentally trained personnel must be completed within three (3) months of admission with diagnostic x-rays taken, if necessary.

Treatment planning for dental services may be initiated at this time or may be deferred to the receiving institution. If treatment needs can be accomplished during the brief reception center stay, this is often very convenient.

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- E. Mental Health services must be initiated during the receiving screening process in accordance with the provisions of HCSD 4.03A, “Adult Mental Health Services.” Urgent problems may be identified at any phase during the screening, and evaluation and treatment must then be initiated. In addition to the general inclusion of mental health concerns in the POE and AHS, a mental health professional must perform a formal Mental Health Intake Appraisal on the designated template in the Electronic Medical Record within 14 days of arrival.

Addiction Recovery Services shall be initiated at Intake if a patient exhibits an urgent need for addiction treatment, is Purposefully Incarcerated, or has been identified as potentially needing treatment related to a diagnosis of Hepatitis C in accordance with the provisions of HCSD 4.01A, “Addiction Recovery Services.” All other patients are assessed for addiction recovery treatment needs upon transfer to their receiving facility.

Behavioral Health staff is responsible for assigning a behavioral health code in accordance with HCSD 2.06A, “Behavioral Health Status Classification for Incarcerated Adults,” that most accurately represents the patient’s behavioral healthcare needs at the time they are screened.

Patients who are thought to be in need of behavioral health services shall be referred to a qualified mental health professional in a timely manner; this may mean an immediate referral, depending upon individual needs. Patients with serious intellectual or developmental disability shall be brought to the immediate attention of the Educational Services staff for further evaluation and intervention as specified in HCSD 4.07A, “Developmental Disabilities and Intellectual Disabilities.” (Routine assessment of education experience is carried out by Educational Services personnel.)

Special attention shall be paid to the potential for suicide during the initial phases of incarceration. All suggestions of suicidal behavior must be considered seriously by Department staff. All incarcerated individuals who are identified as “at risk” for suicide, whether because of current ideation or history, shall be evaluated for suicide risk and shall have appropriate watches or other interventions ordered and applied in accordance with HCSD 4.06A, “Suicide Prevention and Self Injury.”

- F. Special Considerations
All incoming incarcerated individuals must receive instruction regarding how

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to access Health Services. This shall be provided within the first 24 hours of arrival. In addition, each intake facility must post signs in its receiving area describing “how to access care for immediate health needs.”

The written information manual or the “Offender Handbook” provided to incarcerated individuals by each facility must also include information regarding accessing health care services.

Health Services Administrators are expected to review the information contained in the facility manuals and posted in the receiving areas to ensure that this requirement is met.

At the time an incarcerated individual transfers from an Intake unit or facility, any pending tasks or orders listed in the electronic medical record and a detailed transfer note shall be forwarded to the receiving facility.

It is recommended that State Form 46729, “Authorization To Release/ Request Information” along with State Form 55317, “Indiana Physician Orders for Scope of Treatment.” These forms shall be documented into the EMR upon completion by the patient. Education shall be provided that the form is valid for a period of 365 days unless revoked by the patient.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CONTINUITY OF CARE

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCS D) describes the Department's commitment to continuity of care from intake to release and beyond.

II. GUIDELINES:

- A. Providing care in an interrupted manner benefits the patient by ensuring serious conditions are addressed in a consistent and continuing manner. Coordinated care integrates physical, behavioral, and transitional health care to help improve clinical outcomes and ensure continuity of care. Care must be taken to ensure that all patient care is adapted as needed especially that which is recommended by off-site specialists.
- B. Patient health records shall be reviewed by a qualified health care professional upon arrival from outside health care entities as well as those from within the Department.
- C. The Health Services Division has established a system that:
 1. Identifies preexisting conditions at Intake;
 2. Plans continuing therapy;
 3. Provides care for chronic diseases through a structured process;
 4. Reviews ongoing therapy annually and after inter-facility transfers;
 5. Provides age-appropriate care, including vaccinations, preventive screening, and other interventions;

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6. Provides pertinent health education and engages the patient to be involved in treatment planning;
7. Communicates with off-site providers and reviews the information generated by off-site providers;
8. Obtains health records generated prior to incarceration; and,
9. Provides linked referral and information in preparation for, and upon, release from the Department.
10. Provides medications, prescriptions and any prescribed durable medical equipment at time of release per HCSD 2.15, "Medication Management."


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title PHYSICAL HEALTH STATUS CLASSIFICATION ASSIGNMENTS

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes the process through which incarcerated adults are assigned an appropriate healthcare status classification, which facilitates safe placement at Department facilities. The status code classifies incarcerated individuals based on physical health needs and it is utilized by the Department's adult classification system.

II. GUIDELINES:

A. General Information

The assignment of an appropriate and current physical health status classification ensures that an incarcerated individual with health problems is assigned by the Classification Division to a facility with the necessary health care services to address the incarcerated individual's health needs.

B. Physical Health Status Classification Assignment Categories

The following definitions describe the assignment categories. Establishing mutually exclusive categories is impractical because gray areas always remain. For this reason, details accompany each definition:

1. Category:

- A. Free of illness, injury or functional physical impairment; individuals with short-term, self-limiting condition requiring minimal physical health intervention limited to thirty (30) day's duration.

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This category includes all minor health care conditions such as colds or other short-lived viral conditions, simple lacerations requiring sutures, and plaster casts or fixation devices which do not dramatically interfere with ambulation or work.

Conditions in this classification do not require accessibility housing or residential (inpatient or infirmary) support. Health care intervention, if necessary, is limited to periodic consultation, treatment or evaluation by a physical health provider, nursing, or dental personnel.

Patients requiring ongoing clinical assessments or treatments, which must be performed by health care staff several times a week or more, may not be assigned to this classification. Patients capable of performing self-care (i.e. can do their own dressing changes) may remain in this category if they would otherwise qualify

- B. Illnesses that do or will recurrently require skilled nursing care or any chronic physical or cognitive disability which requires on-going nursing care. Needs inpatient bed or immediate access to inpatient bed.

This category includes all conditions in which continuous or intermittent inpatient or infirmary care is needed. Conditions in this classification include terminal illnesses in the late stages such as cancer, AIDS, end stage cardiac, respiratory or liver disease, and chronic physical or cognitive conditions which severely restricts the patient's ability to participate in activities of daily living such as quadriplegia, severe neuromuscular disorders, or late stage Alzheimer's disease requiring skilled nursing care.

- C. Renal failure requiring hemodialysis or peritoneal dialysis.

This category may also include patients with significant renal insufficiency in which a restrictive renal diet is necessary.

- F. Physical health condition (including chronic care) requiring frequent monitoring/surveillance and the on-site availability of licensed health care personnel twenty-four hours per day or the incarcerated individual is frail and debilitated.

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This category includes any condition or illness that is chronic and requires frequent or recurring consultation, evaluation and/or treatment by health care personnel and the immediate availability of licensed health care personnel. Uncontrolled diabetes (e.g. HgbA1C is greater than 8), uncontrolled hypertension, seizure disorders with poor control, asthmatics prone to exacerbations, and unstable angina are examples.

This code should also be used for patients who are frail or debilitated residing on a “medical dorm.”

In general, before an “F” code may be changed to a “G” code, the health status of the patient must be stable, without medication titration for at least 90 days.

G. Any stabilized, permanent or chronic physical or medical condition in which:

- G1. Frequent monitoring/surveillance is not needed;
- G2. The incarcerated individual demonstrates an appropriate degree of knowledge and motivation and is able to perform self-care;
- G3. A twenty (20) pound or greater weightlifting restriction is needed;
- G4. Negative air flow room;
- G5. Traumatic Brain Injury or Dementia.

This category includes any condition or illness in which frequent consultation, evaluation and/or treatment by medical or nursing personnel is not needed. Examples include stable angina, controlled diabetes (e.g. HgbA1C is less than 8), stable asthmatics, controlled seizure disorders.

This category also includes any condition or illness in which the patient has completed a course of rehabilitation and/or received special training or instructions and demonstrates an ability to perform self-care. Examples of these conditions include stable insulin dependent diabetics, patients with

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ostomies, and conditions which require restrictions in lifting to 20 pounds or less.

Patients with reactive TB skin test (Not active disease) receiving TB prophylactic medication such as isoniazid (INH) should be assigned to this category; patients with active disease are to be placed in this code category when they are stable on oral medication and no longer contagious.

- I. Short term self-limiting conditions of 31 to 180 days duration; conditions which may require placement in an observation/short stay infirmary bed or requires that a patient be placed in a negative pressure room.

This category includes any condition or illness which is not permanent or progressive and not expected to last longer than 180 consecutive days. Conditions in this classification may require a limited stay in an observation/short stay infirmary bed. Examples of such conditions are extensive dental treatment, awaiting or recuperating from surgery, fractures requiring the use of casts, stabilizing braces or pins which dramatically affects a patient's ability to ambulate or work for a period of time not to exceed six (6) months or a patient who is being worked up or ruled out for tuberculosis.

- J. Pregnancy
This category includes all pregnant women up to the six (6) weeks post-partum exam.

2. Application

The designation of physical health status classification assignment involves three basic steps:

- a. Determination of the appropriate code assignment,
- b. Completion of State Form 44357, "Report of Medical Status Classification of Offender," in the EMR and,
- c. Forwarding a copy of State Form 44357 to the facility's Classification department

An incarcerated individual's physical health status classification assignment is the only approved mechanism for communicating a

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change in health status to Classification staff. Inattention to the changing dynamics of some health conditions and the need to reassign or re-code an incarcerated individual creates the potential that an incarcerated individual will inadvertently be placed in a facility with limited health care services when more comprehensive or complex services are required. Such situations can be costly to the Department and cause unnecessary delays in providing necessary treatment. For these reasons, incarcerated individuals shall be assigned a new medical status classification code at the following times:

- ◆ At intake (returning incarcerated individuals shall be assigned a new classification with each new confinement)
- ◆ Whenever a new health condition that requires a more intensive level of health services than the classification to which the incarcerated individual is currently assigned is identified
- ◆ Whenever a known health condition improves or deteriorates and the level of health services required has changed
- ◆ Whenever an incarcerated individual has completed a course of rehabilitation such as physical therapy or occupational therapy, and the level of health services required has changed
- ◆ Whenever an incarcerated individual has participated in a course of patient education, and the level of health services required has changed
- ◆ Whenever an identified health condition has been stabilized and the patient no longer requires frequent monitoring by the facility's Health Services staff.

In addition, the incarcerated individual's physical health status classification assignment shall be reviewed at the time of the annual health appraisal and during transfer screening after intra-institutional transfer. Necessary changes in classification assignments should be made at these times and the new code assignment communicated to the facility's Classification

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department.

Health conditions are not static and fluctuations in health status are expected in many chronic diseases. However, multiple changes in category assignments especially during brief time periods cause a cascade of classification events which may result in an unnecessary change in facility assignment. To ensure that appropriate classification assignments are being made, a health condition should generally be stabilized for at least ninety (90) days before a change in code assignment suggesting resolution of a problem should be initiated.

All changes in physical health status classification assignments shall be based on clinical evaluations and needs of the patient. Documentation in the EMR shall clearly support the physical health status classification assignment.

Periodically, an incarcerated individual may volunteer to sign a refusal, or express a desire to sign a waiver, to relieve Health Services staff of any liability in order to be assigned to different medical status code. Noncompliance or an incarcerated individual's refusal to accept necessary treatment shall not result in a change in classification to a less restrictive category assignment. Physical health status codes reflect the patient's needs and not the patient's desires.

To ensure consistency with medical status classification assignments, the facility's Director of Nursing shall be responsible for overseeing this process. Other nursing personnel, designated by the Director of Nursing, may be trained to perform this function. Clinicians responsible for intake health appraisals at the reception centers shall be responsible for the medical status classification assignments of those incarcerated individuals who are new arrivals.

In the event that an incarcerated individual is transferred to another facility due to a change in physical health status classification assignment and the receiving facility does not agree with the current physical health status classification code, the Director of Nursing of the receiving facility is to contact the transferring facility Director of Nursing and discuss the rationale for the change. When an appropriate classification determination remains in dispute despite this contact, the Executive Director of Physical Health shall review the circumstances and issue a written statement regarding the

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appropriate physical health status classification assignment.

C. Confidentiality

Health information is confidential. For this reason, it is sometimes difficult to determine what types of information should be included in the comment section of State Form 44357. Statements included in this section should be limited to the information Classification staff must have in order to place the incarcerated individual in the appropriate setting for their health care needs. Written statements shall focus on the incarcerated individual limitations in work or housing assignments such as, “no repetitive lifting or bending, no stair climbing, etc.”


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

Each incarcerated adult must be assigned a “Disability Status Code” that accurately reflects their sensory and physical disabilities, if any. This code is used by the Department as part of its Classification system and by individual facilities to identify necessary individual accommodations.

II. GUIDELINES:

A. General Information

The assignment of an appropriate disability status classification helps to ensure that each disabled incarcerated individual has access to appropriate supportive devices or services necessary to ensure equal access to Departmental programs.

For the purposes of this Health Care Services Directive (HCSD), activities of daily living (ADLs) refer to, but are not limited to, an incarcerated individual’s ability to ambulate, eat, eliminate, dress, perform personal hygiene, see, hear, communicate, and socialize.

B. Disability Status Classification Assignment Categories

The following definitions and letter codes shall be used:

1. A - No disability: This category applies to all incarcerated individuals without significant physical, visual, hearing, impairment.
2. B - Incarcerated individuals who are blind or have other

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significant visual impairments: This category applies to those incarcerated individuals who are blind or visually impaired with bilateral vision defects that even with best correction seriously adversely affects the incarcerated individual's ability to participate independently in ADLs.

This category is not used for incarcerated individuals who wear contact lenses or who have functional vision in one eye.

Incarcerated individuals with dual sensory impairment in which there is a disturbance of both vision and hearing which seriously adversely affects an offender's ability to participate in ADLs will also be classified to this category.

3. C - Incarcerated individuals with a mobility or ambulation impairment, including wheelchairs and crutches: This category applies to those incarcerated individuals with a neuromuscular impairment that seriously adversely affects the incarcerated individual's locomotion or gross motor functions. The impairment must be such that it seriously interferes with the incarcerated individual's ability to participate independently in ADLs. Examples include, but are not limited to: paralysis; neuromuscular disorders which impair strength such as myasthenia gravis; or, spastic disorders such as cerebral palsy.
4. D - Incarcerated individuals who are deaf or have other profound hearing loss, or who have certain communication impairment disorders: This category applies to those incarcerated individuals who are deaf or suffer from a profound hearing loss in which there is a bilateral disturbance of hearing that cannot be corrected with amplification and that seriously adversely affects the incarcerated individual's ability to participate independently in ADLs. Incarcerated individuals with a hearing loss corrected with a hearing aid do not belong in this category.

Incarcerated individuals with other communication impairment disorders in which there is a disturbance of articulation, speech, voice, or language which seriously adversely affects the incarcerated individual's ability to participate in ADLs despite maximal therapeutic measures will also be assigned to this category.

C. Identification and Evaluation

The designation of a disability status classification assignment involves the:

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- Determination of the presence of a disability; and,
- Development of a disability needs assessment.

An incarcerated individual's disability status classification and disability needs assessment must be initiated during the reception screening/intake health appraisal process. This assessment shall include a review of the following:

1. An evaluation of the incarcerated individual's ability to perform ADL's. This assessment shall include a brief notation regarding those activities in which the incarcerated individual is independent, requires partial assistance, or requires complete assistance;
2. An evaluation of adaptive behavior (proficiency at sign language, proficiency at personal hygiene and grooming, ability to cut up food, hold glasses or cups, etc.);
3. An evaluation of self-care skills (ability to transfer from the bed to chair, use ambulatory aids, read Braille, familiarity with electronic devices such as TTD, etc.);
4. An evaluation of the need for adaptive material, equipment, devices, or services (the use of augmentation communication system such as gestures, picture/word/sentence communication books or boards, electronic devices such as TTD, braces, wheelchairs, etc.); and,
5. A determination of which agency or staff is responsible for provision of the necessary adaptive material, equipment, device or service.

Once completed, State Form 47163, "Report of Disability Status of Offender," shall be completed in the EMR and State Form 47163 shall be forwarded to the facility's Classification department and Transitional Healthcare Facilitator.

D. Review of the Disability Assessment Plan

The disability assessment plan shall be reviewed minimally at the following times:

1. When the presence of a disability is established or changed;

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2. When an incarcerated individual is received after an inter-facility transfer;
3. Annually as part of the annual screening process; and,
4. When discharge from confinement is planned disability codes will be reviewed and required referrals to appropriate State and community resources shall be completed.

E. Documentation

The disability determination and assessment plan shall be documented in the EMR and on State Form 47163. The written findings of the disability needs assessment must be noted in the comment section.

State Form 47163 form is to be forwarded to the facility's Classification department and Transitional Healthcare. The incarcerated individual's disability status classification assignment is used in conjunction with the physical health status classification assignment to determine facility placement.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title BEHAVIORAL HEALTH STATUS CLASSIFICATION ASSIGNMENTS FOR INCARCERATED ADULTS
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Replaces:
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the process through which incarcerated adults are assigned an appropriate behavioral health status classification, which facilitates safe placement and ensures access to appropriate behavioral health care at Department facilities. The behavioral health status code includes psychiatric, psychological, and substance use concerns and is utilized by the Department's adult classification system.

II. GUIDELINES:

A. General Information

The assignment of an appropriate and current behavioral health status classification ensures that an incarcerated individual is assigned by the Classification Division to a facility with the necessary behavioral health care services to address the patient's needs.

B. Behavioral Health Status Classification Assignment Categories

The following definitions describe the assignment categories. Establishing mutually exclusive categories is impractical because gray areas always remain. For this reason, details accompany each definition:

- Code A:** Free of functional behavioral health impairment in the current living environment; individuals with short-term, self-limiting condition requiring minimal behavioral health intervention

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limited to thirty (30) day's duration.

2. **Code B:** Psychiatric disorder that causes little functional impairment and requires infrequent psychiatric services. These services are routine in nature.
3. **Code C:** Psychiatric disorder that causes some functional impairment and requires psychiatric and/or psychological services to support an acute need or recent mental health crisis such as situational social stressors. Services necessary to provide stability, support and skills for self-management such as evidence-based group treatment, peer-led support, or regular psychiatric services. These services may be routine and/or unplanned in nature and may involve mental health monitoring.
4. **Code D:** Psychiatric disorder that requires frequent individual psychiatric and/or psychological services and/or the individual has a history of one or more of the following:
 - a. a serious suicide attempt and are newly (within the last year) admitted to the IDOC; and/or,
 - b. have had a serious suicide attempt or a serious self-injury within the last year; and/or,
 - c. who are on involuntary medication for the treatment of a mental health condition.

Services needed may be routine and/or unplanned in nature and may involve mental health monitoring.

5. **Code E:** Psychiatric disorder that causes significant functional impairment such that the individual is unable to function in a standard prison environment and/or causes significant risk of harm to the individual or others and requires structured psychiatric and/or psychological services. Services needed are provided in a specialized mental health unit.
6. **Code F:** Substance Use needs that cause functional impairment; may only include patients who would otherwise have an A behavioral health code, or a B behavioral health code where the patient's mental health disorder is stable or controlled by psychopharmacological intervention. Primary services needed are provided through the active levels of care in the Recovery While Incarcerated Treatment Program or use of Medication Assisted Treatment (MAT). This code may also be used for patients with identified serious history of overdose but who are unwilling to accept

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treatment in the form of Recovery While Incarcerated and do not qualify for involuntary treatment.

III. APPLICATION:

The designation of behavioral health status classification assignment involves three basic steps:

- A. Determination of the appropriate code assignment:
- B. Completion of State Form 56060, "Report of Mental Health Status Classification of Offender;" and,
- C. Submitting the completed State Form 56060 to the facility Classification department.

A patient's behavioral health status classification assignment is the only approved mechanism for communicating a change in behavioral health status to Classification personnel. Inattention to the changing dynamics of some behavioral health conditions and the need to reassign or re-code an incarcerated individual creates the potential that an incarcerated individual will inadvertently be placed in a facility that cannot provide the care the patient needs. Such situations can be costly to the Department and cause unnecessary delays in providing necessary treatment. For these reasons, incarcerated individual shall be assigned a new behavioral health status classification code at the following times:

- A. At Intake (returning incarcerated individuals shall be assigned a new classification code with each new confinement);
- B. Whenever a new behavioral health condition that requires a more intensive level of services than the classification to which the incarcerated individual is currently assigned is identified;
- C. Whenever a known behavioral health condition improves or deteriorates, and the level of services required has changed;
- D. Whenever a patient has completed a course of treatment such as those provided in a Mental Health Unit or Recovery While Incarcerated treatment program; and/or;
- E. Whenever an identified behavioral health condition has been stabilized or treated and the patient no longer requires frequent treatment or monitoring by the facility behavioral health staff.

In addition, the patient's behavioral health status classification assignment shall be reviewed at the time of the annual health appraisal, annual classification review, and during

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transfer screening after inter-facility transfer. Necessary changes in classification assignments shall be made at these times and the new code assignment communicated to the facility's Classification department.

Behavioral health conditions are not static and fluctuations in health status are expected in many chronic disorders. However, multiple changes in category assignments especially during brief time periods cause a cascade of classification events which may result in an unnecessary change in facility assignment. Therefore, behavioral health staff will need to be mindful of this and will not change codes frequently unless clinically supported and substantial reasoning documented in the EMR.

All changes in behavioral health status classification shall be based on established diagnoses or needs. Documentation in the patient's health record shall clearly support the behavioral health status classification. At times, it may be tempting to change a behavioral health code out of frustration with those patients who fail to follow the advice of the behavioral health staff or present to sick call frequently with complaints that are not serious and when such a change would result in a transfer of the patient to another facility. Similarly, the behavioral health code shall not be determined on the patient's desire, or avoidance of, certain housing environments (i.e., Open dorm, single cell). Behavioral health classification changes must always reflect changes in behavioral health status and need.

Periodically, a patient may volunteer to sign a refusal, or express a desire to sign a waiver, to relieve behavioral health care staff of any liability in order to be assigned to different behavioral status code. Noncompliance or a patient's refusal to accept necessary treatment should not result in a change in classification to a less restrictive category assignment.

To ensure consistency with behavioral health status classification assignments, the facility's designated Psychologist or Mental Health Lead shall be responsible for overseeing this process. Other behavioral health staff, designated by the Mental Health Lead, may be trained to perform this function. Behavioral Health staff responsible for Intake Health Appraisals at the Intake units shall be responsible for the behavioral health status classification of those incarcerated individuals who are new arrivals.

In the event that an incarcerated individual is transferred to another facility due to a change in behavioral health status classification and the receiving facility does not agree with the updated classification, the designated mental health lead of the receiving facility shall contact the transferring facility's designated mental health lead to discuss the rationale for the change. When an appropriate classification determination remains in dispute, the Executive Director of Behavioral Health and the contracted Regional Director of Behavioral Health or designee shall be contacted for advice and direction.

IV. CONFIDENTIALITY:

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Health information is confidential. For this reason, it is sometimes difficult to determine what types of information shall be included in the comment section of State Form 56060. Statements included in this section shall be limited to the information Classification staff must have in order to place the incarcerated individual in the appropriate type of setting for their behavioral health needs. Written statements should focus on the incarcerated individual's functional abilities and how these may impact housing, work, or program assignments.


V. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
INTER-FACILITY TRANSFERS (TRANSFER SCREENING)

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 01-04-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide procedures to staff to ensure all inter-facility transfers receive a health screening and health record review which commences on their arrival at the receiving facility.

II. DEFINITIONS:

- A. **FACILITY STAFF:** Staff employed by the facility, usually a custody officer, who receives the incarcerated individual from the sending facility.
- B. **INTER-FACILITY TRANSFER:** A transfer of an incarcerated individual from one Department facility to another Department facility, including transfers of incarcerated individuals from an intake unit to a receiving facility.
- C. **RECEIVING FACILITY:** The facility accepting the transferring incarcerated individual.
- D. **SENDING FACILITY:** The facility that transfers the incarcerated individual out to another facility.

III. GUIDELINES:

- A. The Department's business hours run 8:00 a.m. to 4:00 p.m., Monday through Friday, excluding State holidays.
 - 1. If a necessary health-related inter-facility transfer is considered, the facility's Health Services staff and Classification staff shall secure

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appropriate authorization, in accordance with Policy and Administrative Procedure 01-04-101, “Adult Offender Classification,” for the transfer prior to 3:00 p.m. in order for the transport to occur same-day.

2. After 3:00 p.m., inter-facility transfers will not be authorized for same-day transport, except in the instance of an emergent medical condition. For emergent physical health transfers, the Executive Director of Physical Health and the Executive Director of Classification must be notified. For emergent behavioral health transfers, the Executive Director of Behavioral Health and the Executive Director of Classification shall be notified.
- B. Transfer screening activities for inter-facility transfers ensure that a patient continues to receive appropriate health care services for health problems which have already been identified and to screen for any new problems which may have developed during transport.
 - C. The patient shall receive necessary health services which were planned or initiated at the previous facility in a continuous manner. This will be verified and communicated with the receiving facility for pending scheduled appointments and procedures.
 - D. The sending facility shall initiate steps to transfer any pending tasks in the electronic medical record (EMR) to the receiving facility.
 - E. Inter-facility transfer screening must commence on the incarcerated individual’s arrival. Facility staff receiving the incarcerated individual upon arrival shall complete a State Form 45998, “Point of Entry,” and ask the following of the incarcerated individual:
 1. Whether the incarcerated individual is being treated for a medical, dental, or mental health problem;
 2. Whether the incarcerated individual is presently on medication including medication used to manage a mental illness, if the medication is in their property, sent from the transferring facility or in the packet from Custody staff.
 3. Whether the incarcerated individual has a current medical, dental, or mental health complaint;

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4. Whether the incarcerated individual has current suicidal ideation;
5. Whether the incarcerated individual has a history of suicidal behavior; and,
6. Whether the incarcerated individual has a history of inpatient and/or outpatient psychiatric treatment or treatment for substance abuse.

F. On State Form 45998, facility staff shall observe and document:

1. The incarcerated individual's general appearance and behavior;
2. The presence of any physical deformities;
3. Whether there is any evidence of abuse or trauma; and,
4. Whether the incarcerated individual is displaying current symptoms suggestive of being under the influence, experience psychosis, depression, anxiety, or aggression (e.g., acting strange or in a bizarre manner, unkempt, disheveled, timid, fearful, hostile, or angry).

G. On State Form 45998, Health Services staff shall document the disposition of the incarcerated individual to one of the following:

1. To General Population;
2. To General Population with appropriate referral to Physical Health, Services, Dental Services, and/or Behavioral Health Services; or,
3. Referral to appropriate Physical Health Services, Dental Services, and/or Behavioral Health Services for emergency treatment. When emergency behavioral health needs are identified, the incarcerated individual shall be immediately evaluated by a Mental Health Professional (MHP). If a MHP is not on-site, the nurse shall contact the appropriate MHP for direction. If an incarcerated individual is potentially suicidal, the incarcerated individual must be placed under direct visual observation until an evaluation by an MHP has been completed.

The facility and Health Services staff completing State Form 45998 shall sign and include date and time the form was completed.

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- H. Non-Health Services staff completing State Form 45998 shall complete the eLearning module (available from Staff Development and Training) on completing and managing State Form 45998.
- I. A licensed nurse shall review State Form 45998 and complete the template for State Form 46053, "Report of Transfer Screen," in the EMR. This template shall be completed within twelve (12) hours of arrival for the incarcerated individual's transferring to a facility with on-site nursing services seven (7) days per week. In facilities with nursing services less than seven (7) days per week, the State Form 46053 (EMR template) shall be completed within twenty-four (24) hours of the incarcerated individual's arrival, however, the nurse shall review the documentation in the EMR within twelve (12) hours after the incarcerated individual's arrival. The review of the EMR record may be completed prior to the incarcerated individual's physical arrival at the facility to ensure that continuity of care is carried forward.
- J. The Suicide Risk Assessment shall be completed in the intake template of the EMR.
- K. The Physical Health, Behavioral Health, and Disability Codes shall be reviewed per HCSD 2.04A, "Physical Health Status Classification Assignments," 2.05A, "Disability Status Classification Assignments," and 2.06A, "Behavioral Health Status Classification Assignments." If any of these Codes are found to be inaccurate, the Code shall be changed at this time. Health Services staff or Behavioral Health Services staff shall notify the Classification Supervisor so that the accurate Code may be entered into the offender information system.
- L. The ability of the incarcerated individual to physically perform kitchen/Foodservices work shall be indicated on the Intake template.
- M. Incarcerated individuals transferred from an Intake Unit who did not receive any portion of the Physical Health, Dental, or Behavioral Health assessments shall have these assessments completed by appropriate staff as soon as possible.
- N. A Snellen eye screening exam shall be completed for those incarcerated individual's transferring from an Intake unit.

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- O. The second step of the Tuberculosis (TB) screening process shall be completed, and any diagnostic tests ordered but not yet performed at the Intake Unit.
- P. Incarcerated individuals enrolled into a Chronic Care Clinic (CCC) shall be seen by a provider in accordance with HCSD 3.01A, "Chronic Disease Intervention Guidelines." Incarcerated individuals requiring enrollment in the CCC shall be added to the facility's Master CCC list. If the incarcerated individual is overdue for CCC services, the appointment shall be scheduled as soon as possible, preferably the CCC physician's next working day.
- R. The nurse reviewing the incarcerated individual's health record shall review the last Annual Health Screen to ensure necessary screening activities, including TB screening, have been completed. If the patient is overdue for their Annual Health Screen, the nurse shall complete the Annual Health Screen at the time the transfer screen is completed, or the nurse shall schedule the patient for their Annual Health Screen as soon as possible. Preventive Services which were due shall be scheduled, or if offered and refused, State Form 9262, "Refusal and Release from Responsibility for Medical, Surgical, Psychiatric, and Other Treatment," shall be completed.
- S. Patients transferring from a Department facility to another Department facility with a behavioral health code of B, C, or D shall be evaluated by an MHP to include the following information within fourteen (14) days of arrival:
 - 1. Mental Status Examination;
 - 2. Suicide Risk Assessment;
 - 3. Review of current Behavioral Health code, diagnosis, Treatment Plan, and Clinical Review Form when applicable for accuracy. These shall be developed or updated as needed;
 - 4. Consent for Treatment and Limits of Confidentiality;
 - 5. Referral to Psychiatry, if indicated; and,
 - 6. Referral to Addiction Recovery, if indicated.

In addition to the above, patient's transferring from a mental health unit to another Department facility shall be evaluated by an MHP within one (1)

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business day to assess for stability after transfer and adjustment to new facility. Additional follow-up for these patients is outlined in HCSD 4.03 “Adult Mental Health Services.”

- T. Incarcerated individuals shall receive information regarding procedures to access Health Services, including copay requirements.


IV. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title ANNUAL HEALTH SCREEN

Legal References (includes but is not limited to) Indiana Code:	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
11-8-2-5 11-8-5-2 11-10-1-2 11-10-2-4 11-10-3-1 11-10-8-2 11-10-8-5 11-10-9-2 11-11-5-4 11-11-6-2	01-02-101	ACA Health Care Standards

I. PURPOSE:

This Health Care Services Directive (HCS D) provides Health Services staff with information and guidelines regarding the annual screening of patients within the Department.

II. ALL PATIENTS:

Annually each health record shall be briefly reviewed and the patient interviewed and screened. This review shall be timed to coincide (approximately) with the patient's birthday. If the patient arrived and was fully screened at an Intake Unit during the previous three (3) months, the annual screen may be deferred one (1) year or at the Chief Medical Officer's (CMO) discretion. The "Medical Birthday Report," in the offender information system may be used to identify patients who are due for an annual health screen.

The review shall be performed by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) directly supervised by a RN. During the review and screening, the following shall be accomplished:

1. Determine whether chronic or serious illness or conditions are present and determine if appropriate interventions have been provided during the previous year. Additional services as necessary shall be scheduled;
2. The Suicide Risk Assessment shall be completed in the Intake template of the EMR
3. Determine which age-appropriate interventions need to be offered in accordance with HCS D 2.09, "Age Appropriate Interventions," and offer or schedule those interventions;

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4. Provide appropriate tuberculosis screening based upon the patient's history, status, and the requirements of the Department's Tuberculosis Prevention and Control Manual;
5. Obtain a brief history of current or recent symptoms suggestive of an active serious illness;
6. Obtain vital signs;
7. Review and update the physical health, behavioral health, and disability status codes, if indicated; and,
8. Determine and document whether the patient is physically capable of performing kitchen work.
9. Ensure there is a completed Clinical Review Form with identified treatment goals for patients with chronic physical health conditions and/or behavioral health codes other than "A." Patients incarcerated prior to January 1, 2022 must opt into the Case Plan Credit Time (CPCT) process. All IDPs incarcerated on or after January 1, 2022 will automatically be enrolled in the CPCT process. Each IDP with identified CPCT goals on a Clinical Review Form must have a review of their progress toward goals completed annually.
10. It is recommended that State Form 46729 "Authorization To Release/ Request Information" along with State Form 55317 "Indiana Physician Orders for Scope of Treatment". These forms shall be documented into the EMR upon completion by the patient. Education shall be provided that the form is valid for a period of 365 days unless revoked by the patient.

III. FEMALE PATIENTS ONLY:

A. Breast Cancer Screening

Patients aged 50 to 74, will receive biennial (every two [2] years) screening mammography.

The decision to start regular, biennial screening mammography before the age of 50 years should be considered, case-by-case, based on the patient's individual risk factors and medical history.

Screening mammography is not recommended for patients over age 75 years or older.

An annual clinical breast exam and teaching breast self-examination is not mandatory but is highly recommended. This may be accomplished by a trained female that is qualified to teach breast self-examination, with a third female medical staff present. A clinical breast exam should be performed when the patient has breast-related symptoms.

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B. Cervical Cancer Screening

The following recommendations apply to women who have a cervix regardless of sexual history. These recommendations do not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (e.g. HIV positive).

For patients aged 21 to 65 screening for cervical cancer with cytology (Pap smear) shall be provided every three (3) years.

Routine cervical cancer screening shall not be done in patients younger than age 21 years, unless the patient has a history of previous abnormal cervical cytology/histology. Screening women younger than age 21 years (regardless of sexual history) with no prior history of abnormal cervical cytology/histology does not reduce cervical cancer incidence and mortality compared with beginning screening at age 21 years.

Patients older than age 65 shall not be screened for cervical cancer if they have had adequate prior screening and are not otherwise at high risk for cervical cancer. Adequate prior screening means three (3) normal Pap tests in a row or two normal human papillomavirus (HPV) tests in a row within the last ten (10) years. The most recent Pap/HPV test must be within the past five (5) years. Screening may be clinically indicated in older women with an inadequate or unknown screening history. Data suggests that ¼ of women aged 45 to 64 years have not been screened for cervical cancer in the preceding 3 years. In particular, women with limited access to care, women from racial/ethnic minority groups, and from countries where screening is not readily available may be less likely to meet criteria for adequate prior screening.

Cervical cancer screening shall not be done for patients who have had a hysterectomy with removal of the cervix and who do not have a history of high grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3 or cervical cancer).

All patients age 21 years and older with an ASCUS cervical cytological result shall receive appropriate clinical follow-up. All adult women age 21 years and older with a high-grade squamous intraepithelial lesion (HSIL) cervical cytological result shall have a colposcopy with endocervical curettage (ECC) or LEEP. All women age 21 years or older with a low-grade squamous intraepithelial lesion (LSIL) cervical cytological result shall have a colposcopy.

C. Osteoporosis

Bone mineral testing shall be offered to patients aged 65 and older. Patient education shall be provided as well.

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Screening for patients, age 60 to 64 shall be conducted on a case-by-case basis if the patient has risk factors for osteoporosis or osteoporotic fracture (e.g., Asian race, low body weight, history of fragility fracture, fracture after age 50, estrogen deficiency at an early age [<45 years] etc.) if the patient has a medical condition associated with increased risk of osteoporosis, or if the patient is taking medication associated with reduced bone mineral density

Repeat bone mineral testing shall be provided at the provider's discretion based on the patient's medical history and fracture risk assessment. Bone mineral testing should not be repeated for at least two (2) years. Intervals longer than two (2) years may be adequate to identify new cases of osteoporosis.

Medical management for the prevention or treatment of osteoporosis shall be provided when clinically indicated.

D. Contraception and STI Education

All women are provided an opportunity for education on contraceptive choices and the importance of condom use and the prevention of STIs and pregnancy prevention and planning.

III. APPLICABILITY:

This HCSD is applicable to all facilities providing health services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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DIRECTIVE-ADULT
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Title

AGE APPROPRIATE INTERVENTIONS

Legal References (includes but is not limited to) Indiana Code:	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
11-8-2-5 11-8-5-2 11-10-1-2 11-10-2-4 11-10-3-1 11-10-8-2 11-10-8-5 11-10-9-2 11-10-10-2	01-02-101	National Correctional Health Care Standards U.S. Preventive Services Task Force

I. PURPOSE:

This Health Care Services Directive (HCSD) presents information and guidelines on the types and frequency of various interventions appropriate for preventive screening purposes.

II. GUIDELINES:

The Department shall provide screening interventions based on the recommendations of the US Preventive Services Task Force (USPSTF). The USPSTF A and B recommendations may be found online at the following link:

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Clinical preventive and age-appropriate interventions shall be provided based upon the patient's age and gender.

If the patient's first annual health screen falls in between the standard preventative services matrix schedule in HCSD 2.08a "Annual Health Screens" based on age, the tests and procedures shall be completed at the time of the first annual health screen, if not already completed at the Intake Unit. The patient's shall then return to the standard screening schedule at age 40, 45, 50, et cetera (e.g., A patient's who is incarcerated for the first time at age 47 shall undergo the standard matrix schedule interventions usually done at age 45, and then again at age 50, 55, 60, and so on).

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III. APPLICABILITY:

This HCSD is applicable to all facilities housing and providing health services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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TELE-HEALTH

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 01-04-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide guidelines for the provision of health care services via Tele-Health equipment.

II. DEFINITIONS:

For the purposes of this HCSD, the following definitions are provided.

- A. **TELE-HEALTH SERVICES:** Health services provided via Tele-Health equipment by a qualified health care professional licensed in the State of Indiana.
- B. **TELE-HEALTH EQUIPMENT:** Computer equipment or other electronic communication devices used to provide patient encounters with health care professional, including, but not limited to monitors, cameras, secure internet connections, and other equipment designed for use in Tele-Health encounters.
- C. **TELE-HEALTH PROVIDER:** Physician, Psychologist, Nurse Practitioner, Physician's Assistant, or Master-Level Mental Health Professional with a valid Indiana license to practice.

III. GUIDELINES:

- A. Tele-Health providers must possess a valid, non-restricted Indiana license in their discipline.
- B. Tele-Health encounters may not proceed unless the patient has expressed consent to the encounter in accordance with HCSD 2.12, "Consent and Refusal."

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- C. All Tele-Health transmissions shall be encrypted, or otherwise secured to ensure patient confidentiality and the protection of health information in accordance with HCSD 1.15A, "Privacy of Care," and HCSD 1.14A, "Health Records."
- D. A Health Services staff member shall accompany patients when required during the Tele-Health encounter, to ensure a safe and secure environment and to assist the provider and patient.
- E. The Tele-Health encounter and the Tele-Health Provider's report shall be documented and integrated into the health record in accordance with HCSD 1.14, "Health Records."
- F. Tele-Health encounters shall be completed only for non-emergent or non-urgent appointments. Tele-Health may be used for emergent or urgent assessment only if after hours, and the on-call provider requests Tele-Health to aid in assessment.
- G. The health services vendor shall be compliant with the rules and regulations of the Medical Licensing Board of Indiana.
- H. Tele-Health delivery shall have the approval of the Chief Medical Officer or designee.


IV. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title TREATMENT PLANNING

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for treatment planning within the Department.

II. DEFINITION:

CASE PLAN CREDIT TIME PROGRAM (CPCT): An earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time, as allowed by law.

III. GUIDELINES:

A. Introduction

A written treatment plan is required for patients requiring any treatment from the medical division. This plan includes directions to Health Services staff and other personnel regarding their roles in the care and supervision of the patient, and is approved by the appropriate licensed clinician, or mental health practitioner for each patient requiring a treatment plan.

Treatment plans are formal written plans that identify serious health conditions referenced from the problem list, describe goals and outcomes, list the planned interventions, and describe which professional discipline is responsible for implementation. Treatment plans shall be entered into the EMR.

For patients enrolled in chronic care clinics, the chronic disease template in the Electronic Medical Record (EMR) shall be used as the treatment plan. The Clinical Review Form shall be used to document treatment goals from the treatment plan and progress review for identified treatment goals to be shared with Unit Team staff for patients participating in the Case Plan Credit Time process. The Clinical Review Form shall be uploaded to the EMR.

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Treatment plans for Dental services shall be recorded in the “description” section of the electronic dental record.

Behavioral health professionals shall utilize the behavioral health treatment plan template in the EMR. The Clinical Review Form shall be used to document treatment goals from the treatment plan and progress reviews for identified treatment goals to be shared with Unit Team staff for patients participating in the Case Plan Credit Time process. The Clinical Review Form shall be uploaded to the EMR.

B. Infirmary Admission

At the time of admission to a Department inpatient unit, the treatment plan shall be updated. The treatment plan including goals for patient care management shall be recorded in the “Reason for Visit” section of the provider’s admission progress note.

All patients admitted to an infirmary shall have formal nursing care plan prepared within eight (8) hours of admission. Nursing care plans shall be recorded on a standardized nursing care plan form. The nursing care plan shall contain reference to problems or needs entered on the problem list and/or interventions listed on a treatment plan, specify their own goals and quantifiable outcomes, describe the planned nursing interventions, and reflect ongoing review. When pre-printed nursing care plans are used the nursing care plan must be individualized for the specific needs of the patient. Nursing care plans may be based upon the patient’s medical diagnosis, a nursing diagnosis, or a simple identification of the patient’s symptoms. The nursing care plan shall contain the professional signature of the nurse who wrote it. If the nursing care plan was prepared by a Licensed Practical Nurse, a Registered Nurse must review and counter sign the nursing care plan.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CONSENT AND REFUSAL

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6 IC 16-36-1	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes the application of informed consent and informed refusal.

II. DEFINITIONS:

- A. **CAPACITY EVALUATION:** The assessment of one's ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.
- B. **CASE PLAN CREDIT TIME PROGRAM (CPCT):** An earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time, as allowed by law.

III. GUIDELINES:

A. General Comments

This directive will provide guidelines regarding the application of informed consent and refusal within Department facilities. If questions develop, legal advice should be sought early.

Incarcerated adults have the right to be informed regarding proposed health interventions and to either provide or withhold consent. It is the responsibility, within contemporary standards of care, for Health Services

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personnel to provide information adequate to permit informed decision making on the part of patients.

Simple health care interventions do not require explicit consent. Rather, consent for simple, non-dangerous interventions is implied by the patient's cooperation. As proposed health care interventions become more complicated and riskier, the need for formal consent increases. Formal written consent is clearly required when surgery (including dental extractions) or the use of dangerous drugs is proposed. Written consent should be in a language that is easily understood by the patient.

In emergency circumstances, when there is either no time for informed consent or when the patient's condition precludes informed consent, the presence of the patient in the treatment setting provides "presumed consent."

B. Capacity for personal autonomy

Personal autonomy or capacity for decision making is assumed unless there is reason to consider it is absent. When the patient appears to potentially lack decision making abilities, a capacity evaluation must be completed by a licensed psychiatrist. If the psychiatrist finds that the patient lacks capacity for decision making the decision-making authority falls to the next of kin. In the event that there is no available next of kin, Health Services staff shall seek legal advice to pursue guardianship. Legal guardians will hold the responsibility for decision making in this instance. It is important to note that patients who lack capacity to refuse care, also lack capacity to consent to care.

C. Public Health Considerations

Refusal of care necessary to the public health (for example, screening or treatment for a communicable disease) may result in the patient being separated from general population or in more extreme cases, court ordered treatment may be sought.

D. Hospitalized Patients

If a hospitalized patient lacks capacity to consent or refuse treatment, the hospital must pursue substituted judgment for consent or refusal. The most common source for substituted judgment is the next-of-kin on record, although formal guardianship may also be requested if next-of-kin is recorded by seeking legal advice.

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Unless guardianship has been assigned, Wardens have no special authority to provide substituted judgement and should advise the hospital personnel to handle the issue as they would for a non-prisoner.

E. Refusal Process

Any proposed health care intervention may be refused by a patient or when applicable, the legal guardian. Documentation of the refusal shall be completed in writing, witnessed by Health Services staff, and documented in the EMR via State Form, 9262, "Refusal and Release from Responsibility for Medical, Surgical, Psychiatric and Other Treatment." Informed refusal presumes that a knowledgeable provider has reviewed the refusal, considered the consequences of refusal on the patient's health, and discussed this with the patient or guardian. Informed refusals to comply with recommended health interventions may be documented as a lack of progress during reviews for patients who are participating in the Case Plan Credit Time process.

Repeated patterns of refusal may be documented in the health record and the licensed clinician may determine, through orders and treatment plans, that formal written refusal may be foregone. (In this event, documentation in the EMR of continuing counseling and refusal must continue.)

Refusals shall include:

1. A description of the health service being refused;
2. Documentation that the patient has been made aware of any adverse consequences to their health that may occur as a result of the refusal;
3. Recommendation regarding refusal;
4. The signature of the patient; and,
5. The signature of the Health Services staff witness

Operations personnel may report refusal to Health Services personnel, but refusal witnessed solely by Operations personnel may not be relied upon to be "informed refusal."

When a patient refuses health services but refuses to sign the refusal form, two (2) staff members may sign and witness the refusal form.

Refusal of critical interventions or the development of a pattern of refusal must be presented to and reviewed by a practitioner.

For patients that lack capacity for decision making, a refusal form will not be accepted.

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In routine circumstances, court intervention shall be sought. The court has the responsibility and authority to appoint a guardian who is authorized to make health care decisions on behalf of the patient. Legal Guardians must be kept informed and, in a position, to provide informed consent or refusal. If a court appointed guardian becomes unavailable, refuses to make any decision, or becomes otherwise unworkable as a guardian, the facility may request the Legal Services Division to take the matter back to court.

When questions or conflicts develop, facility personnel are advised to obtain consultation with Legal Services earlier rather than later.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title ADVANCE DIRECTIVES

Legal References IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides a process for patients to utilize advance directives to determine in advance of need which health care interventions they would prefer to receive or to decline.

II. DEFINITIONS:

- A. **ADVANCE DIRECTIVE:** A document or verbal statement in which an individual either states choices for medical treatment or designates who shall make treatment choices if the individual should lose decision-making capacity. The advanced directive shall be documented on State Form 55317, "Indiana Physician Orders for Scope of Treatment (POST)."
- B. **CAPACITY EVALUATION:** The assessment of one's ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.
- C. **LIVING WILL DECLARATION:** A written and signed declaration instructing the individual's health care providers to withhold or withdraw certain death-delaying procedures when the individual is in a terminal condition and unable to communicate his or her wishes.
- D. **LIFE PROLONGING PROCEDURES DECLARATION:** A written and signed declaration which instructs the individual's health care providers to use life-prolonging procedures when the individual has an incurable injury, disease, or illness determined to be a terminal condition.
- E. **HEALTH CARE REPRESENTATIVE:** A person appointed under the Health Care Consent statute in Indiana to make health care decisions when an individual is unable to communicate decisions about health care.

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- F. **TERMINAL CONDITION:** An incurable and irreversible condition in which death will occur within a short time.
- G. **DEATH DELAYING PROCEDURE:** Any medical procedure or intervention which, in the judgment of the attending physician, would serve only to postpone the moment of death.
- H. **COMPETENT ADULT PATIENT:** Any adult of sound mind who is capable of making informed health care decisions and for whom a court has not appointed a guardian or conservator.
- I. **ATTENDING PHYSICIAN:** The physician selected by, or assigned to, the patient and who has primary responsibility for the treatment or care of the patient.

III. PROCEDURES:

An advance directive consists of written direction from a patient directing Health Services staff either to provide or withhold certain treatment. Each time that a patient is identified as having a terminal disease or is admitted to an infirmary, consideration shall be given to establishing or updating an advance directive. Additionally, Intake and annual health screens are an opportune time to update advance directives.

The advance directive must be specific and clear and must be signed by the patient and witnessed by at least one other person. If implemented during incarceration, at least one of the witnesses must be a member of the health care delivery team who is not the attending physician.

In addition to directions regarding health care services that the patient does not wish to be provided, the advance directive must contain a statement indicating clearly that the directive is provided voluntarily, and Health Services staff have answered all questions that the patient had regarding the advance directive.

The advance directive, documented on State Form 55317, must be signed by both the patient and the physician, dated, and scanned into the electronic medical record with the original filed in the paper health record. A copy shall be provided to the patient.

When decision-making ability regarding health care decisions is questionable, a capacity evaluation shall be completed by a psychiatrist within twenty-four (24) hours of (before or after) the advance directive; otherwise, the advance directive shall be considered invalid. If it is determined that the patient lacks informed decision-making capacity regarding health care decisions, the proper court shall be requested to make a determination on this question.

Emergency medical care is often provided in the absence of a health record by staff not familiar with the patient. The advance directive must contain a statement indicating that the patient understands that possibility. If an advanced directive is violated by Health Services staff acting in

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good faith in this manner, neither the health care staff member, nor the Department, shall be held liable.

Any patient that holds capacity for decision making may initiate an advance directive. No employee shall draft an advance directive for a patient, but the attached form may be provided to any patient, all questions shall be answered, and reasonable assistance shall be given.

Advanced directives may be revoked at any time by the patient, in any of the following ways:

- A. A signed and dated written statement revoking the advance directive;
- B. Physical cancellation or destruction of the declaration by the patient or another person in the individual's presence and at the individual's direction; or,
- C. An oral expression of intent to revoke.

IV. ADDITIONAL CONSIDERATIONS:

- A. It is useful to approach the advance directive process early in the disease process when patients can still think clearly and act on their own accord.
- B. An advance directive established for use in an off-site facility is not applicable within the Department, unless the original is provided to the Department and the patient affirms in writing their wish to have it used. It is usually simpler to establish a new advance directive for local use.
- C. Medical futility refers to any treatment that is considered unlikely to produce any significant benefit to a patient with no reasonable hope for a cure. Medical futility shall only be considered with direct consultation of the Health Care Vendor's Regional Medical Director and the Chief Medical Officer. This is a situation that should only be used for extreme cases when there is no advanced directive on file. Health Services staff shall seek legal advice and work to seek guardianship. When a hospital recommends actions to the facility Warden, the Warden shall consult with the CMO, and will agree to the recommendations unless there is a reasonable justification against agreement.


V. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults and their staff.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title DIRECT ORDERS

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. **PURPOSE:**

This Health Care Services Directive (HCSD) emphasizes the necessity to adhere to professional roles and credential restraints.

II. **GUIDELINES:**

- A. No Health Services employees are permitted to provide services unless the services are within the boundaries created by training, licensure, registration, or certification. In particular, only facility practitioners licensed in accordance with the laws of Indiana may provide orders for Health Services staff.
- B. Orders may be in written (including computer generated by a practitioner) or verbal form.
- C. Verbal orders shall be countersigned by an authorized practitioner by the end of the next business day.
- D. Orders shall include the date and time written and shall be signed by the responsible practitioner.
- E. Pre-printed orders may be used for specialized areas (e.g., dialysis, inpatient units) if they are specific, edited, or individualized for each patient by the responsible practitioner
- F. If a nurse or other health care professional receiving an order questions its validity, the health care professional shall work with their supervisory chain of command to ensure either that the order is modified or is acceptable.

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- G. If the practitioner has questions regarding the appropriateness or validity of an order to be countersigned, a progress note describing the concern shall be placed in the health record and the order may be left unsigned.
- H. All orders shall be reviewed and rewritten when a patient changes levels of care (e.g., admission to an inpatient unit, begins dialysis, etc.). Current orders do not need renewing when the patient transfers from one Department facility to another if the level of care (e.g., outpatient services) has not changed.
- I. Employees transcribing orders shall include date and time the transcription was completed and include the full signature and professional title.
- J. Qualified Health Services staff shall complete twenty-four (24) hour chart checks. The signed twenty-four (24) hour check indicates that the transcription was accurate unless a correction is noted.

III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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Manual of Policies and Procedures**

Title

MEDICATION MANAGEMENT

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6 IC 25-16-15 IC 25-23-1-19.5 848 IAC 5-1 IC 16-42-19-11 856 IAC 1-24-2 856 IAC 1-31-2	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the manner in which Department facilities and personnel prescribe and manage medication.

II. DEFINITIONS:

For the purposes of this HCSD, the following definitions are presented:

- A. CASE PLAN CREDIT TIME (CPCT) is an earned credit time cut structure that is driven by the needs indicated in the IRAS and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time, as allowed by law.
- B. CONTROLLED SUBSTANCES: Those drugs included on Schedules I through V of the Federal Controlled Substances Act or on Schedules I through V of IC 35-48-2. No Schedule I drugs may be used in the Indiana Department of Correction. The Indiana board of Pharmacy may place certain drugs in controlled status
- C. CLINICAL PHARMACIST: A pharmacist who holds a valid license in the State of Indiana and who has been assigned to the facility to serve as a pharmacy advisor on matters of pharmaceutical management. This pharmacist will perform quarterly surveys to review facility medication management.
- D. CONTROLLED SUBSTANCE REGISTRATION (CSR): A registration with the State of Indiana which, like the DEA Certificate, is required for the procurement, storage, administration, dispensing, and destruction of a controlled substance. This registration is required when applying for a DEA Certificate. The application for an Indiana CSR is made through the office

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of Professional Licensing.

- E. DOT (DIRECT OBSERVED THERAPY): Medication that is in the possession of, and is administered by, qualified Health Services staff. Also referred to as “Hand Feed” medication.
- F. DEA CERTIFICATE: A certificate from the DEA, an agency of the Federal Department of Justice, which can be assigned to a prescriber or a facility on the responsibility of a qualified health services professional for that facility. This certificate assigns a DEA number registering the certificate holder and is required for the procurement, storage, dispensing, and processing of a controlled substance which has been discontinued.
- G. DEA FORM 222: The triplicate form used to account for the movement of a schedule II controlled substance that is from stock or to destruction company from one entity to another. It is obtained from the DEA by holders of a DEA Certificate.
- J. KOP (KEEP ON PERSON): Medications that are possessed and self-administered by the patient. Also referred to as “May Carry” medication.
- K. MAR: Medication Administration Record.
- M. MEDICATION ERROR: A discrepancy between what the prescriber ordered and what was or was not administered.
- N. PHARMACY AND THERAPEUTICS (P&T) COMMITTEE: Provides an evaluation, educational, and advisory service to the Health Services staff and organizations administration in all aspects of the use of the available medications and maintaining a formulary list. P&T consists of physicians, clinical pharmacist, nurses, and Department Health Services Division leadership.
- O. PRACTITIONER’S SUPPLY: Pre-packaged medications supplied from a pharmacy but maintained under secure conditions by a prescriber for the purpose of immediate dispensing as required to assure good patient care.
- P. PRESCRIBER: A physician or dentist, with a valid Indiana license, an optician practicing in accordance with IAC 857 (optometry legend drug regulations) or an advanced practice nurse who meets the requirements of IC 25-23-1-19.5 (authority to prescribe legend drugs).

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- Q. **PRESCRIBER'S ORDER:** A written, telephonic, electronic, or verbal prescription, whether directed to an individual or as part of a properly authorized protocol.
- S. **QUALIFIED MEDICATION AIDE (QMA):** an individual who has been certified to administer medications.
- T. **SUPERVISING NURSE:** A registered nurse (RN) authorized to supervise other members of the nursing staff. When only one (1) registered nurse is available at a facility, that nurse shall be considered to be the supervising nurse. When more than one (1) registered nurse is available at a facility, the highest ranking registered nurse shall be considered the supervising nurse.
- U. **SUPPLIES FOR NURSING PROCEDURES:** Items or supplies stocked at the facility, which are necessary for the following purposes: 1) to provide nursing care; or, 2) to treat a health condition in an immediate fashion.

III. GENERAL GUIDELINES:

The Warden in collaboration with the facility's Health Services Administrator (HSA), the Director of Nursing (DON), the Site Medical Director (SMD) and the Clinical Pharmacist shall be responsible for ensuring the development, implementation, and evaluation of local procedures regarding the selection, procurement, dispensing, distribution, administration, storage, and disposal of medication in accordance with local, state, and federal laws, promulgated rules, contemporary standards of accountability, and this HCSD.

The Health Services Division's Pharmacy and Therapeutics (P&T) Committees shall be responsible for determining the scope of pharmaceutical services within the Department, establishing procedural guidelines for medication management, and establishing and maintaining the formulary.

Medical providers authorized to prescribe within the Department are physicians, dentists, podiatrists, optometrists licensed and certified under IC 25-16-15, and advance practice nurses who meet the requirements of IC 25-23-1-19.5 and 848 IAC 5-1 and are employed within the Department as prescribers.

Except for over-the-counter (OTC) medication self-selected by patients in general population through the commissary, all medications, including OTC medications, shall be provided to patients only upon the approval of a prescriber authorized by law to prescribe. Prescription authorization may be in written format as drug orders, be directly communicated through verbal or telephone orders, or be authorized through written protocols comprising standardized treatment guidelines.

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Department prescribers shall adhere to the following general prescribing guidelines:

- Drug therapy is managed by an authorized prescriber acting in good faith in the usual course of their professional practice
- Drug therapy is initiated only after an appropriate clinical evaluation has been completed
- Provision of the drug is the preferred mode of treatment for the condition
- The prescriber shall review all drug-related allergies prior to prescribing the medication
- The strength and quantity of the drug to be dispensed are reasonable; and
- The duration of the drug order does not exceed one hundred eighty (180) days for formulary medication and ninety (90) days for non-formulary medication

All drug orders shall contain the following:

- The name and DOC number of the patient
- The date and time the order was written
- The medication, dose, means and frequency of administration, and duration of treatment
- The quantity of the medication, including the amount to dispense in a certain time frame, when applicable
- The signature and credentials of the prescriber

Drug orders which deviate substantially from a normal pattern, are ambiguous, or are of an unusual quantity or frequency shall not be dispensed until verification of the order is obtained from the prescriber.

The Health Services vendor shall not maintain samples of medications supplied by pharmaceutical companies or other sources.

It is the responsibility of the HSA, the DON, the SMD, and the Clinical Pharmacist to ensure that Health Services staff abide by these guidelines.

IV. SELECTION OF MEDICATION:

A standardized formulary has been established for the purposes of guiding prescribing practices and its use is mandatory by prescribers working within the Department. It shall be readily available to the professional staff who use it. The formulary shall:

- Provides a rational yet limited group of medications,
- Provides a process for obtaining off formulary medications, when necessary,

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- Provides guidance regarding selection of the cost effective, efficacious medication when alternative choices of varying costs exist,
- Discourages the use of medications without proven effectiveness,
- Provides a formal mechanism for adding or removing medications from the approved list, and
- Provides lists of medications for use in different circumstances.

It is imperative that the formulary maintained by the facility is current.

V. P&T COMMITTEE AND FORMULARY MAINTENANCE:

A Statewide Pharmacy and Therapeutic (P&T) Committee shall be established and shall meet quarterly for the purposes of formulary maintenance, reviewing FDA drug alerts, and medication errors. The P&T Committee shall be overseen by the clinical pharmacist for the contracted Health Services vendor. Requested changes to the formulary shall be presented to the P&T committee by the clinical pharmacist with all rationales and descriptions. Formulary shall be maintained by P&T committee and provided to Department Health Services Staff, appropriate Executive Directors, and the CMO. All changes to the formulary shall be shared with facility staff and prescribers. The Vendor's Regional Pharmacist shall disseminate any updates to the formulary to the site HSAs and the P&T Committee within thirty (30) days.

A. Formulary Limitations

The formulary identifies some medications that have limited indications or duration for use. Prescribers are expected to be familiar with the medication limitations listed in the formulary. When the medications are used in accordance with limitations, they are considered formulary medications. When these medications are not used in accordance with the recommendations listed, they are considered off formulary medications and a Non-Formulary Medication Request form must be submitted and approved in advance of non-urgent use.

B. Requests for Non-Formulary Medications

The Health Services vendor shall ensure a process is in place for prescribers to request non-formulary medication. The drug order for a non-formulary medication may not be dispensed by the pharmacy until approval has been obtained. The decision regarding non-formulary medication usage shall be communicated to both the prescriber making the request and the dispensing pharmacy. All decisions regarding clinical care must be documented in the EMR.

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When the non-formulary medication is needed on an urgent or emergent basis, the prescriber may authorize its use by indicating to the dispensing pharmacist that the drug order must be filled urgently. In this situation, approval for the non-formulary medication may be obtained retrospectively. The contracted medical vendor shall ensure that processes are in place to obtain non-formulary medications when required urgently.

C. Therapeutic Substitution

Therapeutic substitution is the replacement of the originally prescribed medication with an alternative molecule with assumed equivalent therapeutic effect. The alternative medication may be within the same class or from another class with assumed therapeutic equivalence. This substitution may be suggested by a clinical pharmacist; however, the pharmacist must obtain full consent and agreement from the prescriber. For all therapeutic substitutions the patient must be made aware and provided education of the new medication and the rationale for the change.

D. Procurement of Medication

1. Routine Procedures

The Health Services vendor shall have a process in place that allows for prescribed medications to be obtained through routine pharmacy methods and plans for a backup pharmacy when medications needs are urgent and cannot be filled immediately. The responsible HSA shall identify an emergency pharmacy for this purpose.

The dispensing pharmacy must receive an original order generated through the EMR except for Schedule II controlled substances when a paper prescription is necessary. The Drug Enforcement Agency (DEA) has written regulations that allow electronic CII prescriptions. The State Board of Pharmacy has also written regulations allowing electronic prescriptions. If all regulations are met and the P&T committee approve electronic CII prescriptions, then this process may be used.

2. Telephone and Verbal Orders

A drug order issued by a prescriber may be communicated to the pharmacist by licensed nursing personnel or another medical provider acting as an agent of the prescriber. Either an RN or an LPN may accept a telephone or verbal order. Verbal/telephone orders shall contain the date and time, patient name and number,

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medication, dose, means and frequency of administration, duration of treatment course, name of the licensed nurse accepting the order, and the name of the prescriber giving the order. The prescriber must countersign the order in the EMR on the next business day. Site HSAs shall ensure a process to verify that verbal orders are obtained and countersigned appropriately.

3. Drug Order Transcription

Both RNs and LPNs may transcribe drug orders onto Kardexes, medication administration records or any other document used to guide patient care. The nurse should affix a professional signature including date and time to indicate that the order has been transcribed. Clerical staff may transcribe drug orders onto Kardexes and medication administration records only if a RN verifies the accuracy of the transcription and co-signs the transcriber's signature.

VI. DISPENSING:

Except for CSIIIs, formulary and nonformulary prescriptions are valid for up to one hundred eighty (180) days. Up to a thirty (30) day supply may be dispensed at one time.

The dispensing pharmacy, in collaboration with facility Health Services staff and in consideration of the available storage space within the facility, may dispense a quantity less than that which is identified on the drug order.

Nursing staff may not repack medications by removing a bulk quantity and placing them into a separate container for subsequent administration. Nurses may not change the instruction or directions for use on a prescription.

When a medication has been dispensed on a drug order and a prescriber subsequently changes the duration of the order, the quantity to be administered, or the frequency or timing of the medication, the nurse may continue to use the previously dispensed medication but may not change the prescription label. Labels that refer the nurse to the Medication Administration Record may be affixed to the container or blister package directing the nurse where to locate current administration information.

Under no circumstances may a prescription dispensed for one patient be diverted to another individual.

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VII. REFILLS AND EXPIRATION OF MEDICATION ORDER:

Health Services staff may not refill a drug order except in the manner designated on the original order. Nursing staff or the dispensing pharmacy may not assume that a prescriber will automatically renew a drug order and authorize a renewal without first verifying the order with the prescriber.

For medications generally administered on a continuing basis, the facility's HSA, the DON or in facilities without DON, the Nursing Supervisor and SMD shall establish a site-specific process for notifying a prescriber of the impending expiration of a drug order so that the prescriber can determine whether the drug should be continued. The prescribers are responsible for writing refill orders and nursing staff shall not prepare refill prescriptions unless the orders are obtained via an appropriately executed telephone or verbal order.

When medications are used to treat a chronic health problem, the prescriber must review the drug regimen at every chronic care appointment. There must be a process in place by the Health Services vendor to ensure that there are no gaps in medication.

VIII. TEMPORARY LEAVES:

From time to time, incarcerated individuals will need to be absent from the facility for court appearances, temporary furloughs, etc. If Health Services staff have sufficient time to plan for this temporary absence, they may obtain from the pharmacy a travel prescription of sufficient quantity to cover the time away from the facility. If Health Services staff do not have time to obtain a travel prescription, the patient's entire prescription must be sent. The Health Services vendor shall ensure a process is in place to ensure continuity of care and no gap in medication services.

IX. STOCK MEDICATIONS:

Stock medications are medications dispensed by a pharmacy, maintained at a facility, properly prescribed, and administered by nursing staff when immediate usage is appropriate.

Supplies of stock medication shall be kept in a designated cabinet or other suitable fixed location, which is durable, and of sufficient design and size to ensure a proper environment for the preservation of the medication. Stock medications must be secured by a lock at all times except when it is necessary to retrieve medications, audit supplies, or manage the inventory.

A separate log sheet shall be kept for each type and dosage of medication.

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The prescriber's order, which directs nursing staff to use stock medications, signals the pharmacy to dispense only the remaining portion of the medication order if necessary.

The dispensing pharmacist is responsible for refilling stock medications as ordered, properly labeling all medications, maintaining records of stock medication dispensing and administration, and assisting in resolving discrepancies if such are noted.

The facility's HSA and DON or Supervising Nurse shall periodically monitor the type and quantity of stock medications to ensure that the available quantity is sufficient to meet the needs of the facility but is not excessive; this is usually a fourteen (14) day supply. If the types or quantities of stock medication are not sufficient or if a supply of medication is not used, the facility may alter the inventory quantities with consultation from the Health Services vendor's clinical pharmacist.

Whenever there is a discrepancy noted in the inventory, whether theft is suspected or not, the employee shall immediately notify the nurse in charge. The HSA and DON or Nursing Supervisor shall coordinate efforts to investigate and shall notify the Executive Director of Physical Health and Quality Assurance Manager as soon as possible. If criminal behavior is thought likely, the Warden and Deputy Warden(s) shall be informed immediately. A medication problem report must be completed using State Form 49107, "Report of Medication Problem," and the facility's Quality Assurance Committee, at its next meeting, shall review the circumstances surrounding the discrepancy, theft or loss.

X. PRACTITIONER SUPPLY OF MEDICATIONS (See Facility Directive):

The prescriber's supply includes medications which must be initiated immediately, and which are maintained by a prescriber for this purpose. They shall be reserved for those occasions when the normal delays in obtaining a medication order through routine processing would cause harm to the patient or would negatively impact the outcome of treatment.

Each prescriber shall individually determine whether their professional practice requires a practitioner's supply. The practitioner's supply of medication may only be used when the prescriber is available on-site and in response to an evaluation, treatment, or intervention carried out by the prescriber. Each prescriber must manage their own supply and this supply shall not be shared or transported to other locations.

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Indiana statutes permit maintenance of practitioner supplies in Department facilities. The Legend Drug Act (IC 16-42-19-11 section 2) permits a prescriber, in good faith in the course of practice, to deliver a legend drug to a patient. This statute requires that the immediate container in which the medication is delivered has a label that contains name of the medication, directions for use, name and address of the prescriber, and name of the patient.

If a prescriber chooses to dispense only a portion of the dispensed medication, the prescriber must write out the name of the medication, the directions for use, the name and address of the prescriber in addition to the name of the patient on a label which is then affixed to the container. In addition, the prescriber must maintain full records of the dispensing process consistent with pharmacy regulation.

When only a single dose is given, the prescriber does not need to label a container, the prescriber may administer the medication directly or provide the nursing staff with a single dose for immediate administration. When the prescriber administers the medication, they are responsible for completing the appropriate documentation on the medication administration record.

When a prescriber distributes medication from their supply, they shall initiate a corresponding medication order in the EMR and indicate that the medication was dispensed from the practitioner's supply.

Prescriber may dispense medication directly to the patient in accordance with the Keep on Person (KOP) procedures or may distribute the medication to nursing personnel for subsequent administration.

The prescriber must also note the patient's name and DOC number, and the date on which the medication was distributed, affixing their initials on the appropriate sections of an inventory of practitioner supply log sheet. When documenting on the log sheet for the first time, the prescriber must complete the signature section signing their name and professional title on the appropriate line and placing their initials in the corresponding initial section.

The practitioner's supply, once packaged by the dispensing pharmacy, will bear a label, which contains the name of the medication, the standard directions for use, and the name and address of the prescriber. If the standard directions for use are ordered, the prescriber shall then have to add only the patient's name and DOC number to the label when the entire blister package is to be dispensed. If the prescriber deviates from the standard directions for use, then additionally the prescriber must label the medication with the specific directions for use.

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Practitioner supply medications shall be dispensed by the dispensing pharmacy which routinely dispenses medication for the facility and will normally be packaged in blister packages in quantities to be determined by the prescriber. Prescribers may elect to limit the quantity dispensed to a seventy-two (72) hour supply of medication or they may choose to have their supplies packaged in larger quantities in order to deliver a complete course of therapy (e.g., 10-day supply of antibiotics).

The pharmacy is responsible for accurately refilling the practitioner's supply, properly labeling all medications, and maintaining records regarding medications dispensed to practitioner's supplies. The prescriber must maintain records regarding dispensing from the practitioner's supply. If problems develop, the pharmacist may assist in the resolution of discrepancies.

The Clinical pharmacist is responsible for verifying the accuracy and appropriateness of practitioner's supply usage and the integrity of the inventory and storage processes.

The prescriber is responsible for maintaining the security and integrity of the practitioner's supply and associated records and reconciling any noted discrepancies. Facility Directives governing the use of the practitioner's supply medications must be established and implemented in accordance with these guidelines.

Any prescriber that fails to abide by these guidelines shall have the privilege to maintain practitioner supplies of medications revoked.

The prescriber must conduct a weekly inventory of the practitioner's supply medication, in a perpetual inventory format.

It is the responsibility of the Health Services Administrator and the Clinical pharmacist in collaboration to ensure that each prescriber maintaining a practitioner's supply abide by these guidelines.

Practitioner supplies shall be stored in a designated cabinet or other suitable fixed location which is durable and of sufficient structure and size to ensure a proper environment for the preservation of the medication. Storage cabinets must be secured by a lock at all times except when it is necessary to retrieve medications, audit supplies, or manage the inventory. In addition, controlled substances must be securely stored in a fashion that requires two different keys for two unique locking mechanisms. The prescriber may not give access rights to their practitioner supply when they are not on-site at the facility.

At the time supplies of practitioner medications arrive at the facility, a practitioner's supply inventory sheet shall be initiated. Separate log sheets must be used for each

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medication. The prescriber must use these log sheets to document and monitor all prescriber medication usage.

Log sheets shall be completed in a timely manner and maintained on file in the facility for two (2) years and be readily available for review. The prescriber shall conduct a physical count of the inventory each week regardless of whether any medications have been removed and, additionally, whenever the storage cabinet is opened. Formal weekly counts shall be documented on the log sheets.

Whenever there is a discrepancy noted in the inventory, whether theft is suspected or not, the staff shall immediately notify the HSA. The HSA shall coordinate efforts to investigate and notify the Executive Director of Physical Health and Quality Assurance Manager as soon as possible. Nursing staff may assist in reconciliation of noted discrepancies. If criminal behavior is thought likely, the Warden and Deputy Warden shall be informed immediately. A medication problem report must be completed and the facility's Quality Assurance Committee, at its subsequent meeting, shall review the circumstances surrounding the discrepancy, theft, or loss.

XI. SUPPLIES FOR NURSING PROCEDURES:

Nursing Supplies are items stocked at the facility for use by nurses to facilitate nursing interventions or to treat health conditions in an immediate fashion. For example, nursing supplies may include both legend and over-the-counter products, such as flu vaccine, purified protein derivative (PPD), povidone-iodine, isopropyl alcohol, and sterile water.

Nursing supplies should include medications needed to respond to drug overdoses (e.g., Narcan) and to treat potential adverse effects of medication (e.g., glucagon, Vitamin K). These supplies can be used pursuant to a prescriber's order or in carrying out standard nursing interventions.

Usage of legend and OTC medications from nursing supplies and nursing protocols must be documented in the EMR

The Clinical pharmacist is responsible for reviewing the types of medications maintained in nursing supplies and may discard or destroy items which do not belong.

Each facility must post the phone numbers for Poison Control Statewide: 1-800-222-1222

XII. MEDICATION STORAGE:

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All medications must be stored under proper conditions of sanitation, temperature, light, moisture, and security. When stability is dependent upon special storage conditions such as refrigeration, these conditions shall be provided and maintained.

Tablets and capsules shall be stored at controlled room temperature (not to exceed 78 degrees Fahrenheit). Medications that require refrigeration shall be stored at a temperature between thirty-six (36) to forty-six (46) degrees Fahrenheit and medication that require storage in the freezer shall be stored below thirty-two (32) degrees Fahrenheit.

The medication refrigerator shall not contain any food, except nutritional supplements drink items, or laboratory specimens. It shall be kept clean and free of excess frost. The temperature maximum and minimum shall be checked and recorded each day on a Refrigeration Temperature Record Form.

A common misconception is that some medications maintain their potency if stored in the refrigerator, but the high humidity environment may accelerate the breakdown of some preparations (e.g., Nitroglycerin SL tablets) and the cold may form a precipitate in some liquids. In addition, advances in formulation of some medications historically refrigerated permit them to remain at room temperature for some time (e.g., Insulin may be kept at room temperature for thirty [30] days).

Medications which are inadvertently stored at an improper temperature shall be discarded in accordance with this HCSD.

Nursing staff are responsible for ensuring the proper storage of medication and the pharmacy or manufacturer's recommendation shall be consulted whenever storage questions (routine or improper) arise.

Medications that are stored in similar containers but do not have similar uses shall be properly labeled and shall not be stored in proximity to each other (e.g., PPD and Tetanus).

XIII. DANGEROUS ITEMS:

Needles, syringes, and other sharps or abusable items must:

- Be stored under proper secured conditions and
- Accounted for by the maintenance of a perpetual inventory sheet, end of shift counting procedures, and other counts as appropriate.

The control of medical instruments shall be in accordance with Policy and Administrative Procedure 02-03-107, "Tool/Equipment Control."

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XIV. MEDICATION DISTRIBUTION (See Facility Directive):

All medications prescribed within Department facilities shall be considered either may carry/keep on person (KOP) or handfeed/directly observed therapy (DOT)

KOPs are dispensed and provided to patients for self-administration. The patient is permitted to possess up to a forty (40) day supply of medication, either on their person or secured in their living area for up to ninety (90) days after the dispensing date or until the expiration date on the medication container's label, whichever is earlier. Delivery of KOPs to patients shall be noted within the health record by the patient's signature on an MAR or other permanent sheet in the health record. Pharmacy packing receipt or inventory forms which accompany dispensed medications from the pharmacy to the facility shall not be used for this purpose.

Medication dispensed as KOP at one facility may be used without re-packaging or new labeling at another facility after a patient is transferred, subject to facility conditions, such as transfer into a restrictive status housing setting.

DOTs shall be provided one dose at a time, and each dose shall be documented on a MAR. In general, DOT medications include:

- Addictive or controlled substances;
- Psychotropic medications;
- Medications used in the control or prevention of dystonic reactions;
- Preparations in flammable vehicles;
- Substances with broad abuse histories;
- Drugs used for treating tuberculosis infection; and,
- Medications currently used to treat cancers, HIV, Hepatitis B, or Hepatitis C

Individual patients who have a propensity to abuse or misuse medication may be required to receive all medications through a DOT process. When this is done, the reasons are to be documented in the EMR and an order to that effect written. Prescribers may prescribe any medication as DOT.

In most settings, DOT medications will be delivered by nurses or QMAs. However, an unlicensed person such as trained Correctional Officer or other staff member may assist or facilitate the self-administration of medication in the following manner. The staff person may:

- Remind the patient to take the medication
- Assist the patient by removing the medication container from the storage area and handing it to the patient. (If the patient is physically unable to open a container, the staff member may open it.)

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- Observe the patient taking the medication to ensure that they adhere to the directions on the container
- At the patient's request, read the label to them to clarify the amount to be taken

When unlicensed staff are used to assist in the self-administration of medication, a Facility Directive must be developed and implemented. Documentation of each dose taken shall be maintained.

KOP medications, when discontinued with any quantity remaining, may not be returned to the pharmacy for credit; however, they may be returned for proper destruction. DOT medication(s) when discontinued, may be returned provided the medication:

1. Is not a controlled substance, and,
2. Has been under the immediate control of licensed nursing personnel,

Medication dispensed from one pharmacy may not be returned to another pharmacy.

XV. ACCOUNTABILITY:

Medication storage and distribution areas shall be devoid of outdated, discontinued, or recalled medications. Once each month, Health Services staff shall review medications in storage, including those maintained as stock medication, Practitioner Supplies, Nursing Supplies, DOT supplies, or KOP supplies waiting to be delivered, and remove from them medications that are out dated.

When checking expiration dates, the last day of the month shall be used if the manufacturer's expiration date simply identifies a month and year.

Multi-dose vials (MDVs) may be used for up to twenty-eight (28) days after the date of first entry or to the manufacturer's expiration date, whichever comes first, subject to a favorable visual inspection using professional judgement of the MDV and its contents. The date of first entry shall be indicated on the vial. In lieu of the date of first entry, the pharmacy fill date on the label must be used as a default date of first entry. Vaccines may be use until manufacturer expiration date

XVI. OUTDATED ORDERS:

Medications retained in the property of patients are considered outdated and are contraband ninety (90) days after the stop date on the label. If expired/contraband medication are seized by facility staff, the staff shall immediately deliver the medication to Health Services staff for timely review.

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XVII. MEDICATION ADMINISTRATION:

Medication shall be administered only upon the authorization of a prescriber and in a manner, which is consistent with the usual and customary practices of medication delivery. All nurses administering medication within the Department have a responsibility to adhere to the eight (8) “rights” of medication by giving the right medication to the right patient, in the right dose, by the right route, at the right time with the right documentation, for the right reason, and with the right response. Medication must be administered by the nurse or the QMA who has set up the doses and must be administered during the shift on which set up occurred.

Student nurses may administer medications when under the direct supervision of the instructor and the activity is part of the student’s educational programs.

While it is impractical to deliver medications to all patients in a facility at the exact time at which scheduled, the generally accepted standard is to provide medications within a one (1) hour window, within sixty (60) minutes before or after the designated time. Periodically, circumstances or situations will arise (e.g., lock downs or emergency counts) which derail the administering staff’s ability to adhere to this standard. In this situation, the administering staff shall make all reasonable attempts to administer the medication as close to the prescribed time as possible. (Of course, certain medications do not permit this much leeway in administration. Examples include pre-meal insulin and pre-procedure pain medication.)

Nurses are also responsible for:

- A. Monitoring for desired therapeutic effects and adverse reactions, documenting these observations, and reporting them to the appropriate prescriber, and,
- B. Recognizing common drug incompatibilities and reporting interactions or potential interactions to the prescriber.

Patients are to receive instruction in the proper manner or technique of self-administration by a prescribing medical provider or nurse for those medications which they are to self-administer. This instruction shall include, but is not necessarily limited to, the name of the drug, the schedule and technique for administration, the duration of therapy, and special storage requirements, if any.

Medication compliance may be identified on the Clinician Review Form as a treatment goal for patients who are participating in the Case Plan Credit Time Review process.

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Medication administration may be accomplished differently in various facilities based upon the type of medication, route of administration, and nature of the facility.

All nurses, QMAs, and Correctional Officers involved in facilitating self-administration shall be fully instructed and trained regarding the medications involved and regarding the administration process. Training shall be documented and records of the training available for inspection.

A nurse or QMA **shall not**:

- A. Administer any medication they are not familiar with or qualified to administer. It is the individual nurse's responsibility to become familiar with all medications they are administering
- B. Provide medication through any route outside their scope of practice
- C. Delegate aspects of medication administration to any nurses or QMAs untrained or unqualified to perform
- D. Accept the delegated assignment of any aspect of medication administration that the nurse or QMA is untrained or unqualified to perform

The following guidelines shall be considered in determining which nurses may use specialized medication administration routes:

- A. RNs who have received additional educational preparation and demonstrated clinical competency may administer medications via intraarterial, intraperitoneal, intravesical, intrapleural, endotracheal, and implanted injection port routes.
- B. LPNs may participate in certain aspects of intravenous (IV) therapy procedures providing the LPN has received training through a continuing education course and has the clinical experience which supports performance of the tasks safely and competently. Under the direction of an RN or prescriber, the LPN may only perform the following aspects of IV therapy procedures:
 - 1. For peripheral catheters;
 - 2. Preparing the administration equipment;
 - 3. Performing the peripheral venipuncture and inserting a butterfly or "over the needle" plastic catheter;
 - 4. Initiating or hanging replacement IV solutions;
 - 5. Calculating or regulating flow rates;

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6. Changing tubing;
7. Observe for therapeutic and adverse effects of IV therapy;
8. Inspect insertion sites, and change dressings;
9. Administration of a routine maintenance medication via a preprogrammed pump; and,
10. Converting continuous infusion to intermittent infusion

For all other IV lines (midline, midclavicular peripheral catheters and, central venous catheters):

1. Calculating or regulating flow rates;
2. Hanging replacement fluid;
3. Changing tubing;
4. Observe for therapeutic and adverse effects of IV therapy;
5. Inspect insertion sites, and change dressings;
6. Administration of a routine maintenance medication via a preprogrammed pump; and,
7. Converting continuous infusion to intermittent infusion

LPNs may administer IV medication and fluids that are mixed and labeled by a RN or pharmacist including “solusets” or “ready or mix” solution infusion systems or given on a routine reoccurring basis to a patient with a stable condition

While the RN may delegate certain activities associated with IV therapy, the RN is responsible for the overall administration and nursing management of the patient receiving this therapy by providing appropriate supervision and delegating only those procedures that the LPN is capable, by education and demonstrated skill, to performing. When delegating to an LPN, the RN shall consider the condition of the patient, the type of IV line being used for therapy, the type of fluid or therapy being administered, the ability of the LPN to recognize adverse reactions and to take appropriate action when adverse events occur, and the proximity and availability of the RN responsible for supervision.

LPNs are not permitted to:

1. Administer blood or blood components, plasma volume expanders, tissue plasminogen activators;
2. Give IV push or bolus medication;
3. Administer medications/fluids via an arterial line;
4. Draw blood samples from central venous access ports;
5. Administer medication requiring titration or continuous patient assessment; or,

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6. Remove peripherally inserted central, midclavicular, and midline catheters.

XVIII. MEDICATION ADMINISTRATION DOCUMENTATION:

The administration of medication shall be documented on an approved MAR, approved receipt form, or elsewhere in the EMR.

Nurses providing medications for KOP usage must properly document the provision, including obtaining patient's signature indicating receipt of the supply, usually on the MAR.

Nurses providing medication under DOT conditions shall document each scheduled dose on the MAR, including whether or not it was administered, and the reason if not administered.

Correctional Officers facilitating self-administration shall document each patient contact for this purpose. This documentation shall be available for inclusion in the MAR.

For transferring patients, an MAR initiated at one (1) facility may be continued at the receiving facility.

XIX. NONADHERENCE AND REFUSALS:

Medication nonadherence and refusals shall be documented appropriately. All refusals shall be documented on the MAR and State Form 9262 obtained and documented. All patients missing three (3) consecutive doses of prescribed medications shall be counselled by qualified health services staff. For repeated and continued nonadherence patients shall be referred to the provider and a determination made on the continuation of medications. No shows shall not be accepted as a refusal of medications.

For patients with KOP medications nonadherence shall also be tracked and refusals obtained and documented. Qualified Health Services staff shall provide patient counselling for nonadherence and refer to the provider for repeated nonadherence.

Nonadherence and refusals may be documented as a lack of progress toward an identified goal of medication compliance during a review of the Clinical Review Form for patients participating in the Case Plan Credit Time process. Compliance with involuntary medications may NOT be included in a patient's Case Plan Credit Time review.

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XX. MEDICATION ERROR REPORTING:

Upon discovery of a problem which has occurred with any aspect of the medication distribution process, from the original prescription to administration, the employee noting the problem is required to submit details in writing on the State Form 49107 "Report of Medication Problem." Medication errors shall be reported to the assigned Department Quality Assurance Managers, the Executive Director of Physical Health, and the CMO at time of discovery.

When completed, the form shall be forwarded it to the Director of Nursing or Nursing Supervisor and the HAS, either directly or through the employee's immediate supervisor.

XXI. CONTINUITY OF CARE AT INTAKE:

Medication brought in by patients from outside sources (e.g., home pharmacy, county jail) may not be administered unless they are being precisely identified and approved pursuant to an order initiated by prescriber.

Precisely identified means that, at a minimum:

1. The pharmaceutical products brought in must be properly labeled in accordance with State Board of Pharmacy regulations (Must show all required elements of a valid prescription label, including but not limited to name/address of Dispensing Pharmacy, name of Patient, Name/Lot number/Exp. Date of Medication);
2. The pharmaceutical products in the container cannot be mixed with any other medications in the same container;
3. The contents of the container must be identified as being the pharmaceutical products identified on the container's label; and,
4. The container must be visually inspected and found to be free of dirt or other adulterant both inside and outside;

Medication brought in with a patient may not be administered if:

1. The medication was kept in the patient's possession at the county jail and not under the supervision of Custody or Health Services staff; and,
2. The medication required refrigeration and this was not provided during transport.

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If such drugs are not to be administered, they shall be destroyed in accordance with established procedures and this HCSD.

XXII. MEDICATION MANAGEMENT DURING OFF-SITE TRIPS:

There are three (3) major circumstances, which may require medication management during off site trips. These are diabetes, controlled substances and DOT medications, and routine KOP medication. In each of these instances facility health care staff shall work with operations and transport team to ensure necessary medication and clinical management is addressed. Facility health care staff shall ensure that appropriate medical records are shared with the receiving off-site clinic and that the transporting officers are provided with the appropriate instructions. Clinicians shall determine what medications are needed prior, during, and following all off-site transports.

XXIII. INTRA-FACILITY TRANSFERS:

To ensure continuity of care, medication dispensed for a patient transferring from facility to another is to accompany the patient. Transporting staff shall receive special instruction from Health Services staff if medication will need to be made available to a patient during transport (including short stays in an interim location) to another facility.

Medication which should not be interrupted must be made available to a patient in a timely manner upon arrival at the receiving facility. Health Services staff conducting the transfer screening shall review the medication and corresponding drug order(s). If both the dispensed medication and the corresponding drug order are current, the medication shall be returned to the patient or set up for the next scheduled medication pass. Health Services staff do not need to obtain a new order from a prescriber.

XXIV. RELEASE FROM CONFINEMENT:

When a patient is released from a facility, the existing supply of prescribed medication (legend or over the counter) shall be provided to the departing patient. If the medication supply is for less than seven (7) days , additional medication shall be obtained from the pharmacy. . The seven (7) day release supply shall be regarded as a minimum quantity, but on a case-by-case basis, it may be necessary to obtain up to a thirty (30) day supply of medication from the pharmacy and the sending facility shall provide the patient with a written prescription.

If the patient is receiving medication to control tuberculosis (infection or disease), HIV, HCV, psychiatric medications, and any medication deemed appropriate, a minimum thirty (30) day supply shall be provided upon release.

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If a patient is receiving insulin or other medication for diabetes control, the patient shall also be provided with a simple home glucose testing device and associated materials including control test materials and a seven (7) day supply of test strips at the patient's current usage rate. In addition, the patient shall receive instructions on self-monitoring techniques and how to obtain supplies in the community. If the diabetic patient injects insulin, a seven (7) day, or greater, supply of insulin, syringes, and alcohol swabs shall be provided.

The Health Services vendor shall communicate within one (1) day business day with the site Transitional Healthcare Facilitator when notified of a patient's immediate release to determine Medicaid eligibility.

If a patient is released from a facility without required medications and/or written prescriptions, the Health Services vendor shall send required medications and written prescriptions via overnight mail to the patient's release address.

If a patient is receiving medication requiring mechanical assistance such as inhaler spacers, oxygen concentrators, or nebulization machines, adequate support shall be provided in order reasonably to assure continuity of care upon release, which may include releasing with equipment

If a patient is in the process of receiving a series of vaccinations (e.g., Hepatitis B), the patient shall be instructed regarding the date the next injection is due and the location of public health or other community based clinics where the vaccination series can be completed.

Education shall be provided to the patient regarding how to obtain vaccination records in the community.

XXV. MEDICATION DESTRUCTION AND RETURNS:

Unused portions of prescribed medications excluding controlled substances (Expired, recalled, or discontinued) must be returned to the pharmacy.

Medication return logs must contain patient identifiers, name and strength of the drug, prescription number, reason for return, quantity returned, date of return, and signature of person completing the return.

Completed medication return logs shall be maintained on file for two (2) years. Medication logs must be verified once a week and when sent out for return of medication.

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XXVI. MANAGEMENT OF CONTROLLED SUBSTANCES (See Facility Directive):

Controlled substances are permitted for use when prescribed for an individual patient, and in stock medications, but may not be included in Nursing Supplies.

A licensed prescriber holding valid federal DEA and State Controlled Substance Registration certificates may prescribe Schedules II-V controlled substances in accordance with applicable laws and regulations. In accordance with IC 35-48-39-9 CS III-V drugs may be transmitted to the dispensing pharmacy in written, electronic, or oral form. CS II drugs may be transmitted via written or electronic methods.

All controlled substance shall be secured in a location and with two separate locks. All controlled substances shall be counted in a manner that ensures accountability until the medication is either consumed or destroyed. When controlled substances are under the supervision of employees under twenty-four/seven (24/7) conditions, they must be counted at the beginning and end of each shift by two (2) employees, preferably one (1) employee from the ending shift and one (1) from the oncoming shift. These counts shall be recorded on the appropriate form. If controlled substances are maintained in facility without twenty four/seven (24/7) nursing coverage, the substances shall be counted when staff come on or depart from the shifts using the same form as described above. The Clinical pharmacist shall review the process at each visit.

When counting procedures identify a discrepancy, staff shall attempt to resolve it. If it cannot be resolved, whether theft is suspected or not, the staff shall immediately notify the HSA and the DON, Nursing Supervisor, or designee. The HSA and DON or Nursing Supervisor shall coordinate efforts to investigate and notify the Executive Director of Physical Health and the Quality Assurance Manager. If criminal behavior is thought likely (theft or diversion), the Warden and Deputy Warden(s) shall be informed immediately and the Drug Enforcement Agency (DEA) and State Board of Pharmacy must be contacted to determine if a Theft and Loss sheet must be completed and submitted. This is a DEA Form 106 and may be completed on the DEA website. A medication problem report must be completed and the facility's Quality Assurance Committee, at its subsequent meeting, shall review the circumstances surrounding the discrepancy

A. Proof of Use Sheets

The Health Services vendor shall ensure written policies are in place at each facility to maintain completed and accurate records for all controlled substances and account for each dose from the time the prescription arrives from the pharmacy until the medication is administered, returned, shipped to the reclamation company, or destroyed. Proof-of-use sheets shall be

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maintained for this purpose for every controlled substance dispensed for every individual patient. Proof of use sheets shall contain patient identifier, date medication received, name and strength of medication, drug form, total received. Date, time, amount administered with staff signature, and the quantity remaining.

The proof-of-use sheet shall be used in addition to the MAR and does not substitute for it. The proof-of-use sheets shall be maintained in a location which is separate from the controlled substances.

The original copy of a proof-of-use sheet shall be maintained onsite for two (2) years. A photocopy shall accompany any controlled substance which is sent when a patient transfers from one facility to another.

B. Administration of a Controlled Substance

When a dose of a controlled substance is administered, the dose is removed from its container, offered to the patient, and, whether or not taken, recorded on both the proof-of-use sheet and the MAR.

Once an individual dose has been removed from its container, under no circumstances is the dose to be returned to the container (i.e., taped back into the blister package). The dose will be appropriately destroyed and witnessed by two nurses and recorded on the proof of use sheet and signed by two witnesses.

C. Destruction of a Controlled substance

The Health Services vendor in conjunction with the clinical pharmacist shall ensure a secure process is in place for the destruction and return of all controlled substances in accordance with applicable laws and regulations. Each facility shall develop a Facility Directive to cover this process.

Bulk destruction may be completed by using the RX destroyer or a cactus type system. The Health Services vendor in conjunction with the clinical pharmacist shall ensure a written policy outlining this procedure is in place. This shall be done for any quantity of a controlled substance remaining in a container (even as single dose) which will no longer be administered to the patient for whom it was dispensed. Medications on schedules III, IV, or V may also be forwarded to an approved medication reclamation company.

CSIIIs may only be destroyed when there is presence of a DEA license reversal.

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If a medication reclamation company performs the destruction, the company provides standard forms for documentation purposes. These forms must identify each prescription number, drug name, and quantity of each controlled substance sent for destruction. The overall form shall be dated and signed by the person preparing the form and a staff member acting as a witness.

If the medication being sent to the medication reclamation company is a CSII, the facility must contact the company prior to forwarding the medication. The company will send the facility a completed DEA Form 222 identifying the quantity to be destroyed. Once the facility provides the information for the DEA Form 222, the facility may not alter the form or include additional CSII drugs not previously identified of the form.

When the DEA Form 222 arrives, Health Services staff at the facility is responsible for verification of form and forwarding second page to DEA regional office.

Regardless of the methods employed, the proof-of-use sheets shall be cancelled by striking a line across the remaining lines of the sheet and writing the number of units destroyed, the date, and the signature of the authorized person completing the sheet.

The facility must maintain on file for two (2) years all proof of use sheets, standard forms used by reverse distributor company, and DEA Form 222, if applicable.

Controlled substances held for destruction shall be kept in a double locked area and counted each shift. Facilities may not store bulk controlled substances awaiting destruction for more than one (1) month. Additionally, the quantity of controlled substances awaiting destruction shall not be permitted to grow to the point that the storage area becomes crowded or cluttered. All efforts shall be made to ensure that controlled substances are promptly returned or destroyed per the Health Services vendor's policy and per applicable statutes and Indiana Law.

XXVII.OVER-THE-COUNTER (OTC) MEDICATIONS AND COMMISSARY:

The Department shall provide a limited list of Over-The-Counter (OTC) medications on a determined commissary list. Routine medications such as antihistamines, antacids, pain relief, multivitamins, antifungal cream, anti-itch cream, anti-dandruff shampoos, lotion, laxatives, Aspirin, and fiber powder. All requests for changes shall be forwarded to the Executive Director of Physical Health for review.

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The Chief Medical Officer (CMO) or designee shall approve a list of OTC medications that are available outside of Health Services through the Commissary. Indiana Correctional Industries shall work cooperatively to develop the list of approved OTC medications.

Patients are expected to purchase OTCs from the facility commissary for use other than if needed for a serious health conditions; the Department shall provide patient's with OTC medication when necessary to treat a serious health need. Patients are expected to plan in advance of need and purchase and keep OTCs in accordance with facility personal property procedures.

Certain exceptions shall be made within inpatient settings, special needs units, and restrictive status housing when patients do not have access or means to purchase commissary medications. All medications used during inpatient and mental health unit stays shall be ordered and supplied by Health Services staff. OTCs useful for the management of minor symptoms or conditions shall be provided by Health Services staff in accordance with orders from an authorized prescriber.

XXIX. SUPPLY SHORTAGE AND DRUG RECALLS:

Occasionally, supplies of medications, vaccines, or other therapeutics may not be available or may be in limited supply. When the dispensing pharmacy becomes aware of an actual or potential shortage, the dispensing pharmacy must take all reasonable steps to supply the product including procurement outside or their standard supply chain. In the event the pharmacy cannot obtain adequate stock, the pharmacy must notify the facilities which it serves and the CMO regarding the anticipated duration of the shortage and recommendations for alternative therapies.

When alternate therapies or therapeutic substitution are adequate, the prescriber must review the recommendation and determine if it is appropriate for each individual patient affected. Health record documentation shall reflect this review and new drug orders written.

When no alternate therapies are available (e.g., vaccines), Health Services staff shall document the reason the therapy was not administered and establish a process for follow-up when the product is once again available.

When the shortage has been resolved, the dispensing pharmacy must notify the facilities and the CMO.

In the event a medication is recalled by the manufacturer, the dispensing pharmacy must provide facilities and the CMO with a list of:

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- Patients for whom the recalled medication was prescribed
- Recalled medications potentially maintained in stock supplies, practitioner supplies or nursing supplies
- Instruction provided to the facility on the proper disposition of the recalled medications.

When the facility receives recall information, Health Services staff shall review it and take appropriate action.

XXX. CLINICAL PHARMACIST DUTIES:

Quarterly, a clinical pharmacist shall inspect and review management of pharmaceuticals at every facility. This review shall include:

- Onsite review of the pharmaceutical services program
- Determination that drug records are in order including but not limited to medication inventories, Practitioner Supplies, MARs, and proof-of-use sheets
- Identification of discrepancies and deviations from accepted pharmaceutical practices as defined in applicable rules, regulations, laws, and Department requirements
- Completion of the Clinical Pharmacist Review form; and
- Narrative description of additional issues as identified.

The results of the pharmacist review shall be shared initially with the Health Services Administrator and, after completion of the written report, with the Executive Director of Health Services, the facility QAM, and the Warden.


XXXII. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title MEDICATION ASSISTED TREATMENT (MAT)

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Adult Health Care Services Directive (HCSO) is to provide written guidelines to implement medication assisted treatment (MAT) during a patient's incarceration and prior to their release to lessen the chance of relapse or overdose .

II. GUIDELINES:

Several medications have been approved by the United States Food and Drug Administration (FDA) to treat and prevent relapses and can be used in conjunction with behavioral health interventions to treat individuals with problematic substance use. Appropriate referrals shall include a screening by Addiction Recovery Staff to ensure clinically significant problems with a substance to which there is an FDA approved medication, a motivation for treatment and a commitment to remaining free of the substance during participation in MAT.

The patient is not required to be enrolled in Addiction Recovery Services (ARS) at their facility but is encouraged to do so. Patients housed in a unit which precludes their participation in traditional addiction recovery group treatment (for example, a mental health unit or restrictive status housing unit) may be enrolled in the Foundations Independent Study of the Recovery While Incarcerated Treatment Program. The expectation is that, once a patient transfers from that unit, they will have the opportunity to begin active participation in ARS group treatment but is not a requirement.

The decision for a patient to begin treatment with the chosen medication rests solely with the facility Provider, who may collaborate with the Health Services vendor's Regional Medical Director to determine appropriateness for MAT.

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III. PROCEDURE:

A. Referral and Assessment Process

1. Patients shall be provided verbal and written educational material by the assigned ARS staff regarding the MAT requirements and information about the medication approved for their substance of dependence, including the potential benefits, side effects, and risks of treatment.
 - a. Patients who express interest and meet the above guidelines shall be processed further via completion of the MAT Referral Form.
 - b. Patients shall review the MAT Information Sheet and sign the form, indicating their agreement to participate in MAT .
 - c. The MAT Referral Form and signed MAT Information Sheet shall be submitted to the Health Services vendor's Assistant Director of ARS .
 - d. The Health Services vendor's Assistant Director of ARS shall review the signed MAT information and referral forms and forward the forms to the facility Health Services Administrator (HSA) and Director of Nursing (DON).
2. An appointment shall be scheduled with the facility Provider within seven (7) business days of receipt of referral, at which time the patient is assessed for medical appropriateness to begin MAT. The required physical examination shall be completed, appropriate work up ordered and course of treatment discussed with the patient. A tolerance test maybe considered at the discretion of the provider.
3. As with all health care provided within the Department, treatment for MAT shall be in accordance with established standards of care.

B. Follow Up and Compliance Monitoring Procedures

1. Patients beginning a regimen of MAT are required to be seen by the facility Provider every six (6) months following the initial assessment, or more frequently at the discretion of the facility provider.

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2. The facility Director of ARS shall meet with the patient upon initiation of MAT to update their behavioral health code and add to MAT Roster. ARS staff shall meet with patient every six (6) months if they are not involved in the Recovery While Incarcerated treatment program.
3. Nursing staff shall monitor medication compliance through review of the MAR, notifying the facility Provider if a patient misses three (3) consecutive doses of their medication , or six (6) doses within the previous thirty (30) day period.
 - a. When non-compliance is recorded and the facility Provider is notified, an appointment shall be scheduled within five (5) business days to allow for non-compliance counseling and determination of appropriateness to continue or restart treatment.
 - b. A non-compliant patient may be subject to a breathalyzer test and/or urine drug screen at the discretion of the staff. A positive breathalyzer test for alcohol or urine drug screen of other substances may result in the medication being discontinued.
4. When clinically indicated or at the discretion of the facility Provider or ARS Director, a multidisciplinary treatment team meeting shall be convened, to assess and review a patient's participation in MAT.
 - a. The multidisciplinary treatment team shall include facility representatives from Health Services and Addiction Recovery Services and may include representatives from other clinical and non-clinical facility divisions (for example, Mental Health, Unit Team, Custody/Operations).
 - b. A multidisciplinary treatment team meeting should be strongly considered whenever a decision is pending regarding discontinuing a patient's participation in MAT, especially when medication non-compliance or abuse is present.

C. Criteria for Possible Discontinuation of Treatment Medication

1. A determination of successful completion of MAT shall rest with the facility Provider.
2. Medication non-compliance in conjunction with clinical judgment.

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3. Active substance use as evidenced by direct observation, direct report, or positive urine drug screen or breathalyzer test, in conjunction with clinical judgment.
4. The patient has been identified as a candidate to receive a long-acting MAT prior to release from the Department and continues services under MAT Pre-Release procedures below.
5. The provider shall place a medication order for the long acting MAT medication in the EMR. Nursing staff shall transcribe and administer as directed.

D. Pre-Release Treatment

1. Patients on MAT will be classified as an “F” Behavioral Health Code and identified as a special needs release as outlined in HCSD 5.01, “Transitional Health Care.”
2. Patient’s seeking long-acting injectable MAT for pre-release shall have a referral completed no less than forty-five (45) days prior to their Earliest Probable Release Date (EPRD) and submitted to the Health Services vendor’s Associate Regional Director of Addiction Recovery and Associate Regional Director of Transitional Health.
 - a. The Health Services vendor’s Associate Regional Director of Transitional Health (or designee) shall identify a community provider/resource that will allow for continued care for patients who qualify and are interested in long-acting injectable MAT at the time of their release. Upon identification, the community resource is communicated to the Associate Regional Director of Addictions Recovery, the facility Transitional Healthcare Facilitator, Provider, and the patient.
 - b. At two (2) weeks prior to EPRD, the Health Services vendor’s Transitional Health Facilitator confirms that an appointment has been made with a community provider to allow for continued services following the patient’s release and confirms with Case Management/Unit Team staff that insurance has been secured and a referral to Recovery Works has been offered to the patient.

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- c. The Provider shall order a urine drug screen to occur five (5) to seven (7) days prior to release, and upon the screen being negative, order one (1) injection to be administered the same day of the urine screen. Upon the injection being administered, the order for oral MAT can be discontinued if not already ended.

D. Pregnant Women and MAT

Pregnant women shall remain on MAT unless consultation or evaluation with a practicing maternal fetal medicine physician provides other recommendations.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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HEALTH SERVICES FOR TRANSGENDER AND GENDER DIVERSE PATIENTS

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IC 11-8-2-5	01-02-101 02-01-115 01-04-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide guidance for the diagnosis, treatment, and management of individuals who identify differently than the gender they were assigned at birth. The intent of the Indiana Department of Correction is to avoid any discriminatory actions and to ensure appropriate continuum of care for this population, maintaining the dignity and respect for all.

II. DEFINITIONS:

- A. GENDER: The male or female division of a species, especially as differentiated by social and cultural roles and behavior.
- B. GENDER-AFFIRMING SURGERY: A surgical procedure or procedures by which a person who is transgender's physical appearance and existing sexual characteristics are altered to resemble those that are socially associated with their identified gender.
- C. GENDER DYSPHORIA: A condition in which an incongruence between one's sex assigned at birth and one's gender identity results in psychological distress. Individuals who experience gender dysphoria may pursue multiple domains of gender affirmation which include social, legal, medical, and/or surgical interventions. Not all individuals who are transgender will desire all domains of gender affirmation, and not all individuals who identify as transgender or gender diverse will have a diagnosis of gender dysphoria.

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- D. GENDER IDENTITY: An internal sense of being a man, woman, or something outside that binary. This is different from physical sex, which is assigned at birth based on sex characteristics.
- E. GENDER DIVERSE: An umbrella term covering any gender identity or expression that does not fit within the gender binary. The label may also be used by individuals wishing to identify as falling outside of the gender binary without being any more specific about the nature of their gender. Examples include gender fluid, gender queer, intergender, or agender.
- F. GENDER DYSPHORIA REVIEW COMMITTEE: The evaluating psychologist and psychiatrist in addition to the regional mental health team who review and discuss whether a gender dysphoria diagnosis is present and what corresponding treatment is necessary to recommend.
- G. HORMONE REPLACEMENT THERAPY: A form of hormone therapy in which sex hormones and other hormonal medications are administered to individuals who are transgender or gender nonconforming for the purpose of more closely aligning their secondary sexual characteristics with their gender identity.
- H. INTERSEX: A condition usually present at birth that involves reproductive, genetic, or sexual anatomy that does not seem to fit the typical definitions of female or male. Intersex identification does not necessarily mean the patient also identifies as transgender or experiences gender dysphoria.
- I. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.
- J. PRISON RAPE ELIMINATION ACT (PREA): The federal law addressing sexual violence in prison, jails, and other correctional facilities. Under PREA, the National Prison Rape Elimination Commission was created with the responsibility for establishing standards for the prevention, detection, response, and monitoring of sexual abuse and violence within correctional systems.
- K. TRANSGENDER (TG): An individual whose gender identity or gender expression differs from the sex they were assigned at birth. It is not a diagnosis and is often the self-label assumed by individuals with cross-gender feelings and behaviors.
- L. TRANSGENDER REVIEW COMMITTEE: A treatment team comprised of individuals from different on-site disciplines that contribute a broad range of

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perspective and treatment modalities in the management of patients' needs. This committee should include the classification supervisor, PREA Compliance Manager, Medical, Mental Health, Unit Team staff, Custody, and Deputy Warden at minimum.

- M. **TRANSITIONING:** A process that an individual who is transgender goes through to begin living their life in a way that aligns with their gender identity. Transitioning may also be regarded as an ongoing process of physical change and psychological adaptation. This may or may not include social, legal, medical, or surgical treatment.
- N. **WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH):** An interdisciplinary professional and educational organization devoted to transgender health. WPATH publishes the Standards of Care and Ethical Guidelines, which articulate a professional consensus about the psychiatric, psychological, medical and surgical management of gender dysphoria and help professionals understand the parameters within which they may offer assistance to those with these conditions.

III. IDENTIFICATION :

While persons who are transgender or gender diverse often have this realization early in life, that is not always the case. Additionally, the person may not always have the support or feel safe to come out for many years. The stress and fear of being different during incarceration may exacerbate this reluctance and prevent some patients from identifying as transgender upon intake into the Department. Therefore, this outlined process is applicable to all incoming patients committed to the Department, Parole Violators arriving from outside agencies and those who self-identify as transgender or diagnosed as intersex after Intake. The process and timelines outlined shall be followed regardless of identifying to a nurse during the Arrival Health Screen (AHS), identifying to the PREA Compliance Manager, Behavioral Health provider, Health Services Provider, or any other Department staff.

It should be noted that if a patient reports being transgender or gender diverse in a therapeutic setting and asks that it not be disclosed, confidentiality does still exist and the process does not need to continue per this policy.

- B. A patient who self-identifies as transgender, or has been diagnosed as intersex, shall be referred, for an appointment with a medical provider within twenty-four (24) hours and seen within seven (7) days of referral.

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This evaluation shall include but is not limited to an assessment of the patient's gender identification, history of treatment such as taking hormones or undergoing any surgeries to align with their identified gender, and determination of the genital status (if previously unknown or previously diagnosed as ambiguous). If the patient has already begun a process of transitioning, continued health service needs such as continuation of hormone replacement therapy should be evaluated and managed during this appointment for continuity of care.

This assessment will assist with housing assignments to provide the safest and most secure environment for the patient, the incarcerated population, the Department, and Department staff. Therefore, the medical provider will be required to complete State Form 56492 "Transgender Evaluation" medical evaluation portion during this evaluation and submit the form to the HSA.

- C. A patient who self-identifies as transgender, or is diagnosed as intersex, shall also be referred for a mental health evaluation by a qualified mental health professional within twenty-four (24) hours and seen within seven (7) days of referral.

This evaluation shall include but is not limited to an assessment of the patient's gender identification, treatment and life experiences prior and during incarceration, current and previous treatment such as therapy, hormone replacement therapy, surgical interventions, legal interventions such a change to name or sex on identification documents, and social or private expressions that conform to their gender identity. This assessment will also evaluate the patient's current emotional status, suicide risk, and treatment desires.

This assessment will also be used in assisting with housing assignments and possible accommodations and therefore the mental health provider shall complete State Form 56492 "Transgender Evaluation." mental health evaluation and treatment summary sections and submit to HSA.

- D. Once State Form 56492, "Transgender Evaluation" is complete, the Health Services Administrator will forward a copy to the Regional Director of Mental Health and PREA Compliance Manager. The PREA Compliance Manager then must schedule a Transgender Review Committee meeting to review applicable forms and discuss the patient's requests for potential accommodations. The patient should also be invited to this meeting. A summary of this Transgender Review Committee should be documented in the EMR by the mental health provider.

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- D. Following this Transgender Review Committee meeting, the PREA Compliance Manager shall forward the completed State Form 56615 “Transgender/Intersex Placement Review,” the most current completed SVAT and State Form 56492, “Transgender Evaluation,” and the psychiatry note affirming a diagnosis of gender dysphoria if applicable to the Executive Director of PREA Compliance within five (5) business days.

Within thirty (30) days of receipt, the Executive Director of PREA Compliance shall convene a Facility Placement Review meeting including Executive Staff from Classification, Operations, Programs and Re-entry Readiness, Behavioral Health, and Policy Development to discuss treatment suggestions and accommodations made by the Transgender Review Committee and determine whether the patient is housed in a location that will offer optimal safety and security for them and the Department.

- E. The Department has a number of available accommodations for gender diverse patients to promote healthy gender identification and prevent unnecessary distress and psychological suffering. All gender diverse persons will be encouraged to share their preferred pronouns and staff are encouraged to refer to them as such. They shall have access to a gender-neutral commissary, cross-gender undergarments, and access to Health Services providers as established in accordance with HCSD 2.01A, “Access to Care.” Mental health providers are trained on this population’s needs in order to support culturally competent care in Individual Treatment Plans, such as social role transition, exploration of gender identity, role and experience, alleviating internal transphobia and promoting resilience.

If a diagnosis of Gender Dysphoria is being considered or the patient is requesting accommodations or treatment for Gender Dysphoria that is not available to the incarcerated population as listed above or following advocacy of such at the facility Transgender Review Committee, the patient shall be referred to a licensed psychologist and psychiatrist for further evaluation. Within ninety days (90) days of the referral, the psychologist and psychiatrist shall meet with the patient and complete their evaluation for presence of Gender Dysphoria.

- F. Once both evaluations have been completed, a Gender Dysphoria Review Committee encompassing the evaluating psychologist and psychiatrist along with the Regional Director of Mental Health, Regional Director of Behavioral Health and Regional Director of Psychiatry will convene to review and discuss the evaluations completed for the patient and whether a GD diagnosis is present. If the patient is experiencing GD, the Gender Dysphoria Review Committee will also

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discuss what treatment is medically necessary and what accommodations should be recommended to alleviate symptoms of dysphoria.

V. TREATMENT OPTIONS FOR GENDER DYSPHORIA:

Patients diagnosed with Gender Dysphoria or intersex shall be enrolled on the mental health roster and in chronic care clinic to develop an Individualized Treatment Plan. Patients shall receive treatment in accordance with HCSD 3.01A, “Chronic Disease Intervention Guidelines,” HCSD 2.15A “Medication Management,” HCSD 4.03A, “Adult Mental Health Services,” HCSD 2.11A, “Treatment Planning,” and any other applicable HCSD, policy and administrative procedure, or facility directive or operational procedure.

Treatment options to alleviate symptoms of Gender Dysphoria, reduce comorbid mental health conditions, prevent suicidality, and improve overall quality of life may include:

- A. Psychotherapy: For many gender diverse or transgender patients, anxiety and depression are managed through psychotherapy alone and may be encouraged to remain in therapy as needed. Others may find support and some social changes in gender expression (i.e., feminine products off commissary for male to female transition or masculine products for female to male transition) to be enough to relieve any psychological distress.
- B. Hormonal Therapy: For some patients, psychotherapy and social support changes may not be enough to relieve their dysphoria. In those cases, if clinically indicated, the patient and mental health professionals may consider hormone therapy.

If the Gender Dysphoria Review Committee agrees that hormone treatment is appropriate, the patient shall be referred to the site level Medical Director for evaluation and consideration for hormone therapy initiation.

- C. Gender Affirmation Surgery (GAS): Although individuals may live successfully as transgender persons without surgery, gender affirming surgery, if medically necessary to alleviate GD may be appropriate for some. The Gender Dysphoria Review Committee shall follow WPATH Standards of Care and consider on a case-by-case basis.

If approved by the Gender Dysphoria Review Committee, a referral shall be made to the Health Services vendor’s Regional Medical Director and Utilization Management for approval/denial.

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In the event that surgery is recommended, notification from the Regional Director of Behavioral Health shall be made to the Executive Director or Behavioral Health for review. The Executive Director of Behavioral Health shall make a recommendation to the CMO, who shall make the final decision.

At any time during treatment of a patient who is gender diverse, transgender, or intersex , staff at the facility may initiate a Transgender Review Committee at the facility or request from the Executive Director of PREA Compliance to reconvene a Facility Placement Review meeting to review and ensure the patient is housed in a location that will offer optimal affirmation as well as safety and security for them and the Department.


VI. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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OFFICER BREANN LEATH MEMORIAL MATERNAL-CHILD HEALTH UNIT

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to establish guidelines and procedures for operational, medical, transitional healthcare, and program staff to use in providing healthcare services to the incarcerated mother population and children participating in the Officer Breann Leath Memorial Maternal-Child Health Unit at Indiana Women's Prison. This HCSD describes processes for ensuring that pre-and post-natal mothers and their children receive appropriate, timely, quality holistic care.

II. DEFINITIONS:

- A. **ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP):** A committee within the United States Centers for Disease Control and Prevention that provides advice and guidance on effective control of vaccine-preventable diseases in the U.S. civilian population
- B. **BED SHARING:** Practice where a baby or young child sleeps in the same bed, sharing the same sleeping surface, as a parent(s).
- C. **CHIEF MEDICAL OFFICER:** The Executive leadership position within the Department designated as head of Health Services, who serves to advise and lead a team of health services experts on matters of public health importance.
- D. **DEPARTMENT OF CHILD SERVICES:** An Indiana State agency that engages with families and collaborates with state, local and community partners to protect children from abuse and neglect and to provide child support services.

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- E. **EMERGENCY CONTACT PERSON:** Person or agency that is approved to take custody of an incarcerated mother's baby in the event of an emergency or the mother is terminated from the MCHU Program. This person is authorized to take possession of the baby's property when the baby leaves the institution.
- F. **EXECUTIVE DIRECTOR OF TRANSITIONAL HEALTHCARE:** An executive leadership member within the Department that oversees and supervises the Transitional Healthcare Department.
- G. **FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA):** FSSA is a health care and social service funding agency of the State that oversees five (5) care divisions that administer services to Indiana residents.
- H. **MATERNAL CHILD HEALTHCARE COORDINATOR:** The employee responsible for the management of the Officer Breann Leath Maternal Child Health Unit along with ensuring all maternal health participant's and child's needs are acknowledged and addressed.
- I. **MOTHER:** An incarcerated adult female who resides at Indiana Women's Prison who gave birth to an Officer Breann Leath Memorial Maternal-Child Health Unit child while serving her current commitment.
- J. **NANNY:** An incarcerated adult female who meets the criteria to participate in the Officer Breann Leath Memorial Maternal-Child Health Unit (MCHU) Program as an assistant to the mothers, staff, and volunteers operating the MCHU Program.
- K. **NEWBORN:** A baby from birth to eight weeks old
- L. **OFFICER BREANN LEATH MATERNAL CHILD HEALTH CENTER (MCHU):** Voluntary program at Indiana Women's Prison for pregnant mothers that encourages family preservation and uses a holistic approach for the continuum of care. The housing unit at the facility provides a Residential Mother-Infant Nursery Program.
- M. **PEDIATRIC:** Specialty of medical science concerned with the physical, mental, and social health of children from birth to young adulthood.
- N. **PEDIATRICIAN:** A licensed medical practitioner who specializes in the care of children.

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- O. SUPERVISOR OF CLASSIFICATION: The facility employee who renders the final decisions on all offender classification activities at the facility.
- P. TRANSITIONAL HEALTHCARE MANAGER (THM): A member of the Transitional Healthcare Division within the Department that supervises the Transitional Healthcare Specialist and the Maternal Child Health Coordinator.
- Q. TRANSITIONAL HEALTHCARE SPECIALIST (THS): A member of the Transitional Healthcare Division that completes Medicaid application on behalf of offenders along with assisting in continuum of care plans post release.

III. OFFICER BREANN LEATH MATERNAL-CHILD HEALTH UNIT (OBLLEATH MCHU):

The LEATH MCHU encourages the preservation of family by providing incarcerated mothers and their children a meaningful transition into the community. The Nursery utilizes a holistic approach for the continuum of care by recognizing the mother's strengths and barriers to social determinants of health.

IV. OFFICER BREANN LEATH MATERNAL-CHILD HEALTH UNIT ADMISSIONS:

The Transitional Healthcare team within the Health Services Division determines the programmatic components and procedures for the Officer Breann Leath Memorial Maternal-Child Health Unit. The Director of Transitional Healthcare and Contract Compliance is responsible for ensuring the development and administration of operational, medical, and transitional healthcare components of the program.

V. MATERNAL HEALTHCARE POLICIES AND PROCEDURES:

See Health Care Service Directive 3.09A, "Maternal Health Care" for procedures on prenatal care, labor and delivery, and post-partum care.

VI. OFFICER BREANN LEATH MATERNAL-CHILD HEALTH UNIT ELIGIBILITY CRITERIA:

- A. Eligibility Criteria for Mothers:
 - 1. Incarcerated female shall be pregnant;

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2. Incarcerated female's earliest possible release date is thirty (30) months or less to the incarcerated female's projected delivery date, including good time credit offered;
3. Incarcerated females who have been charged with a sex crime or any type of violence, abuse or endangerment of a child shall be reviewed by the Director of Transitional Healthcare and Contract Compliance, and Maternal Child Health Coordinator;
4. Mother and child are free of severe functional impairment impacting daily living classified by physical and/or mental health diagnoses by a physician;
5. Mother is the sole, legal custodian of child;
6. Mother must be willing to sign a consent agreeing to abide by all rules and stipulations of the unit;
7. Mother must be willing to sign a release of information to research any involvement with Department of Child Services; and,
8. Mother may be denied participation for any reason deemed appropriate by the Chief Medical Officer.

B. Eligibility Criteria for Mentors:

1. Prospective mentor has no history of violence against a child or sexual abuse against adults or children;
2. Prospective mentor has never been convicted of a sex crime or any type of violence, abuse or endangerment of a child;
3. Prospective mentor should be CPR/First Aid certified prior to a job reclassification;
4. Prospective mentor must be determined by the Director of Transitional Healthcare and Contract Compliance to be physically and mentally capable of caring for children of all ages;
5. Prospective mentor must be willing to sign a release of information to research any involvement in the Department of Child Services;

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6. Prospective mentor must be willing to sign a consent agreeing to abide by all rules and stipulations of the unit.

C. Selection and Enrollment:

1. Maternal Child Health Coordinator or (designee) shall keep an active database of all incarcerated females who are pregnant at the time they are received in the custody of the Department.
2. Designated Transitional Healthcare staff must review all pregnant incarcerated females' charges and conduct history on a case-by-case basis for eligibility into the program.
4. The Maternal-Child Health Coordinator must schedule a consultation with all pregnant incarcerated individuals deemed eligible. No incarcerated individuals shall be admitted into the LEATH MCHU without meeting with the Maternal Child Health Coordinator
5. The Maternal-Child Health Coordinator shall:
 - a. Explain the intent of program;
 - b. Review program information;
 - c. Explain program requirements, guidelines, and expectations;
 - d. Determine enrollment status;
 - e. Informed Consent and Refusal, HCSD 2.12A; and,
 - f. Provide pregnant incarcerated female with a LEATH MCHU Handbook (Attachment A), rules and expectations document, and a copy of the signed consent if the pregnant incarcerated female desires to participate in the program
6. Upon completion of the consultation, the Maternal-Child Health Coordinator shall:
 - a. Keep record of all pregnant incarcerated females' program acceptance/denial status;
 - b. Begin processing paperwork for newly enrolled mothers in the LEATH MCHU housing unit; and,

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- c. Notify Health Services vendor's Pre-Natal Nurse, Maternal Child Health Coordinator, Transitional Healthcare, Supervisor of Classification, Health Services Administrator (HSA), Deputy Wardens of Operations and Re-Entry, and Warden of acceptance.

- 7. If the mother declines to participate in the program, they shall be advised that they may contact the Maternal Child Health Coordinator at any time if they change their mind and be provided with a LEATH MCHU Handbook.
- 8. If the mother indicates their desire to participate in the program, they shall be provided with a LEATH MCHU handbook, rules and expectations documents, and a copy of the signed consent, indicating that they shall participate in all aspects of the unit and comply with all program rules and regulations.
- 9. A mother may submit a one-time appeal if denied admission into LEATH MCHU by writing to the Maternal Child Health Coordinator within seven (7) days of notification. The appeal shall be reviewed by the Chief Medical Officer for reconsideration.

D. LEATH MCHU Participation:

- 1. Participation in the LEATH MCHU program is strictly voluntary. No reprisals shall be taken against mothers for participation or non-participation.
- 2. The LEATH MCHU classification takes precedence over other facility classifications; mothers and mentors shall complete all pre-delivery program requirements and training prior to attending educational, vocational, substance abuse, and work assignments.
- 3. Placement in the LEATH MCHU shall be considered a work assignment, and program participants shall receive a State wage for their participation.
 - a. The State wages paid to LEATH MCHU mothers is Class C and they shall be paid for five (5) work days a week.
 - b. The State wages paid to LEATH MCHU mentors is Class B and they shall be paid for five (5) work days a week. Mentors may only claim hours that they have worked.

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4. LEATH MCHU program participants are expected to abide by the program rules and provide signed consent of their acknowledgment of the program rules and expectations (Attachment A). Removal due to disciplinary conduct shall be determined by the Executive Director of Transitional Healthcare.

VII. TRANSPORTATION OF LEATH MCHU PARTICIPANTS

Transportation officers shall contact the HSA (or designee) when departing hospital grounds with a LEATH MCHU participant. When contact has been made, the HSA (or designee) shall prepare an area in Health Services for arrival of LEATH MCHU participant and newborn. The HSA shall notify the Maternal-Child Health Coordinator via email when the LEATH MCHU participant and child have returned to the facility.

VIII. MOTHER PARTICIPATION IN FACILITY ACTIVITIES:

- A. Mothers are permitted to leave the LEATH MCHU housing unit to participate in facility activities (e.g., educational assignments, work assignments, meals, religious services, commissary, educational, and recreational activities) outside of movement procedures.
- B. It is the mother's responsibility to arrange for a mentor or another mother to supervise their child during their participation in facility activities.
- C. The separation time between mother and child shall not exceed four (4) consecutive hours unless special circumstances or medical emergencies arise. Should a mother have to leave the LEATH MCHU housing unit for a time period exceeding forty-eight (48) consecutive hours, the Director of Transitional Healthcare shall be contacted to review the child's status in the nursery.

IX. CHILD EDUCATION AND ENRICHMENT:

- A. Program Requirements for New Participants:
 1. Mothers shall complete a Parenting Plan (Attachment B) within thirty (30) days of arriving to LEATH MCHU. The Parenting Plan and Birthing Plan documents shall be provided by the Maternal-Child Health Coordinator upon movement onto the LEATH MCHU unit and shall be returned to the Maternal Child Health Coordinator within thirty (30) days.

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2. Mothers shall receive a “Mommy and Me” Binder (Attachment C) within thirty (30) days of arriving to the unit provided by the Maternal-Child Health Coordinator.
- 3 All individuals housed in LEATH MCHU and designated staff shall complete Maternal Health and Care Seat Installation training and be certified in Infant CPR/First Aid within ninety (90) days of program enrollment scheduled by the Maternal-Child Health Coordinator.

B. Weekly Program Requirements:

Mothers shall participate in courses related to childhood development including, but not limited to parenting styles, safe sleep, child safety, mental health/post-partum mood disorders, overuse of medication, breastfeeding, nutrition, cost/finances of living with child, birth control/family planning. Refusal to participate in these courses shall be reviewed by the Director of Transitional Healthcare and Contract Compliance

X. PEDIATRIC MEDICAL CARE:

A Transitional Healthcare Specialist shall complete a healthcare coverage application on behalf of the newborn within two (2) weeks of birth. The mother is responsible for providing all required documents to ensure the application is completed in its entirety. Any refusal to provided necessary information shall be reviewed by the Director of Transitional Healthcare and Contract Compliance.

Mothers are encouraged to use the Department’s Central Office address when giving an address for vital documents after delivery. Transitional Healthcare staff shall be unable to assist in reapplication for any vital documents for children of mothers who chose to use another address.

A. Infant Pediatrician Visits:

The Maternal-Child Health Coordinator or other designated staff shall schedule all appointments for the infants/children in the LEATH MCHU.

All children in the LEATH MCHU are to be seen routinely according to American Academy of Pediatrics (AAP) recommendations and when necessary if concerns arise as follows:

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- 3-5 days old (first week visit)
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old (2 years)
- 30 months old (2 ½ years)

All children needing to be transported off grounds shall be transported in a State vehicle. The Maternal-Child Health Coordinator or other designated staff shall be responsible to prepare the State vehicle in accordance with Policy and Administrative Procedure 04-06-101, "Fleet Management and Vehicle Use," and Policy and Administrative Procedure 02-03-110, "Adult Offender Transportation." The Maternal-Child Health Coordinator or other designated staff shall secure the child in a rear-facing, unexpired car seat in accordance with the State's Child Restraint laws.

1. The Maternal-Child Health Coordinator or other designated staff shall prepare infant/child for doctors' appointments including any necessary documents required for appointment.
2. If appointment is off-site, the Maternal-Child Health Coordinator shall make every attempt to engage the mother in all child's pediatric appointments via telephone conference facilitated by Health Services staff or designee or utilizing telephonic recording as needed.
3. The Maternal-Child Health Coordinator or other designated staff shall remain with the infant/child at all times during the infant's/child's absence from the LEATH MCHU housing unit.
4. Any medications the child may be prescribed shall be filled by the Maternal-Child Health Coordinator or other designated staff prior to return of the facility or as soon as the pharmacy denotes that the prescription medication is ready.

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B. Infant Medications:

1. Children in LEATH MCHU are only to receive medication prescribed specified to them by a pediatrician or physician. Prescribed vitamins or other nutritional supplements for the infants are permitted to be kept in the mothers' room in their personal property and do not need to be logged.
2. All child medications shall be located in a designated secure area.
3. All child medication administrations shall be overseen by staff. These medications shall be monitored by staff and signed in/out for use by the mother when requested.
4. The Maternal-Child Health Coordinator shall:
 - Fill all children's medication prior to returning to the facility
 - Notify facility Safety Hazard Manager of medications brought back into the facility by close of business same day;
 - Log all medications received for child;
 - Secure and store medications in the LEATH MCHU housing unit in a secure cabinet or refrigerator, only accessible by authorized staff.

C. Infant Vaccinations:

All children in LEATH MCHU are encouraged to be vaccinated according to the Advisory Committee on Immunization Practices (ACIP) recommendations. ACIP recommends a seven-vaccine series for all children by age 19 months as follows:

- 4 doses of diphtheria, tetanus, and acellular pertussis vaccine (DTaP)
- 3 doses of inactivated poliovirus vaccine (IPV)
- 1 dose of measles, mumps, and rubella vaccine (MMR)
- 3 or 4 doses of haemophilus influenza type b vaccine (Hib)
- 3 doses of hepatitis B vaccine (HepB)
- 1 dose of varicella vaccine (VAR)
- 4 doses of pneumococcal conjugate vaccine (PCV)
- 2 doses of influenza (IIV)

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Mothers refusing to vaccinate their children shall be provided with additional education and resources regarding vaccination information.

D. Infant Emergencies:

In the event of an infant/child emergency or medical need after normal business hours, the Shift Supervisor shall utilize LEATH MCHU decision tree provided by the Director of Transitional Healthcare and Contract Compliance.

E. Infant Injury:

In the event of an infant injury, staff shall adhere to the Indiana Women's Prison Facility Directive for the Unit.

An Infant Injury- Report (Attachment D) must be completed by the unit officer or designated unit staff within one (1) hour of the incident. The unit officer must notify the Custody Supervisor, the Director of Transitional Healthcare, and Contract Compliance of the incident upon completion of the report.

Any suspected behavior of child abuse or neglect shall be submitted via email to the Executive Director of Transitional Healthcare and Director of Transitional Healthcare and Contract Compliance by witnessing staff within one (1) hour of occurrence. Submitted claims shall be reviewed within twenty-four (24) hours of notification.

F. Safe Sleep:

1. All babies shall be placed on their back and in their crib to sleep.
2. Mothers and mentors are prohibited from bed sharing with babies.
3. Nothing should be in the baby's crib, with the exception of a pacifier. If there is a concern of keeping a baby warm, mothers must obtain a wearable blanket for the infant. If there is a concern of a baby developing a flat head from sleep on their back, mothers should be instructed by housing unit staff or the Maternal-Child Health Coordinator to change the baby's direction in the crib each week and increase the amount of monitored tummy time when the baby is awake.

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4. If a baby can roll over on their own and rolls onto their stomach during sleep, mothers and mentors do not have to flip the baby back over.
5. Any incidents of unsafe sleep practices including the infant being placed to sleep on their stomach, bed-sharing, or objects found in crib, shall be documented by the unit officer and communicated to the Maternal-Child Health Coordinator via email within twenty-four (24) hours of the incident. These incidents shall be reviewed by the Maternal Child Health Coordinator and Director of Transitional Healthcare and Contract Compliance within twenty-four (24) hours of notification.
6. Custody Staff or LEATH MCHU staff shall complete a Safe Sleep/Safety Violation Form (Attachment I) each time an incident occurs.

G. LEATH MCHU Pediatric Wellness Clinic

1. All infant wellness appointments shall take place in the onsite LEATH MCHU Pediatric Wellness Clinic unless otherwise indicated by pediatrician.
2. Staff are not authorized to use the onsite LEATH MCHU clinic unless directed by the Maternal-Child Health Coordinator.
3. The Maternal-Child Health Coordinator shall schedule and monitor all onsite child wellness appointments, notify mothers of their child's appointment, and manage all medical paperwork from the appointment.

XI. OUTDOOR ACTIVITY:

Mothers and children shall be provided daily outdoor playtime in accordance with FSSA Child Welfare Service guidelines for childcare providers. Outdoor activities shall take place at the unit's enclosed playground

Mothers and children shall be allowed daily outdoor playtime, except when the severity of the weather poses a safety hazard, the wind-chill temperature is below twenty-five (25) degrees Fahrenheit (25°F), or if there is a health-related reason documented by a physician for the child to remain indoors.

Children in LEATH MCHU shall be dressed appropriately for the weather, taking into consideration the temperature, wind chill, precipitation factor, and amount of direct

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sunlight. Sunscreen shall be used on babies over six (6) months of age. Sunscreen is to be reapplied to the infant each time they return to the play yard. Infants shall not be in direct sunlight for more than fifteen (15) minutes at a time. Babies under six (6) months shall not use sunscreen and shall use a hat to protect against the sun. Babies under six (6) months shall be kept in partially shaded and shaded areas while outside.

Should the weather become inclement (i.e., thunder, lightning, raining, hailing, or sleeting) the children must immediately be brought inside. Children may return to the fenced play yard when the inclement weather has ceased for at least sixty (60) minutes.

Use of the outdoor play yard shall be restricted to daylight hours (i.e., dawn to dusk).

Use of the outdoor play yard does not count as a Recreation movement and shall not be restricted to Recreation movements with the general population.

Every effort shall be made by the officer in charge to allow mothers and children time outside daily. Outside Play Area Logs (Attachment E) are to be completed by the officer and times are to be logged when the mother and child are let outside and when mother and child return to the unit. Each time a mother requests to take a child outside, a new row must be filled out on the Outside Play Area Log. Each child must be logged individually.

Should the officer in charge deny the mother the ability to take the child outside, the “Denial for Use of Outdoor Play Area” (Attachment F) form must be completed, signed by a sergeant or higher-ranking Custody staff, and be submitted to the Maternal-Child Health Coordinator within twenty-four (24) hours for review by the Director of Transitional Healthcare and Contract Compliance.

If a mother does not comply with the outdoor activity policy for three (3) consecutive days, the Maternal-Child Health Coordinator shall contact the Director of Transitional Healthcare and Contract Compliance within twenty-four (24) hours of the incident report.

Any time the Maternal-Child Health Coordinator or other designated staff is escorting an infant/child from LEATH MCHU, the Shift Supervisor shall stop movement via radio announcement until infant/child has entered designated location.

XII. BREASTFEEDING:

Mothers are permitted to breastfeed their child at any time in their bedroom, the nurseries, and in the unit dayroom. Mothers shall make every effort to conceal themselves when in a public area, in the line of sight of a security camera, and when male officers are present.

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Male staff must loudly announce themselves during tours, security checks, and upon entering the unit, and the announcement shall be documented in the unit log. Custody Officers shall not restrict a mother's use of the dayroom or nursery based upon whether the mother is breastfeeding.

Mothers shall be issued a breast pump within seven (7) business days of delivery by the Maternal Child Health Coordinator. If a pump is not available, the Maternal-Child Health Coordinator shall make every effort to obtain a breast pump as soon as one is available. LEATH MCHU participants are not guaranteed their own breast pump and may have to share with other participants until one can be obtained.

XIII. INFECTIOUS DISEASE CONTROL:

Staff members, visitors, and volunteers who exhibit symptoms of illness are prohibited from entering the LEATH MCHU unit. Symptoms of illness include:

- Diarrhea
- Vomiting
- Nasal congestion (Stuffy/runny nose)
- Persistent cough
- Jaundice
- Sore throat
- Fever
- Skin rash / infected cut or wound

Supervisors are responsible for observing staff, visitors, and volunteers for signs of illness throughout the day. Staff members have the responsibility of reporting, to the Custody Supervisor, any signs of infection or illness that may pose a hazard to the health of children and other staff. All staff members, visitors, and volunteers shall be excluded from the LEATH MCHU unit until they have been symptom-free for at least twenty-four (24) hours or have a doctor's note stating they have been on an antibiotic for more than twenty-four (24) hours, or they are free from infection/illness.

XIV. MOTHER VISITATION:

Mothers are permitted to take their child with them to the Visiting Room for their visits scheduled in accordance with Policy and Administrative Procedure 02-01-102, "Offender Visitation." Mothers do not obtain additional visitation time for the child's paternal and maternal relatives to visit the child.

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XV. GLASS JAR EXEMPTION:

The LEATH MCHU is exempt from the mandate to not have glass items on the housing units. The LEATH MCHU housing unit is permitted to have glass baby food containers stored on the living unit. Locations where glass food containers must be stored are in a locked area only accessible by staff. Any open glass container must be disposed of in the waste can within two (2) days of opening.

XVI. PERSONAL PROPERTY:

- A. The property designated for use by the infant shall not be included in the personal property permitted for the mother. However, all infant property must be neatly contained in the mother's room, except for large items, which may be kept in the unit day room.
- B. Mothers shall not trade, sell, barter, loan, or give away any item of their infants' personal property at any time.
- C. Property of the infant shall not exceed the following:
 - Five (5) season appropriate outfits
 - Four (4) sleepers
 - Ten (10) onesies
 - Five (5) pairs of pants
 - Three (3) pairs of socks
 - Two (2) pairs of shoes
 - One (1) coat or jacket
 - One (1) diaper bag
- D. The Maternal-Child Health Coordinator shall conduct a monthly inventory of supplies and submit inventory via email to the Director of Transitional Healthcare and Contract Compliance. Transitional Healthcare staff may reduce a LEATH MCHU participant's infant property if the participant is unable or unwilling to maintain a neat and clean living environment for her child.

XV. CHILD CHRISTENING:

- A. Mothers desiring christening for their child may request this religious rite by submitting a request to the Chaplain. Upon receiving the request, the Chaplain shall obtain the following information:

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1. Is the mother requesting christening by the Chaplain or by a clergy person outside the institution. If an outside clergy person is being requested, the mother shall provide the name and address of the church and pastor;
 2. The method of christening being requested (sprinkling with water or no use of water);
 3. The Chaplain may request the mother to complete a written form stating the above information.
- B. The facility Chaplain may assist the mother in locating a supporting congregation.
- C. The Chaplain shall issue a memo a week in advance of the christening date to the Shift Supervisor, Control and Maternal-Child Healthcare Coordinator. This memo shall include the date, time, location, requested assistance, and names of any incarcerated individuals, staff, visitors, and volunteers attending the christening.

XVI. LEATH MCHU MENTOR:

1. Selection of the mentors shall be approved by the Director of Transitional Healthcare and Contract Compliance
2. Incarcerated individuals interested in a mentor position must complete the “Mentor Application Packet” (Attachment H)
3. Mentors must be CPR and First Aid certified prior to job assignment.
4. Mentors cannot watch more than two (2) children at a time.
5. Mentors are not assigned to care for specific children and may not refuse to watch a child when appropriate practices for securing childcare have been followed by the mother.
6. Mentors must be physically and mentally capable of caring for children of all ages.
7. In the event of an accident or infant injury an Infant injury report (Attachment D) must be completed within one (1) hour of incident. Custody Supervisor must be contacted.

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XVII. OFFENDER COUNT:

The children living in the LEATH MCHU housing unit are not included in the facility's offender count procedures.

XVIII. STAFF AND TRAINING FOR LEATH MCHU UNIT:

Employees assigned to the LEATH MCHU unit shall participate in specialized training. Training shall be coordinated by the Maternal-Child Health Coordinator. The specialized training shall include but not limited to guidelines, policies, and procedures for the following:

1. Breastfeeding;
2. Safe sleep;
3. Outdoor playtime;
4. Appropriate search/shakedown times;
5. Quietness;
6. Infant emergency; and,
7. Child abuse reporting

XIX. TRANSPORTS:

1. During standard business hours, the Maternal-Child Healthcare Coordinator or Transitional Healthcare team member shall transport newborns to and from the facility should the newborn be unable to be transported with the mother.
2. Custody staff shall pick up newborns outside of business hours, weekends, and on State holidays. Whenever possible, newborns shall be transported with their mothers by Custody staff.
3. Staff transporting newborns shall be trained in car seat installation or shall ensure that another facility or hospital staff member that has completed car seat installation training installs the car seat prior to transport.
4. Prior to transporting newborns, staff shall obtain the infant's medical file, all relevant paperwork, and a car seat from the designated location prior to retrieving the newborn. The hospital shall have a scanned copy of the infant's Power of Attorney and State Form 53845, "State Owned Vehicle's Passenger Waiver of Liability."

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5. The newborn's medical paperwork shall remain with them through pickup and shall return to the LEATH MCHU file storage upon return to the facility. All documents obtained during the visit shall be kept in the LEATH MCHU. No documents are permitted to be removed from the folder. The Health Services vendor shall not receive any of a LEATH MCHU child's medical paperwork
6. LEATH MCHU mothers are permitted to keep all childcare supplies and post-delivery supplies given to them by the hospital. These supplies shall be transported back with the mother.

XX. LEATH MCHU INFANT MEDICAL FILES:

1. Files should remain in a locked cabinet on the LEATH MCHU;
2. Custody staff should not access files unless needed for newborn transport or an emergency medical need;
3. LEATH MCHU child files contain but are not limited to records from all medical appointments, insurance cards and paperwork, Social Security cards, and Birth Certificates received for the child. Files shall also contain the infant's power of attorney, birth confirmation letter, and Maternal Health History paperwork.

XXI. USE OF VOLUNTEERS:

The LEATH MCHU shall utilize volunteers as educational programming providers, mentors, and for other purposes as needed in the LEATH MCHU housing unit as approved by the Director of Transitional Healthcare and Contract Compliance. The use of volunteers shall be in accordance with Policy and Administrative Procedure 01-03-103, "Community Engagement."

XXII. MOTHERS NOT ELIGIBLE FOR LEATH MCHU:

A supportive transition plan shall be created for mothers not eligible for LEATH Unit participation prior to delivery or within three (3) days of returning to the Indiana Women's Prison post-delivery.

Staff shall adhere to HCSD 3.09A, "Maternal Health Care," regarding mothers not eligible for LEATH MCHU.

XXIII. MEDIA INVOLVEMENT:

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At no time shall a LEATH MCHU child's full name be distributed on any social media site or media release. Social media post and media releases involving LEATH MCHU participants and children shall adhere to Policy and Administrative Procedure 00-03-101, "Distribution of Information."

XXIV. TRANSITION INTO COMMUNITY:

The Maternal-Child Health Coordinator shall contact the Health Services vendor's Regional Director of Transitional Healthcare (or designee) and arrange for a comprehensive and individualized release plan to be established within ninety (90) days from the mother's earliest projected release date (EPRD) or as soon as the Maternal-Child Health Coordinator is made aware of the impending release. The release plan shall include, but is not limited to locating a pediatrician, community family enrichment activities, childcare options, and social services.

LEATH MCHU child shall be released with the minimum items:

- Three (3) season appropriate outfits
- Three (3) sleepers
- Three (3) onesies
- Two (2) pairs of socks
- Two (2) pairs of shoes
- One (1) coat or jacket
- One (1) diaper bag

Mothers may request additional childcare items for release. The Maternal-Child Health Coordinator shall attempt to obtain needed items as available through donated property.

XXV. DATA COLLECTION:

The Health Service Administrator shall provide data including but not limited to mother's name, estimated due date, substance use history, and any potential health concerns to the Maternal-Child Health Coordinator within 7 (seven) calendar days of the mother's arrival to the facility.

Maternal-Child Health Coordinator shall collect data post-delivery for all incarcerated pregnant women including but not limited to baby's name, birth date, birth weight, location of child post-delivery, and birth complications. Data collected shall be provided to the

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Director of Transitional Health and Contract Compliance (or designee) within seven (7) calendar days of delivery.

XXVI. TERMINATION FROM PROGRAM:

LEATH MCHU program mothers and mentors may be removed from the program at any time at the discretion of the Director of Transitional Healthcare and Contract Compliance.


XXVII. APPLICABILITY:

This HCSD is applicable to the Indiana Women's Prison and the Department's Health Services Division.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title INCARCERATED INDIVIDUALS WITH DISABILITIES
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Legal References Americans with Disabilities Act	Related Policies/Procedures (includes but is not limited to) 00-02-201, 01-01-101, 01-01-102, 01-01-103, 01-02-101, 01-05-101, 01-06-101, 02-01-101, 02-01-105, 04-02-102, 04-03-103,	Other: National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides a process for identifying incarcerated individuals with disabilities as defined in the Americans with Disabilities Act (ADA).

II. DEFINITIONS:

- A. ADAPATIVE TECHNOLOGY: Any product that helps people who are unable to use regular versions of products.
- B. ADA MEDICAL FACILTATOR: The identified person responsible for coordinating assistance needed to reduce limitations to regular activities.
- C. AMERICAN SIGN LANGUAGE (ASL): The language used by individuals that are hard of hearing or deaf.
- D. AMERICANS WITH DISABILITIES ACT (ADA) OF 1990: The civil rights law that prohibits discrimination against an individual with disabilities in areas of public life including incarcerated individuals.
- E. ASSISTIVE TECHNOLOGY (AT): Any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.
- F. DISABILITY: With respect to an individual, the term “disability” means 1) a physical or mental impairment that substantially limits one or more major life activities of such individual; 2) a record of such an impairment; or, 3) being regarded as having such an impairment.
- G. EFFECTIVE COMMUNICATION: The ability to convey information to another adequately and efficiently.

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- H. ELECTRONIC MEDICAL RECORD (EMR): Digital version of paper charts that contain the medical and treatment history of patients in a single location.
- I. IMPAIRMENT (PHYSICAL OR MENTAL): Any physiological or psychological disorder that substantially limits one or more of the major life activities.
- J. INCARCERATED INDIVIDUAL: An adult person committed to a department of correction (federal, state, or local) and housed or supervised in a facility either operated by the department of correction or with which the department of correction has a contract, including and adult under parole supervision; under probation supervision following a commitment to a department of correction; in a minimum security.
- K. MAJOR LIFE ACTIVITIES: Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
- L. MITIGATING MEASURE: Any act utilized that eliminates or reduces the symptoms of an impairment in a way that makes it no longer substantially limiting.
- M. REASONABLE ACCOMMODATION: Any modification or adjustment that enables an individual with a disability to actively participate in regular activities.
- N. SPEECH TO SPEECH (STS): A relay service available to any telephone callers with a speech disability to actively speak with another.
- O. SUBSTANTIAL LIMITATION: An individual who is unable to perform, or is significantly limited in the ability to perform, a major life activity that the average person in general population can perform.
- P. TELEPHONE TO TEXT (TTY): A telecommunication device for the deaf and hard of hearing that allows the individual to type messages while using the telephone.

III. PROCEDURES:

The Department and any vendor contracted for health services shall not discriminate against an incarcerated individual based on a disability regarding the provision of services, programs, treatment, and activities. The Department shall ensure the rights of incarcerated individuals with disabilities and that needs are addressed in a manner consistent with the health and well-being of the person.

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All incarcerated individuals must be screened for physical or psychological impairment at Intake by the contracted medical vendor in accordance with HCSD 2.02, "Reception Screening." The contracted medical vendor must appropriately assign a disability code as described in HCSD 2.05A, "Disability Status Classification Assignments for Adult Offenders," and notify the ADA Medical Facilitator of the disability code of the disabled IDP. All referrals must be placed in the EMR. The ADA Medical Facilitator shall also be identified as the HSA or designee. This role shall work with the Health Services staff and the disabled incarcerated individual to determine and identify level of limitation and the mitigating measures needed. Mitigating measures include but are not limited to: TTY, ASL translator, braille services, mobility devices, and companions. The ADA Medical Facilitator must collaborate with the facility ADA Coordinator to ensure reasonable accommodations can be made and met. Services to alleviate substantially limiting activities may be provided following direct request by the incarcerated individual or referral from the ADA Medical Facilitator.

The disability intake assessment and determination shall be based upon the following:

1. Self-report of physiological or psychological impairment;
2. Staff observation during assessment;
3. Received records noting recorded disability from other agencies or medical facilities; or,
4. Any other method used to assist in determining disabilities.

In the event an incarcerated individual arrives to the Department without a disability but develops one while incarcerated, the incarcerated individual shall be assessed by the Health Services vendor. If it is determined that a disability is present, and reasonable accommodations can be made, the ADA Medical Facilitator shall work with the incarcerated individual to determine needs. The facilitator shall arrange services or meet with the facility ADA Coordinator to meet those needs. Health Services staff shall update the disability code and changes shall be reported to the Classification department.

The disability code review shall take place annually during the annual health screening process as defined in HCSD 2.08A, "Annual Screening," and at the time of any facility transfer. Any changes shall be reported to the Classification department as well the facility ADA Coordinator.

IV. ADDITIONAL CONSIDERATIONS:

- A. If it is determined that the incarcerated individual's disability is hearing impairment, the Medical ADA Facilitator shall contact the Deaf and Hard of Hearing Services (DHHS), Division of Disability and Rehabilitative Services (DDRS) of the Family and Social Services Administration, to arrange for an assessment by DHHS staff. Upon completion of the assessment, the ADA Medical Facilitator and the clinician shall review the results of the assessment with any appropriate staff and determine what reasonable accommodations are necessary to ensure that the incarcerated individual can perform normal life activities without substantial limitations. Facilities may use licensed/certified interpreters, computers with voice recognition software, interpretation equipment, TTY telephone equipment, staff, other incarcerated individuals or any other appropriate

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mechanism to ensure proper communication. The ADA Medical Facilitator shall take all necessary steps to ensure IDP is able to engage in effective communication. The ADA Medical Facilitator shall inform the facility ADA Coordinator of any needs. The use of assistive devices and auxiliary aids shall be based on clinical decisions after medical examinations and appropriate referrals shall be made.

- B. If staff determine that the incarcerated individual's disability is a physical impairment, the Health Services staff shall coordinate care and needs with the ADA Medical Facilitator. Coordination shall occur between the Health Services division, facility ADA Coordinator, and Operations staff (including Classification) to determine if needs can be met at the current facility or if a transfer is needed.
- C. If an incarcerated individual suffers from more than one disability (e.g., blindness and mobility issue), the ADA Medical Facilitator shall consult with the Health Services staff to determine which issue most substantially limits normal activities to aide in determining the reasonable accommodations that will meet the needs of the incarcerated individual.


V. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title COMMUNICATION REGARDING SPECIAL NEEDS PATIENTS
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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) requires that Health Services personnel assist operations personnel in managing prison facilities by providing, when necessary, health information regarding incarcerated individuals with special needs.

II. GUIDELINES:

- A. Personal health information (PHI) is confidential and must not be released to those not authorized to receive it. Within the Department, all health information will be released according to HIPAA guidelines. Department
- B Health Services personnel identify for Classification staff general patient needs by providing Medical, Behavioral Health, and Disability Status Codes. This general information must be maintained, as it guides incarcerated individuals placement throughout the Department. Additional specific information is often necessary when the following are considered:

- ◆ Housing assignments
- ◆ Work assignments
- ◆ Program assignments
- ◆ Disciplinary measures
- ◆ Admission to and transfer from facilities.

This is especially true for the following identified groups:

- ◆ Those with serious chronic illness
- ◆ Those with serious communicable disease
- ◆ Those with physical disabilities causing significant problems with performance of activities of daily living (ADLs)
- ◆ Those with serious behavioral health needs
- ◆ Those with severe developmental disabilities
- ◆ Those with serious cognitive impairment

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- ◆ Those who are terminally ill
- ◆ Those who, because of age or frailty, have significantly decreased ability to carry out ADLs
- ◆ Those who are pregnant

When specific activity limitation is necessary, this shall be communicated to the managers involved, in writing and/or verbally as appropriate. Facilities may create individual methodologies to carry out this requirement. No patient may be isolated based on the above needs.

- C Special mention of disciplinary proceedings and restrictive status housing placement must be made. Health Services staff with physical health or behavioral health knowledge relevant to a disciplinary conduct received by a patient should communicate this to those who are implementing / reviewing such conduct. Prior to screening for a conduct violation, behavioral health staff should be contacted by the screening officer and asked to provide feedback about whether the patient's behavioral health condition may have contributed to the conduct violation. If it is determined that the event in question was the result of the patient's behavioral health condition, the patient will receive a written reprimand documenting the behavior but will not receive other discipline per Policy and Administrative Procedure 02-04-101, "Disciplinary Code for Adult Offenders."

Placement in restrictive status housing carries with it certain risks. To ensure that those placed in restrictive status housing do not deteriorate during such placement, special attention must be paid to those going into or remaining in restrictive status housing. This is detailed more fully in HCSD 2.21 , "Health Evaluation of Incarcerated Individuals in Restrictive Status Housing."


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title HEALTH EVALUATION OF INCARCERATED INDIVIDUALS IN RESTRICTIVE STATUS HOUSING
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 02-01-111 02-04-102	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to ensure incarcerated individuals housed in restrictive status have unimpeded access to comprehensive medical Services.

II. DEFINITION:

RESTRICTIVE STATUS HOUSING: A form of housing for incarcerated individuals whose continued presence in the general population would pose a serious threat to life, property, self, staff, or other incarcerated individuals, or to the security or orderly operation of a facility. Restrictive Status includes disciplinary restrictive status and administrative restrictive status including, for the purpose of this HCSD, protective custody. This term and this HCSD do not apply to incarcerated individuals who are classified to a facility program or specialized unit where the incarcerated individuals eat, recreate, and socialize together.

III. GUIDELINES:

- A. Incarcerated individuals in restrictive status housing are completely dependent upon facility staff for all services. incarcerated individuals shall continue to receive comprehensive medical services including prescribed medication while in restrictive status housing.
- B. An incarcerated individual assigned to restrictive status settings may have health conditions for which restrictive status housing may be contraindicated. When an incarcerated individual is transferred to restrictive status housing, the Custody or Operations staff making the decision to transfer the incarcerated individual must immediately inform nursing of the transfer. The nurse shall review the incarcerated individual's

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health record immediately to determine whether restrictive status housing is contraindicated due to existing physical, dental, or behavioral health needs.

- C. If the health record suggests the presence of a health condition in which restrictive status housing placement is contraindicated, the nurse must contact the appropriate provider (e.g., physician, dentist, or psychologist) for direction and orders and alert the Warden or designee of the concern.
- D. If the provider agrees that restrictive status housing is contraindicated, the provider must make direct contact with the Warden or designee to inform him or her of the reason. If the Warden or designee is able to arrange accommodations for the incarcerated individual's unique health needs and the provider is satisfied that the special accommodations will meet the incarcerated individual's health needs, the incarcerated individual may remain in restrictive status housing. The provider's contact with the Warden or designee and any decisions resulting from that contact must be documented in the incarcerated individual's health record. The provider must also update the incarcerated individual's therapeutic regimen with new orders if necessary.
- E. If the health record review shows that the patient is a "D" Behavioral Health code or is within the thirty (30) day period of post-release follow up after having been removed from suicide watch precautions, the reviewer must immediately conduct the suicide risk and mental health screening and contact the facility's lead psychologist or designee. During business hours, the psychologist or designee must assess the patient to determine if any immediate action is necessary. If placement and review occur after normal business hours, the lead psychologist or designee must assess the patient on the next business day.
- F. All incarcerated individuals admitted to Restrictive Status Housing shall be screened for suicide risk and mental health problems within twenty-four (24) hours of admission. Mental health trained nursing staff shall inquire about:
 - Current suicidal ideation and history of suicidal ideation and behavior;
 - Current mental health complaints;
 - Current mental health treatment and history of mental health treatment including the use of psychotropic medications and inpatient and outpatient treatment;
 - Substance use history including history of substance use treatment; and
 - Drug intoxication or withdrawal symptoms.

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Mental health trained nursing staff shall document observation of:

- Appearance
- Behavior
- Affect and mood
- Speech
- State of consciousness
- Activity level
- Evidence of abuse or trauma
- Current symptoms suggestive of psychosis, depression, anxiety, or aggression.

Mental health trained nursing staff shall document disposition of patient:

- No Behavioral Health referral
- Referral to Behavioral Health services
- Referral to appropriate Behavioral/Mental Health care service for emergency treatment

When mental health needs are identified, the incarcerated individual shall be referred to an MHP for a mental health evaluation. An incarcerated individual who presents with serious suicidal intent, psychotic symptoms, or is a danger to self or others shall be seen immediately by the MHP. If the MHP is not on site, the nurse shall contact the MHP for consultation and direction.

Within seventy-two hours (72) hours of placement in a restrictive status housing unit, an MHP shall conduct an evaluation of the incarcerated individual to determine if the incarcerated individual meets criteria for classification as Seriously Mentally Ill or if there are other clinical reasons why extended restrictive status housing placement is contraindicated. This evaluation shall include a review of the incarcerated individual pertinent mental health history, a thorough review of all active and provisional diagnoses, a validation of current mental health needs, and a determination of the severity of both the clinical symptoms and any resulting functional impairment. If the MHP determines placement in a MHU may be more appropriate, they will begin the process by completing a Transfer Summary and submitting it to the contracted Regional Director of Mental Health for review on the weekly Mental Health Movement Call.

Incarcerated individuals may be identified as meeting Serious Mental Illness criteria as a part of either the initial restrictive status housing review

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process (as noted above) or as part of a subsequent identification during mental health monitoring at any time during Restrictive Status Housing placement. When an incarcerated individual is identified as meeting criteria for Serious Mental Illness, the MHP shall notify the contracted Director of Behavioral Health or designee, the Director of Mental Health, and the facility SMI point of contact by email within one (1) business day of the incarcerated individual's diagnosis. This shall be discussed with the facility Restrictive Status Housing Multidisciplinary Team and determination made by the Team as to the anticipated length of stay in the restrictive status housing unit.

If the offender is determined to be stable by the mental health professional and removing a Seriously Mentally Ill offender from restrictive status housing would pose a threat to the safety and security of offenders and/or staff, the Warden may request an exception to house the offender in restrictive housing longer than thirty (30) days from the Executive Director of Behavioral Health. The decision shall be recorded in the incarcerated individual's facility packet and shall be reviewed by Unit Team staff and documented in writing every fourteen (14) days. In the event that a Seriously Mentally Ill offender is required by exceptional circumstances to remain in restrictive status housing, a specific treatment plan shall be developed which will determine the frequency of contact at or above those required in the attached matrix to this HCSD "Restrictive Status Housing Mental Health Treatment Matrix/Continuum."

If a determination is made that the incarcerated individual is unlikely to return to general population in thirty (30) days, the incarcerated individual is not clinically appropriate to be permitted to consent to remain in restrictive status housing, and the incarcerated individual is not clinically appropriate to be considered for a safety and security exception then the MHP should complete and submit a Transfer Summary to the contracted Director of Behavioral Health to be presented on the Mental Health Movement Call for potential placement in a MHU.

- G. All incarcerated individuals in restrictive status housing areas shall be seen once per shift by nursing personnel and must be documented in the incarcerated individuals' health record or on State Form 46026, "Restrictive Status Housing Rounds Flow Sheet." Restrictive status housing rounds are required in addition to routine health services including nursing triage, although nursing triage may be conducted during rounds when an incarcerated individual raises a concern. The presence of a nurse or other health care provider on the restrictive status housing unit must be announced and the announcement must be recorded. If a serious health condition is

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present, Health Services personnel shall ensure that proper services and support continue to be provided during restrictive status housing placement. Clinical evaluations must be done in an appropriate clinical setting and not conducted at the incarcerated individual's cell. When it is essential that an incarcerated individual be escorted out of restrictive status housing in order to receive health services, this shall be accomplished by Operations staff. Additionally, the nurse shall refer any incarcerated individual who expresses suicidal intent, incarcerated individual with psychotic symptoms, severe or persistent self-neglect, or changes in mental status to an MHP. The MHP shall evaluate the incarcerated individual and revise the treatment plan if necessary. Any incarcerated individual at risk for suicide must be placed under direct visual observation until an evaluation by an MHP has been completed. For routine referrals, the incarcerated individual shall be evaluated by an MHP in accordance with the parameters of Health Care Services Directive 2.01, "Access to Care."

- H. All incarcerated individuals in restrictive status housing must be evaluated by a qualified MHP within thirty (30) days of placement and every thirty (30) days after even if no mental illness is present. Mental health evaluations of incarcerated individuals with an identified mental health need(s) must be conducted in a location which affords the incarcerated individual confidentiality; the evaluation may not be done at the incarcerated individual's cell front unless offender refuses an out of cell visit. Follow up evaluations shall be done in accordance with the time frames noted in the ITP which may not exceed thirty (30) days.

If not seriously mentally ill but other mental health needs are identified by MHP evaluation, the MHP must make a determination regarding the frequency of contacts necessary for maintenance during restrictive status housing placement and modify the treatment plan accordingly. Mental health services personnel must ensure that proper services and support continue to be provided during restrictive status housing placement by escorting the incarcerated individual to the appropriate location for services or by providing services in an appropriate setting on the restrictive status housing unit. If at any time the incarcerated individual treatment needs cannot be met in restrictive status housing and they are not appropriate to return to a general population setting, the MHP should complete and submit a Transfer Summary to the contracted Director of Mental Health to be presented on the Mental Health Movement Call for potential placement in an MHU.

In accordance with a Settlement Agreement between the Indiana Protection and Advocacy Services Commission (IPAS) and the Department, MHPs

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assigned to restrictive status housing areas within the Department are required to fulfill unique assessment responsibilities. The attachment to this HCSD, “Restrictive Status Housing Mental Health Treatment Matrix/Continuum” presents a matrix for the types of mental health contacts, frequency of contacts, location of contacts, and documentation required for patients in restrictive status housing.

- I. Unless mental health attention is needed more frequently, a mental health professional shall make weekly, documented rounds of the restrictive status housing units to ensure that incarcerated individuals have access to the behavioral health system.
- J. All incarcerated individuals in restrictive status housing with an identified mental health diagnosis must be seen by the mental health provider in a confidential out-of-cell location for mental health evaluations including the thirty (30) day restrictive status housing reviews. These evaluations may not be done at the cell-front unless the patient refuses to come out of cell. Each facility with a restrictive status housing unit shall ensure that there is adequate office space available in or near the unit that will allow mental health staff to meet with incarcerated individuals. The space must permit mental health evaluations to be conducted in a confidential manner. Unit and mental health staff must coordinate activities to ensure the room is available when mental health staff is scheduled on the restrictive status housing unit.
- K. If at any time while an incarcerated individual is in restrictive status housing a member of the Physical Health or Behavioral Health Services staff determine that restrictive status housing placement is causing deterioration in health or behavioral health status or the incarcerated individual’s health or behavioral health needs cannot be met in restrictive status housing, the Health Services staff member must notify the Warden or designee so special accommodations may be made or the incarcerated individual must be transferred to a more appropriate setting.

VI. APPLICABILITY:

This HCSD is applicable to all Department facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



**HEALTH CARE SERVICES
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Title

SEXUAL ASSAULT

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 02-01-115	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Service Directive (HCSD) describes the required response to alleged sexual assault occurring within the prison setting.

II. GUIDELINES:

- A. Any sexual act including sexual touching performed without the full consent of all participating parties is a sexual assault. Sexual assault is a criminal act. Sexual assault can result in physical injury and in emotional trauma. It is the responsibility of Health Services personnel responding to victims of sexual assault to treat physical injuries, help minimize emotional trauma, and preserve physical evidence (e.g. no clothing is removed or cleaned, no showers etc.).
- B. The initial assessment of an alleged sexual assault victim must include assessment of injury and determination of immediate health needs, provision of emergency care for trauma, and determination if the sexual assault was recent or remote. During the initial assessment a Correctional Officer (preferably of the same gender as the victim) shall be present both as a chaperone and to preserve security. Separation between the alleged victim and the alleged perpetrator shall be maintained with the assistance of Custody personnel when necessary.
- C. Clothing, objects, and other potential evidence shall be saved in clean paper bags usually completed by Office of Investigations and Intelligence Staff. Health services staff are responsible to ensure that any physical evidence is not disturbed. The alleged victim must be informed that a crime has been alleged and that Custody and administrative staff will be fully informed.
- D. If the sexual assault was recent, Health Services staff shall initiate an off-site referral to an emergency room with access to a Sexual Assault Nurse

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Examiner (SANE). Completion of the formal evidence kit for the State Police will be accomplished at the emergency room. If the sexual assault was remote in time, the physician shall be contacted regarding required follow up. If an emergency room is used, it is anticipated that testing for, and prophylaxis against, sexually transmitted diseases including HIV, if necessary, will be initiated there; if the care is provided by the facility (because of the remoteness in time of the alleged assault) these services should be provided on-site.

- E. All alleged victims of sexual assault shall be provided with opportunities for counseling from mental health professionals within 7 days of referral.
- F. If the victim of a sexual assault is a juvenile, the Warden must be fully apprised. The Warden, rather than the Health Services personnel, shall notify the appropriate child protection authorities.
- G. The “Sexual Assault Manual” provides guidelines regarding response to specific situations.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title	HUNGER STRIKES
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for managing incarcerated individuals who are refusing to accept food and/or drink.

II. DEFINITIONS:

- A. **HEALTH EMERGENCY:** A health problem that, if not attended to immediately, is likely to lead to a loss of life, significant pain, or a significant disability.
- B. **HUNGER STRIKE:** The voluntary refusal to eat and/or drink. This does not include brief periods of abstinence between meals or short term fasts, such as occur for religious purposes or for diagnostic tests.

II. GUIDELINES:

- A. The Department's response to hunger strikers shall be in proportion to the problem presented and shall respect an individual's rights to manage their own body when they have capacity to make such decisions.
- B. A hunger strike may come to the attention of facility staff because an incarcerated individual may declare themselves to be refusing food and/or drink, through staff noting such a refusal, or through a third party bringing the matter to staff's attention. An incarcerated individual shall be considered to be on a hunger strike when staff have observed that the incarcerated individual has not eaten four consecutive (4) meals or has not eaten for more than 48 hours. Non-Health Services staff may refer

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an incarcerated individual for a medical evaluation before 4 meals are missed if the staff member considers it prudent (e.g., the incarcerated individual is lethargic or acting in a bizarre manner).

- C. If the incarcerated individual suffers from a physical or mental illness in which judgment is impaired (e.g., dementia, encephalopathy, paranoia), this Health Care Services Directive is not applicable. In this situation, the Physical Health or Behavioral Health staff shall manage the underlying physical or mental illness.
- D. Hunger strikes have the potential to become life threatening. Patients that are pregnant, older than 65 years of age, have a baseline body mass index (BMI of less than 18), or certain health conditions may be at a higher risk to develop serious complications from prolonged hunger strikes.
- E. Due to the potential risks in these groups the following steps must occur:
 1. Ascertain whether a hunger strike is occurring and determine the nature of the strike (food, drink, both, etc.);
 - a. Documentation in the EMR of the nature of the hunger strike;
 - b. Review of patient's record to determine level of risk;
 - c. Operations staff shall document intake of food and fluids; and,
 - d. In a collaborative and routine fashion determine the appropriate housing for the patient participating in the hunger strike
 2. Assess the patient for the presence of serious physical or mental illness;
 - a. Health Care Staff shall perform a baseline evaluation including a visual observation of health status, complete set of vital signs (including height and weight), and a chart review;
 - b. Refusals of care shall be documented on State Form 9262 and in the EMR. Refusal of medications shall be referred to the prescribing clinician;
 - c. Obtain urine for dip stick analysis and report positive findings to clinician;
 - d. Refer to behavioral staff, urgently if Serious Mental Illness is present; and,

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- e. If capacity is questioned, an urgent referral to psychiatry is necessary.
3. Monitor the patient and take steps as necessary to maintain order in the facility;
 - a. Daily observation by Health Services Professional
 1. Complete set of vital signs (including height and weight)
 2. Frequent monitoring of BMI
 3. Visual observation for immediate signs of deterioration of health such as obvious signs of malnutrition or dehydration;
 - b. Daily education should be provided regarding the effects of starvation, signs of dehydration, and importance of fluid intake and medical compliance;
 - c. Clinician visits weekly, or as directed by the clinician with an updated treatment plan;
 - d. With any decline in status, immediate intervention must be scheduled with a clinician for additional testing and monitoring; and,
 - e. Routine behavioral health evaluations as clinically indicated.
4. Intervene as appropriate;
 - a. Housing changes may be required for closer monitoring;
 - b. Health Services staff shall seek Legal advice if guardianship or court ordered interventions become necessary;
 - c. Advanced Directives offered and discussed with patient;
 - d. Emergent care/ interventions when necessary to maintain patients' health status. No forced interventions are to be performed without legal direction; and
 - e. An evaluation to determine capacity may be indicated.

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Of note, a provider can implement these interventions at any time based on clinical decision making.

- F. If a patient does not meet the above high risk criteria, the patient must be seen by nursing staff at least weekly for a complete set of vitals , visual observation for immediate signs of deterioration of health and patient education. This information shall be documented in the EMR and reported to the provider. Additional intervention maybe indicated and close communication as a multidisciplinary team is to occur.
- G. When the patient has resumed eating, periodic assessments may be stopped. The patient shall be seen within seven (7) days after the strike has ended or as otherwise prescribed by the provider to ensure the patient is not experiencing any adverse effects and has regained weight.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CLINICAL CRITICAL INCIDENT REVIEWS (CCI)
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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 02-03-114	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to ensure all mortalities , sentinel events, and serious suicide attempts are reviewed to determine the appropriateness of clinical care, to ascertain whether change to policies, procedures, or practices are warranted and to identify processes which may need improvement.

II. DEFINITIONS:

- A. **ADMINISTRATIVE REVIEW:** An assessment of correctional and emergency response actions surrounding a patient's CCI. The purpose is to identify areas where facility operations, policies, and procedures can be improved.
- B. **CLINICAL CRITICAL INCIDENT REVIEW (CCI Review):** An assessment of the clinical care provided and the circumstances leading up to the mortality, sentinel event or serious suicide attempt. The purpose is to identify areas of patient care or system policies and procedures that can be improved.
- C. **MORTALITY REVIEW:** An assessment of the clinical care provided the circumstances leading up to the death. The purpose is to identify areas of patient care or system policies and procedures that can be improved.
- D. **PSYCHOLOGICAL AUTOPSY:** A formal systematic review, conducted after a death presumed to be from a suicide, to examine the mental and emotional state of the patient. Prior to the suicide, as well as a review of the other factors or circumstances including staff training, adherence to procedures, access to care, etc., to determine why the patient ended their life. To be conducted by a psychologist or other qualified mental health professional.
- E. **SENTINEL EVENT (SE):** Any unanticipated event in a healthcare setting resulting in death serious physical or psychological injury to an IDP that is not related to the natural course of the IDP's illness.

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- F. SERIOUS SUICIDE ATTEMPT (SSA): Any self-injurious action that would have been lethal without rapid and effective emergency treatment or with evidence to show intent to die.

III. GUIDELINES:

A. General Information

All CCI reviews shall be conducted for every patient mortality, SE, or SSA to determine the appropriateness of the clinical care provided and the effectiveness of the facility's response at the time of death.

Every patient CCI must be reviewed by facility operations, facility Health Services staff, Contracted Regional Medical Staff, and Health Services Division staff. A CCI review consists of:

1. An administrative review;
2. A clinical review to include a comprehensive narrative by the Health Services vendor;
3. A psychological autopsy if the death is by suicide;

When a CCI need has been identified, both appropriate facility Health Services and Administrative staff shall review the circumstances and quality of care within 96 hours and forward to the Health Services vendor's regional office. Reviews shall include at least one physician not involved in the care of the patient. Health Services vendor's regional office staff shall have a secondary review completed including any corrective action plans identified no later than 14 days from date of the event in order to:

1. Assess performance and outcomes;
2. Identify strengths and weaknesses; and,
3. Improve services.

Once this review is completed it shall be forwarded to the appropriate Executive Director or designee for final review and assignment of category. This shall be completed within 30 days of the event. If the Executive Director assigns a category 3 or 4, a formal collaborative review process shall be scheduled.

B. Contents of the Review

When Health Services staff review a CCI the following items shall be used to facilitate the review:

1. Health Record;
2. Incident reports and associated staff and patient statements;
3. Pertinent ambulance "run sheets;"
4. Pertinent hospital records;
5. Autopsy report (preliminary, if only that is available); and,

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6. Pertinent laboratory results including those ordered by pathologist/medical examiner, if available.

During the CCI review, the following shall be determined and summarized in a comprehensive narrative:

1. Identifying information;
2. Date of event
3. Date of report;
4. Name and DOC number of the patient;
5. Names, credentials, and positions of the person(s) completing the State Form 46896 "Report of Clinical Critical Incident";
6. Current/Final diagnosis;
7. Manner of death if applicable (e.g., natural)
7. Cause of death if applicable;
8. Pre-existing medical conditions;
9. Past history, heredity, risk factors;
10. Comments regarding labs, x-rays, and other tests;
11. Prognosis, if indicated;
12. Determination whether appropriate care was provided
13. Description of the incident at the time of event
14. Description of interventions provided at, or about, the time of event;
15. Clinical judgment regarding any interventions necessary to improve future outcomes or reduce risk(s).

Treating staff shall be informed of the CCI review and administrative findings.

Each CCI shall be assigned to one of the following classes:

1. Exemplary Care (Care above expectations);
2. Appropriate Care;
3. Errors of omission/commission which may have contributed to the adverse outcome; and,
4. Errors of omission/commission that likely contributed to an adverse outcome.

A working document with CCI information including assigned class shall be maintained and be available on a shared drive to appropriate Quality Assurance Managers, Executive Director's and the CMO. These metrics shall be available for review at Continuous Quality Improvement (CQI) meetings.

Corrective actions identified through the CCI review process are implemented and monitored through the facility's Quality Assurance Committee. All corrective action plans shall be forwarded to the appropriate QAM for review. These plans will be available at CQI meetings.

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The object of the review process is to promote improvements in quality of care. While assignment of blame is not a direct part of the process, on occasion, an individual's performance may be identified as having been substandard. In such cases, the CCI review cannot be used to initiate either discipline or performance improvement. The review may be used to initiate another review of the case, outside this review process. This outside review may be used to initiate personnel interventions as necessary without compromising the confidentiality of the review process itself.

C. Confidentiality

Investigations, reviews, and other documents developed as part of a medical quality assurance activity shall be considered confidential and are exempt from disclosure, even in legal discovery processes, in accordance with all appropriate statutes, such as Indiana Codes 11-8-5-2 and 34-4-12.6.

Copies of CCI reviews shall not be filed in the patient's health record. Copies of CCI reviews shall be maintained on file only by the facility and contractor quality assurance staff.


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM
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Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) establishes guidelines for facility and Regional Continuous Quality Improvement Committees.

II. PROCEDURES:

A. Continuous Quality Improvement (CQI) monitors and improves health care delivery internally by:

- Examining their work and establishing appropriate thresholds;
- Identifying successes and opportunities for improvement
- Plan improvements;
- Implement improvements; and,
- Reexamine their work to determine whether the changes have had the desired effects.

This process, repeated in an integrative fashion, constitutes the Quality Improvement cycle. The CQI program must include both process and outcome quality improvement studies.

B. Each facility shall establish an integrated and multidisciplinary CQI Committee that shall be responsible for site specific CQI activities as summarized in “A” above.

C. The Facility CQI Committee shall include representation from all Health Service disciplines represented at the facility and appropriate representation from Operations staff. A facility’s CQI Committee shall meet at least monthly. These meetings may be held in conjunction with other committee meetings, but separate confidential minutes must be maintained.

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Title CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM			

- D. The Health Services vendor shall additionally establish a Regional CQI Committee chaired by a CQI Nurse. This Committee shall include representatives from all major disciplines operating at the Statewide level and shall meet monthly to include Department Health Services Leadership. The CQI Committee shall guide and provide oversight to the facility level CQI programs and shall conduct or coordinate CQI activities that span multiple facilities.
- E. If an outside vendor participates in health services delivery at a facility and maintains a separate CQI process, the facility CQI Committee shall include review of pertinent portions of the outside vendor CQI activities and must invite representation from the vendor to serve on its CQI Committee. If an outside vendor has a statewide CQI process, representative may be invited to the Regional Office CQI Committee.
- F. CQI activities are held strictly confidential. The CQI product may not be released outside of the CQI process, including in discovery during lawsuits, without review by Legal counsel. CQI products may also not be used in personnel actions, although it may be used to trigger additional reviews.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title END-OF-LIFE SERVICES (EOLS)

Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) presents general guidelines for provision of end-of-life and palliative care.

II. GUIDELINES (See Facility Directive):

Patients who are approaching the end of life shall be offered general health care services that include supportive and palliative care. Patients have the right to receive life-sustaining treatment if desired, and to not have the dying process prolonged through programs such as palliative care. Palliative care can be defined as health care and support services aimed at providing comfort, including adequate pain management. Treatment shall be focused on symptom control and quality of life rather than curative in nature.

Palliative care enrollment is contingent on independent reviews and patient-centered choice. When a patient is incapacitated, the next of kin or legally appointed guardian must evaluate and consent to or refuse to this program. Palliative care may also be referred to as hospice services.

A. EOLS include:

1. Care and encouragement to remain independent in activities of daily living until the progressive disease process makes that impossible;
2. Encouragement to maintain important social contacts and to participate in important life activities;
3. Health care services (as guided by individual patient desires as documented in Advance Directives);

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4. Alleviation of pain and unpleasant symptoms;
5. Support in understanding the process of dying;
6. Support and assistance in addressing the health, emotional, and spiritual aspects of death and dying;
7. Assistance to family members visiting the prison facility;
8. Companionship; and,
9. Access to Religious Services

B. Patients approaching the end of life shall be permitted to execute an advanced directive in accordance with Health Care Services Directive 2.13, "Advance Directives." These advanced directives shall be signed only after the terminally ill patient has received appropriate information regarding his or her disease process and the meaning and consequences of signing these documents. There must be documentation in the electronic medical record (EMR) to support the patient approaching end of life has been provided with sufficient and appropriate information to make a voluntary and informed decision regarding his or her advanced directive.

C. Each facility that provides EOLS for patients shall establish a formal program addressing EOLS and palliative care services.

EOLS and Palliative Care services may use incarcerated individuals as volunteers, in accordance with applicable policies, procedures, and directives. Incarcerated volunteers working with EOLS patients must be screened for emotional stability, trained in the tasks that are expected to perform, and supervised by qualified health care professionals.

Facility Directives and manuals necessary to the programs shall be written and made site specific. Facilities are encouraged to assist each other in this process.

D. EOLS and Palliative Care shall be coordinated by an interdisciplinary team which includes the patient management team and additional representation from other service areas including physical and behavior health, operations staff, clergy, IDP volunteers, and additional staff as directed by patient needs.

The team is responsible for:

- Establishing and maintaining an individualized treatment care plan
- Coordinating services from each discipline

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- Planning incarcerated volunteer activity, as appropriate
- Ensuring services are attentive to issues of language, culture, religion, and relationships with family, friends, and other patients
- Ensuring that involved employees are debriefed and receive support as necessary.

III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



**HEALTH CARE SERVICES
DIRECTIVE-ADULT
Manual of Policies and Procedures**

Title

**PROCEDURE IN THE EVENT OF THE DEATH OF AN
INCARCERATED INDIVIDUAL**

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 01-04-101 01-04-105	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide direction regarding actions taken after the death of an incarcerated individual. This HCSD is not applicable in the event of an execution.

II. PROCEDURE:

In all cases of medical emergencies when CPR is indicated 911 must be called and the clinician notified.

When clear signs a patient has expired (i.e., rigor mortis or lividity) are present upon arrival of a medical emergency at a facility, the facility Health Services staff may call the clinician with this report and verify the time of death without calling 911 or initiating CPR.

In the event that clear signs of death are present but CPR was initiated, CPR must continue until time of death is called by a practitioner.

A. Upon learning that a time of death was called for a patient (on-site or off-site), the nurse in charge shall:

1. Notify the highest ranking on-site Operations employee and the facility physician;
2. Document immediately and fully in the patient's health record;
3. Inform other Health Services staff as appropriate;
4. Secure the health record, and
5. Notify the CMO, Executive Director of Physical Health, and the Epidemiologist.

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B. The Warden or designee shall:

1. Inform the patient's next of kin using the procedure outlined in HCSD 1.21 , "Notification in Emergencies;"
2. Request the Coroner's Office or Medical Examiner (depending on the locality) and the Indiana State Police to review the circumstances surrounding the death, if the death occurred on-site and was unexpected or under suspicious circumstances (the Medical Examiner acts as an agent of the Coroner). Until the Coroner's/Medical Examiner's Office and State Police permit otherwise, the area in which the death occurred shall remain secure and intact (unless safety and security considerations make this impossible);
3. May request through the Coroner's/Medical Examiner's office that an autopsy be performed; however, the Coroner's/Medical Examiner's office has final authority regarding whether an autopsy is performed. In the event that an autopsy is completed a copy of the coroner's report is to be forwarded to the facility's Health Services Administrator, the Health Services vendor's Regional Director of Nursing, and Executive Director of Physical Health.
4. If the death occurred in a hospital or other location, the Coroner/Medical Examiner responsibilities are accomplished by the hospital. Autopsies are always encouraged by the Department; and,
5. Upon receipt of a copy of the official Certificate of Death and/or Autopsy Report (if applicable), the Warden shall provide a copy of each document with a corresponding cover letter addressed to the Executive Director of Classification and the Executive Director of Physical Health that summarizes the patient's sentencing information, cause of death, and any additional information deemed relevant in the matter.
6. If the deceased patient was a foreign national, the Warden or designee shall ensure that the nearest embassy or consulate of the deceased's home nation is notified.

C. All employees are expected to fully cooperate with the Coroner's/Medical Examiner's office and the Indiana State Police. Access to the health record as necessary for investigation shall be provided, within the limits of the applicable rules and regulations.

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- D. The Health Services Administrator shall alert the Health Services' Division Leadership; including the appropriate Executive Directors, Quality Assurance Managers and CMO in regards to the death, including time of death, patient name, date of birth, DOC number, past medical history, and circumstances surrounding the death (the Warden carries out a similar notification through the Warden's chain of command), and schedule a clinical critical incident review in compliance with HCSD 2.24, "Clinical Critical Incident Reviews"). After the Critical Clinical Incident review is completed, the paper health record shall be prepared for record storage.

III. APPLICABILITY:

This HCSD is applicable to all facilities housing and providing health care for incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



**HEALTH CARE SERVICES
DIRECTIVE-ADULT
Manual of Policies and Procedures**

Title

HEALTHY LIFESTYLE EDUCATION AND PROMOTION

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSA) describes requirements to provide health education and promotion to all incarcerated individuals

II. GUIDELINES:

A. Health education on self-care strategies and promoting a healthy lifestyle shall be made available to all incarcerated individuals at each facility and during each health care contact for individualized health conditions. Health education and promotion may be accomplished by the following:

1. Brochures and pamphlets in areas accessible to all patients, and on tablets, when available;
2. Audio and video presentations;
3. Instructional classes; and,
4. One-on-one settings.

B. The following are examples of educational and health promotional activities:

1. At Intake, education regarding HIV; Hepatitis A, B, and C; and oral hygiene;
2. At Intake for identified sex offenders, a psychoeducational class emphasizing victim awareness;
3. At all facilities general information regarding, but not limited to, the following:
 - a. Acne;

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- b. Athlete's foot/Jock itch;
 - c. Bruises;
 - d. Common cold;
 - e. Constipation;
 - f. Cuts and scrapes;
 - g. Diarrhea;
 - h. Headaches;
 - i. Indigestion;
 - j. Self-breast examination;
 - k. Nutrition;
 - l. Sore throat and follow-up
 - m. Sports injuries;
 - n. Dental hygiene;
 - o. Personal hygiene;
 - p. HIV infection;
 - q. Hepatitis (A,B,C);
 - r. Immunizations and age-appropriate interventions;
 - q. Substance abuse/Addiction Recovery;
 - r. Smoking/tobacco use;
 - s. Sexually Transmitted Infections (STI prevention);
 - t. Testicular self-examination.
 - u. Parenting skills;
 - v. Perinatal care for women;
 - w. Stress management.
4. For those patients with chronic diseases, education regarding their diagnosed condition and risk factors;
 5. For those patients provided with medication, instructions regarding administration;
 6. For those patients approaching their Earliest Possible Release Date, instructions regarding obtaining physical and behavioral health services, healthcare coverage, access to food and clothing in the community and any other needs related to social determinants of health;
 7. Facilities utilizing incarcerated individuals in clean up of blood or other potentially infectious materials shall be provided instruction regarding avoidance of exposure incidents and Hepatitis B vaccination.

Intake facilities shall provide incarcerated individuals with instruction in personal hygiene and infectious diseases.

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III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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HEALTH CARE SERVICES DIRECTIVE-ADULT Manual of Policies and Procedures					

Title PERSONAL HYGIENE

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 02-01-104 04-01-104	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes required support for appropriate personal hygiene.

II. GUIDELINES:

A. Incarcerated individuals shall be provided with the opportunity to practice appropriate personal hygiene. Articles necessary for maintaining proper personal hygiene must be available to all incarcerated individuals and provided to those who meet the definition of indigent as found in Policy and Administrative Procedure 04-01-104, "Inmate Trust Fund." To this end, the following items must be made available, either at no charge or through commissary sources:

- Soap and shampoo
- Comb
- Toothbrush and toothpaste or powder
- Denture cleaner and adhesive, if necessary; Dental floss (engineered for safety and security in a prison environment)
- Toilet paper
- Deodorant
- Shaving equipment
- For females, sanitary napkins/tampons

B. If an individual abuses any of these items or uses any in a manner that endangers safety or security, the privilege of having them may be suspended.

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Title PERSONAL HYGIENE			

- C. In areas in which incarcerated individuals are held for more than forty-eight (48) hours, access to a tub or shower with tempered running water must be provided, with a daily opportunity to bathe.
- D. Incarcerated individuals with disabilities shall be provided support to perform self-care and personal hygiene in a reasonably private environment.
- E. Laundry services shall be offered at least weekly.
- F. Haircuts and shaving implements shall be made available periodically subject to security regulations and behavioral health considerations for all patients.
- G. Implements for cutting fingernails and toenails shall be made available periodically subject to security regulation and behavioral health considerations for all patients.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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HEALTH CARE SERVICES DIRECTIVE-ADULT Manual of Policies and Procedures				

Title CHRONIC DISEASE INTERVENTION GUIDELINES

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. **PURPOSE:**

This Health Care Services Directive (HCS D) describes the provision of care to patients with chronic serious health conditions.

II. **DEFINITION:**

CASE PLAN CREDIT TIME (CPCT): An earned credit time cut structure that is driven by the needs indicated in the Indiana Risk Assessment System (IRAS) and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time, as allowed by law.

III. **GUIDELINES:**

- A. Patients with chronic health conditions such as asthma, hypertension, diabetes, high blood cholesterol, HIV, seizure disorder, Hepatitis C, and other major medical illnesses must be identified and enrolled in a chronic care clinic.
- B. The diagnosis of the chronic disease should be as clear as possible and adequate support for it must be fully documented in the health record. Diagnosis list shall appropriately reflect all active chronic conditions.
- C. For each patient enrolled in Chronic Care Clinic (CCC) there must be a plan for the treatment of their condition. The plan must address the monitoring of medication, laboratory testing, the use of chronic care clinics, health record forms, and the frequency of any specialist consultation of review, if indicated.

Physical health providers shall collaborate with Unit Team staff by identifying and documenting treatment goals within the patient's control for patients who have chronic diseases and have opted in to the CPCT process prior to January 1, 2022 or who have entered the Department on or after January 1, 2022. A Clinical Review Form with identified goals shall be completed during a routine Chronic Care visit. A copy of the form shall be uploaded to the EMR and shared with the patient's Unit Team staff to coordinate treatment plan and case plan goals. The Clinical Review Form shall be updated annually with progress on previously assigned goals during a regularly scheduled 90- or 180-day contact. A copy of the completed form

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shall be uploaded to the EMR and shared with the patient's Unit Team staff for consideration in their CPCT review. A new Clinical Review Form with newly identified or continued goals shall be completed, scanned into the EMR and a copy provided to the patient's Unit Team staff at each annual review.

- D. Patient chronic health condition must be listed on the "Master Problem List," in the Electronic Medical Record (EMR).
- E. Treatment of patients with chronic health condition shall be consistent with national clinical practice guidelines.
- F. Frequency of Chronic Care Clinics:
 - 1. Patients with an unstable chronic health condition(s) shall be seen, by a provider, a minimum of every ninety (90) days, or more frequently if directed by the provider's individualized treatment plan.
 - 2. Patients with stable chronic health condition(s) shall be seen, by a provider, a minimum of every year (365 days), or more frequently if directed by the provider's individualized treatment plan.

If a patient wishes to see the provider or other health services in between Chronic Care Clinic visits, they shall submit a completed State Form 45913, "Request for Health Care," in accordance with Health Care Services Directive 2.01, "Access to Care." A co-pay will be charged when State Form 45913 is submitted outside of scheduled CCC visits unless considered an emergency or the contact was initiated by staff in accordance with Policy and Administrative Procedure 04-01-104, "Offender Trust Fund."

- G. Each facility shall maintain a current list of chronic care patients.

III. SITE SPECIFIC NEEDS:

Each facility shall establish a facility directive guiding the management of the Chronic Care Clinics.


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing health services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title HERNIA MANAGEMENT GUIDELINES
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
Indiana Code 11-10-3	01-02-101	ACA Health Services Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) is intended to serve as a method of decision support and reference for the clinicians with information regarding the medical management of hernias in the incarcerated population of the Department. A hernia is a protrusion of a viscous (hernia sac) through an opening in the wall of the cavity (hernial orifice) in which it is contained. A hernia is reducible when the protruded viscous can be returned to the cavity and is a non-reducible hernia when it cannot be returned to the cavity. A non-reducible hernia is also referred to as an “incarcerated hernia.” Clinically, incarcerated hernias most commonly are not on the verge of becoming strangulated hernias. A strangulated hernia (a surgical emergency) is one in which the vascularity of the non-reducible hernia is compromised, usually at the neck of the hernia sac. Strangulated hernias most likely occur in situations involving small hernial orifices and relatively voluminous hernia sacs. It is recognized that the outcome of hernia surgery is very surgeon-dependent and perfect results continue to elude surgeons.

II. PROCEDURE:

- A. Reducible hernias shall be evaluated for potential referral for a treatment consultation and hernia care recommendation(s) after an unsuccessful trial of non-surgical (conservative) management is conducted with the cooperation of the patient, unless the hernia defect is small and the sac voluminous is making it high risk.
- B. The clinician shall perform patient evaluation(s) to determine the necessity for off-site consultation and for referral requests to the Utilization Management department, Health Services vendor’s Regional Medical Director or Associate Regional Medical Director. The clinician shall record in the patient health record an accurate and complete history concerning the hernia condition and the results of physical examinations. If a referral is medically necessary, the

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findings of the examinations shall be reported to the Health Services vendor's Regional Medical Director, or designee with the request.

- C. In the case of reducible hernias, the clinician and contracted Regional Medical Director, in the exercise of reasonable medical judgment, shall consider credible indicia of the following factors, either singularly, or in combination, before seeking and approving an off-site consultation and surgical consideration:
 1. Whether the patient is suffering from pain; and,
 2. The patient's current ability to perform necessary activities of daily living in a prison environment.
- D. The clinician and Health Services vendor's Regional Medical Director, in the exercise of reasonable medical judgment, shall also consider credible indicia of the following factors before seeking and approving an off-site consultation and surgical consideration:
 1. The patient's age, general physical and behavioral health, and pre-hernia activities of daily living;
 2. The degree of risk that the hernia will become incarcerated or strangulated;
 3. The presence of other circumstances or conditions increasing the risk of harm to the patient's health if a surgical repair is not attempted;
 4. The presence of other circumstances or conditions increasing the risk of harm to the patient's health if a surgical repair is attempted;
 5. The substantial likelihood that the patients will cooperate with the Health Services staff and follow reasonable instructions concerning personal hygiene, wound care, and activity levels in the pre-operative and post-operative periods and including the ability to provide informed consent;
 6. The likelihood of recurrence of the hernia after surgical repair; and,
 7. Any other pertinent and articulable medical and social factors in determining whether a request for referral is appropriate.
- E. Surgical repair of reducible hernias unnecessarily involves risks of serious bodily injury, incapacity, or death. The on-site Health Services staff and the

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Health Services vendor's Regional Medical Director shall consider all reasonably ascertainable factors during the hernia referral evaluation process in order to promote the overall health of the patient. The Health Services vendor's Regional Medical Director may obtain additional evaluations and consultation referrals before deciding whether to approve the referral request.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title	HUMAN IMMUNODEFICIENCY VIRUS
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for addressing Human Immunodeficiency Virus (HIV) issues within the Department. This document does not address clinical management of HIV patients.

II. DEFINITIONS:

- A. **DIRECT CONTACT TRANSMISSION:** Transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person.
- B. **HUMAN IMMUNODEFICIENCY VIRUS (HIV):** A virus that attacks the body's immune system, making a person more vulnerable to other infections and diseases.
- C. **PATIENTS LIVING WITH HIV (PLWH):** A term to identify incarcerated individuals living with HIV.
- D. **UNIVERSAL PRECAUTIONS:** An approach to infection control in which all human blood and certain body fluids are treated as if they are known to be infectious.
- E. **WINDOW PERIOD:** The time period between when a patient may have been exposed to HIV and when a test can determine if they have the virus.

II. GUIDELINES:

- A. General Information

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Title HUMAN IMMUNODEFICIENCY VIRUS			

HIV is the virus that can lead to acquired immune deficiency syndrome, or AIDS. There is currently no cure, nor vaccine, for HIV infection.

Over a period of years HIV attacks the human immune system and weakens it. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells. A diagnosis of AIDS is established when the CD4 cells fall to a certain level or the HIV infected individual develops certain infections and/or cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of "highly active" combinations of medications that were introduced in the mid-1990s. The Department shall follow guidelines established by the US Department of Health and Human Services.

HIV is transmitted by direct contact transmission of infectious body fluid from one person into another. Usually this occurs through:

- Direct contact of infectious blood or other body fluid (needle sharing, tattooing, body piercing, accident, etc.),
- Exchange through sexual contact of infectious semen, vaginal/cervical secretions, rectal secretions, or blood,
- Exchange of maternal fluids with an infant during delivery, or
- Ingestion of infectious breast milk.

Infection can be prevented by avoidance of shared body fluids. To this end the Department shall practice Universal Precautions (sometimes referred to as Standard Precautions). Universal Precautions advise all persons to consider all blood or body fluids to be infected with bloodborne viruses.

B. Universal Precautions

Universal precautions (UP) represent the cornerstone on which all workplace programs designed to interrupt HIV transmission are based.

UP include the use of barriers and personal protective equipment (PPE) to prevent contact with infectious blood or other substances, the use of engineering controls to decrease the likelihood of inadvertent exposure to infectious substances, and the use of disinfecting and/or sterilizing processes to render innocuous potentially infectious objects or spills. UP detailed in the Department's Bloodborne Pathogen Control Plan and will not be further described here. All Department employees and incarcerated individuals who have occupational risk of exposure to blood or other potentially infectious materials must receive training in this area.

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The Bloodborne Pathogen Control Plan includes information regarding post-exposure prophylaxis against HIV (and against Hepatitis B and Hepatitis C).

C. HIV Testing

All patients entering the Department are tested for the presence of HIV antibody in accordance with legislative mandate. In addition to testing at Intake, testing may be suggested by clinical staff caring for patients whose HIV status may be uncertain and who, upon clinical grounds, would benefit from such testing. Also, patients are permitted to request HIV testing once per year. Testing for clinical purposes or upon request should be preceded by pre-test counseling and followed by post-test counseling. With this type of testing, counseling will usually be on an individual basis.

Pre-test counseling will not be offered as part of this mandatory testing.

Pre-test counseling shall be offered and documented in the EMR when voluntary testing is carried out and should address:

- ◆ general educational issues regarding the nature of HIV
- ◆ the manner in which it is transmitted
- ◆ the meaning of positive and negative HIV antibody test results,
- ◆ the nature of confidentiality
- ◆ the necessity of informing possible contacts should the test results be positive
- ◆ the concept of Universal Precautions and
- ◆ all areas described below under general HIV education and training,

Pre-test counseling may be documented in the health record, using State Form 46258, "Information and Consent to be Tested for the Human Immunodeficiency Virus" the form shall be scanned into the EMR with a notation that pre-test counseling was completed.

When HIV test results are received, post-test counseling must be provided individually to all patients who tested positively. Post- test counseling shall include those that are antibody negative and emphasize prevention (individualized risk reduction) and include instructions concerning the "window period concept".

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Post-test counseling for antibody positive patients should include information regarding treatment and counseling services available for PLWH and should include at a minimum:

1. Prevention of further transmission;
2. The need for a healthy diet;
3. Infection control practices;
4. Provision of Information (previously known as “Duty to Warn”); and,
5. The enrollment into Chronic Care Clinic.

Chronic Care clinics for PLWH are every 90 days or less as directed by the clinician.

Post-test counseling shall include discussion about submitting a case report “State Form 51201” to the Indiana Department of Health (IDOH) as this is outlined in Indiana Code. All information submitted to IDOH will be kept confidential.

The PLWH should be informed that housing placement will not be affected solely by HIV positivity. Long term restrictive status housing may be implemented to protect others if the PLWH participates in any of the behaviors that have been epidemiologically demonstrated, as determined by the federal Centers for Disease Control and Prevention, to bear a significant risk of transmitting HIV in the institutional setting. This includes participating in sexual (anal/ vaginal) and/ or needle sharing behaviors.

D. Classification and Placement

PLWH shall be housed in accordance with general classification procedures, and individual physical health, disability or behavioral health status codes. PLWH will not be segregated in relation to their status except in extreme cases as explained above.

E. Counseling and Support

All PLWH shall receive disease specific education at each chronic care clinic encounter. Each PLWH shall be offered supportive counseling by the behavioral department at the patients’ request.

Outside agencies or individuals that comply with departmental guidelines for volunteers and for HIV counselors may be used. Facilities using volunteers for this purpose must monitor the services provided to make certain that the volunteers comply with the Department’s guidelines.

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Additionally, all PLWH are to receive counseling regarding continuing health needs. Plans for continuing care after release from incarceration shall be completed during this time, and release from incarceration accompanied with planned medical follow up.

All education, counseling, and supportive interventions provided are to be documented in the electronic medical record.

F. Education and Training

Intake facilities shall provide education regarding HIV to all incoming incarcerated individuals. At a minimum, this educational process shall describe:

1. The nature of HIV;
2. Definitions of common HIV related terms;
3. How HIV affects the immune system;
4. The spectrum of HIV infection;
5. High risk behaviors through which HIV is spread and other common routes of HIV transmission;
6. Universal Precautions and other risk reduction strategies; and,
7. The Department's approach both to provision of health services for HIV infection and to the prevention of transmission of HIV infection in the facilities.

Other facilities shall provide HIV related information upon request or when other circumstances develop; no other general educational programs relating to HIV are required.

All facilities must maintain current educational materials for those incarcerated individuals interested in HIV or diagnosed with HIV. Materials shall be appropriate for the educational range and major ethnic and language groups found in the incarcerated population.

All staff involved in pre- and post-test counseling must be knowledgeable regarding HIV infection, transmission, prevention, and management.

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All staff involved in managing incarcerated individuals must be knowledgeable regarding HIV infection and universal precautions. In addition to training regarding universal precautions, all employees must receive training covering HIV infection, at the inception of employment and periodically during employment. This training may be combined with training about other infectious diseases and/or Universal Precautions.

Education and training provided to employees must be documented in training records and, in the case of bloodborne pathogen related training, in the personnel records as required by the Department's Bloodborne Pathogen Control Plan.

G. Confidentiality

Information regarding HIV infection (or its absence) must be maintained confidentially. Staff shall not knowingly, recklessly, or intentionally disclose or fail to protect health or epidemiological information including the HIV status of incarcerated individuals. The improper release of or failure to protect this type of information is prohibited by Indiana law and is classified as a Class A misdemeanor. Staff who knowingly, recklessly, or intentionally disclose or fail to protect health and/or epidemiological information regarding HIV may be subject to disciplinary action, up to and including dismissal, and potentially, prosecution.

Health information including HIV related information may be released in accordance with Indiana law in reports submitted to the IDOH, to local public health officials, and to health care workers who have direct contact with patients and have a need to know this information in order to manage them. If protected health information needs to be shared for placement or treatment issues in the community, all HIPAA laws shall be followed.

Health or epidemiological information may be released for statistical purposes only if the data is de-identified of all identifying information. Confidential HIV related information also may be released to the extent necessary to enforce public health laws as indicated in Indiana Code 35-38-1-7 or to protect the health or life of a named party. Generally, this latter type of process will involve communication with and actions by the IDOH and/or local public health agency, or to facilitate appropriate medical responses to exposure incidents.

H. Discharge Planning and Public Health Reporting Requirements

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No earlier than 180 days and no later than forty-five days from IDP's release, the Transitional Healthcare Facilitator shall offer post release community care coordination through the IDOH Division of HIV/STD/Viral Hepatitis. If patient agrees to community care coordination, the Transitional Healthcare Facilitator shall ensure patient signs State Form 46729, "Authorization to Release/Request Information," and forward on to IDOH designee within five business days of signature. The Transitional Healthcare Facilitator shall be responsible for the facilitation of any pre-release communication between patient and community care coordinator.

If patient refuses post release community care coordination, the refusal shall be documented in OCMS and EMR following HIPPA guidelines. A patient may rescind their refusal at any time prior to release.

When a diagnosis of HIV infection or acquired immunodeficiency syndrome (AIDS) is made, Health Services staff shall report the particulars to the facility health authority. The facility health authority shall ensure that appropriate reports and forms are forwarded to the IDOH.

A completed State Form 44993, "Notification of Release of HIV/AIDS Offenders," must be forwarded to the IDOH sixty (60) days prior to release from Department incarceration.

Information necessary to accomplish discharge planning or required for reports to the IDOH may be shared without specific written consent from the involved patient.

I. Miscellaneous

Personal hygiene tools (razors, toothbrushes, etc.) that may be contaminated with small amounts of blood must not be shared. In no case shall the Department require an incarcerated individual to use a razor or toothbrush that has been used by another person. Depending upon the facility incarcerated individuals may be permitted to purchase disposable safety razors or may be supplied with individual razors.

Therapeutic diets are not required for the treatment of HIV infection. From time to time management of weight loss or of opportunistic infections may require diet modification. All diet modifications shall be identified by qualified healthcare professionals.

Pap smears for PLWH who were assigned female at birth shall be done at Intake or when the patient is first diagnosed. A second pap smear should be done 6 months later. If both tests are negative, yearly screenings shall be

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performed. Patients who have had dysplasia should receive a pap smear every 6 months.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title MANAGEMENT OF HEPATITIS C

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
Indiana Code: 11-8-2-5 11-8-5-2 11-10-1-2	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to provide information and guidelines concerning the management of Hepatitis C Virus (HCV) infections.

II. GUIDELINES:

A. General Information

HCV is the most common chronic bloodborne viral infection in the United States and correctional facilities have a disproportionate number of infected individuals. Within the Department, approximately 15-20% of arriving incarcerated individuals at Intake are HCV-Antibody positive.

HCV is spread by contact with infected blood and blood products from a person living with HCV (PLWHCV). Currently, the majority of PLWHCV become infected by sharing needles or other equipment used in injectable drugs. Other common risk factors include receiving a blood transfusion prior June 1992, receiving clotting factor concentrates before 1987, hemodialysis, birth to an HCV-infected mother, tattooing and suffering a needle-stick accident from a person with HCV. However, some individuals who acquire HCV have no known risk factors.

Hepatitis C Virus can be acute or chronic.

Acute HCV can present clinically with a discrete onset of fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, and/or abdominal pain; and,

1. jaundice;

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2. Peak elevated bilirubin levels greater than or equal to 3.0 mg/dl;
3. a peak elevated serum alanine aminotransferase (ALT) level greater than 200 IU/L during the period of acute illness; and,
4. The absence of a more likely diagnosis which may include evidence of acute liver disease due to other causes of advanced liver disease due to pre-existing chronic hepatitis C or other causes, such as alcohol exposure, other viral hepatitis hemochromatosis, etc.

Laboratory criteria for an acute probable HCV diagnosis includes a positive/reactive test for antibodies to Hepatitis C virus (anti-HCV). An acute confirmed HCV diagnosis includes a positive Hepatitis C virus detection test. These tests could also be utilized to determine an acute confirmed case (e.g., Nucleic Acid Test [NAT] for HCV RNA positive [including qualitative, quantitative, or genotype testing]).

The Centers for Disease Control and Prevention (CDC) report that half of the PLWHCV will clear the virus spontaneously. In at least two-thirds of patients who spontaneously clear acute HCV infection, this occurs within 6 months of the estimated time of infection. Only 11% of those who remain viremic at 6 months will spontaneously clear the infection at a later time. Thus, detectable HCV RNA at 6 months after the time of infection may signify chronic HCV. Once established, the chronic infection rarely resolves spontaneously. The clinical course of HCV varies greatly; some individuals have no signs or symptoms and normal levels of serum enzymes, some have mild to moderate elevations in liver enzymes with an uncertain prognosis, and some have severe disease with symptoms, high viral load, and elevated serum enzymes.

The standard of care for HCV treatment is with direct active virals and in some cases may require the use of interferon, peginterferon, ribavirin or any HCV direct-acting antiviral agents (DAA). Antiviral medication regimen choice should be determined based on patient-specific data, including drug-drug interactions. Patients receiving antiviral therapy require careful pretreatment assessment for comorbidities that may influence treatment response or reactivate hepatitis B infection. All patients require careful monitoring during treatment.

Another component of treatment for PLWHCV is substance use treatment. In accordance with HCSD 4.01, "Addiction Recovery Services", all patients newly diagnosed with Hepatitis C (that is, the diagnosis was made after the patient was committed to the Department) or the patient currently being treated for Hepatitis C shall be referred for substance abuse assessment by Unit Team personnel. Newly diagnosed patients shall be referred for substance abuse assessment within fourteen (14) days of diagnosis date.

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B. Screening for HCV Infection

In accordance with the provisions of HCSD 2.02 , “Reception Screening,” after an incarcerated individual arrives at an Intake site, the incarcerated individual must complete State Form 45999, “Offender Health History.” This is a directed screening history designed to identify serious health conditions, and to provide staff with information that will be useful in managing and anticipating serious health conditions. The health history should be completed after the Point of Entry screening and prior to or during the Arrival Health Screening completed with Health Services staff.

All incoming and returning incarcerated individuals shall have mandatory Hepatitis C antibody testing completed in accordance with State statute.

Initial testing with an HCV RNA test is recommended for cases with a known prior positive HCV Ab if they are at risk for reinfection or suspected of reinfection, and if they previously cleared the HCV spontaneously or achieved a sustained virologic response with treatment.

Patients who decline testing at the baseline visit, should be counseled about and offered HCV testing during periodic preventative health visits. A treatment refusal form must be completed for every testing and treatment refusal.

C. Baseline Evaluation

Initial evaluation of anti-HCV positive patients shall include, but is not limited to the following:

1. A baseline history and physical examination within the first ninety (90) days with emphasis on evaluation for other possible causes of liver disease and inquiry regarding prior treatment and testing for HCV infection;
2. Baseline laboratory tests within the first ninety (90) days;
3. Assessment regarding the need for preventative health interventions, such as vaccines, and screenings for other conditions;
4. Counseling with information on HCV infection;
5. Enrollment in HCV Chronic Care Clinic; and,
6. An attempt to estimate the earliest possible date of infection, including when risk factors for exposures started and stopped.

All positive HCV labs and new HCV diagnoses shall be reported to authorities at Indiana Department of Health (IDOH).

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III. MANAGEMENT OF HCV:

All PLWHCV, regardless of liver inflammation, shall be counseled regarding HCV disease. This counseling shall include information on HCV infection, transmission, avoiding transmission, the nature of the HCV disease, its long-term sequelae, and the pros and cons of the treatment for HCV disease.

All PLWHCV shall be offered vaccination against Hepatitis B and Hepatitis A, unless previous infection or vaccination has been documented, or the attending physician believes that vaccination is unnecessary or contraindicated. All PLWHCV disease shall be offered vaccination against pneumococcus once, and against influenza annually. Any refusals shall be signed and scanned into the patient's health record.

Informed consent for treatment must be obtained prior to initiating treatment in accordance with HCSD 2.12, "Consent and Refusal."

A. Acute Hepatitis C Monitoring and Management

This section provides guidance on the diagnosis and medical management of acute HCV infection, which is defined as presenting within six (6) months of the exposure

1. Counseling is recommended for PLWHCV acute infection to avoid hepatotoxic insults, including hepatotoxic drugs (e.g., acetaminophen) and alcohol consumption, and to reduce the risk of HCV transmission to others;
2. A referral to Addictions Recovery Services shall be completed;
3. Regular clinical monitoring, including routine laboratory testing, is recommended in the setting of acute HCV infection for six (6) months to determine spontaneous clearance versus persistence of HCV infection.

Laboratory monitoring should continue until the ALT level normalizes and HCV RNA becomes repeatedly undetectable, suggesting spontaneous resolution. If this does not occur, frequency of laboratory monitoring for patients with persistently detectable HCV RNA and elevated ALT levels should follow recommendations for monitoring PLWHCV as outlined in Section III, B.

B. Chronic Hepatitis C Treatment

All sentenced PLWHCV infection are eligible for consideration of treatment.

Certain cases are at higher risk for complications or disease progression and may require more urgent consideration for treatment. The Department has established

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a framework to ensure that patients with the greatest need are identified and treated. (AST PLATELET RATIO INDEX-APRI)

1. Treatment Group One
 - a. Advanced Hepatic Fibrosis
 - 1) APRI ≥ 1.5 , or;
 - 2) Metavir or Batts/Ludwig Stage 3 or 4 on liver biopsy, or as indicated by transient elastography; or,
 - 3) Known or suspected cirrhosis.
 - b. Liver Transplant Recipients
 - c. Hepatocellular Carcinoma (HCC)
 - d. Comorbid Medical Conditions Associated with HCV
 - 1) Cryoglobulinemia with renal disease or vasculitis;
 - 2) Certain types of lymphomas or hematologic malignancies; and,
 - 3) Porphyria cutanea tarda
 - e. Immunosuppressant Medication for a Comorbid Medical Condition

Some immunosuppressant medications (e.g., certain chemotherapy agents and tumor necrosis factor inhibitors) may be needed to treat a comorbid medical condition but are not recommended for use when infection is present. Although data are insufficient and current guidelines are inconsistent regarding treatment of HCV in this setting, such cases shall be considered for prioritized treatment on an individual basis.
 - f. Continuity of Care for those already started on treatment, including patients newly incarcerated in the Department. These patients shall be immediately added to the HCV Comprehensive Log and reported to the Executive Director of Physical Health and the Department's Epidemiologist.

Recommended treatment for patients in Treatment Group One includes medications to treat chronic HCV and an Addictions Recovery Services referral. Patients in Treatment Group One shall be seen at minimum every thirty (30) days in chronic care clinic, unless otherwise clinically determined. A targeted history and physical examination to evaluate for

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signs and symptoms of liver disease shall be completed each visit. Labs shall be obtained at least every thirty (30) days for monitoring purposes.

2. Treatment Group Two

Patients in Treatment Group Two have been identified as being at increased risk for liver disease, yet stable. This Group requires prompt consideration for treatment, including antiviral medications. Treatment groups are mutually exclusive, thus patients in Treatment Group Two would not possess any of the clinical indicators listed in Treatment Group One, but can possess one or more of the following:

- a. Evidence for Progressive Fibrosis
 - 1) APRI Score ≥ 0.7
 - 2) Stage 2 fibrosis on liver biopsy or as indicated by transient elastography
- b. Comorbid medical conditions associated with more rapid progression of fibrosis
 - 1) Coinfection with HBV or HIV
 - 2) Comorbid liver diseases (e.g., autoimmune, hepatitis, hemochromatosis, fatty infiltration of the liver, steatohepatitis)
 - 3) Diabetes mellitus
- c. Chronic Kidney Disease (CKD) with GFR ≥ 59 ML/min per 1.73 m²
- d. Birth Cohort 1945-1965

Recommended treatment for patients in Treatment Group Two includes medications to treat chronic HCV and an Addictions Recovery Services referral. Patients in group two shall be seen at minimum every ninety (90) days in chronic care clinic, unless otherwise clinically determined. A targeted history and physical examination to evaluate for signs and symptoms of liver disease shall be completed each visit. Labs shall be obtained at least every ninety (90) days for monitoring purposes.

3. Treatment Group Three

Patients in Treatment Group Three have been identified as being at a lower risk for liver disease. This Group requires consideration for treatment, including antiviral medications. Patients in Treatment Group Three would

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not have any of the clinical indicators listed in Treatment Group One or Two, but would have one or more of the following:

- a. Stage 0 to Stage 1 fibrosis on liver biopsy
- b. APRI < 0.7
- c. All other cases of HCV infection meeting the eligibility criteria for treatment, as noted below under *Other Criteria for Treatment*.

Recommended treatment for patients in Treatment Group Three includes consideration for medications to treat chronic HCV and an Addictions Recovery Services referral. Patients in Treatment Group Three shall be seen at a minimum of every ninety (90) days in chronic care clinic, unless otherwise clinically determined. A targeted history and physical examination to evaluate for signs and symptoms of liver disease shall be completed each visit. Labs shall be obtained every ninety (90) days for monitoring purposes.

4. Other Criteria for Treatment

In addition to the above groups, HCV infected patients being considered for treatment with antiviral medications should:

- a) Have no contraindications to, or significant drug interactions with, any component of the treatment regimen;
- b) Not be pregnant, especially for any regimen that would require ribavirin or interferon;
- c) Have sufficient time remaining on their incarceration in the Department to complete a course of treatment;

Patients in Treatment Group One that have insufficient time remaining in Department custody, may be considered for treatment if they will have access to antiviral medications and health care providers for continuity of care at the time of release;

- d) Have a life expectancy > 18 months;
- e) Demonstrate a willingness and an ability to adhere to a rigorous treatment regimen and to abstain from high-risk activities while incarcerated; and,
- f) Patients with evidence for ongoing high-risk behaviors (e.g., injection drug use) shall be considered for HCV treatment on an

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individual basis. Referral for evaluation and treatment with Addictions Recovery Services shall be completed.

Treatment of HCV will be based on clinical indication. At any time, a patient can be moved up from one treatment group based on the attending physicians individualized treatment plan for the patient.

Upon release of a patient from Department custody, the patient shall be reviewed for healthcare coverage. Transitional Healthcare Services shall ensure activation of benefits if managed care entity is known. Patient information shall be sent for coordination of care in the community by Transitional Health Specialist. A patient experiencing a treatment interruption or in need of initial treatment after release shall be referred to IDOH designee by site Transitional Healthcare Facilitator for linkage to care in the community. .

IV. END STAGE LIVER DISEASE:

Patients in end stage liver disease secondary to HCV shall be provided with off-site consultation with a hepatologist or GI specialist for recommendations. If a liver transplant is recommended, the patient shall be referred to the appropriate off-site provider.

V. HCV COMPREHENSIVE LOG:

The HCV Comprehensive Log contains health information on currently patient with HCV diagnosis/known HCV antibodies. The HCV Comprehensive Log is maintained by the Department's Data Analytics team and the Department Epidemiologist. This Log shall be updated weekly by the Epidemiologist and health services vendor Infection Control Nurse. This Log shall be distributed weekly by the Epidemiologist to Health Services Division Executives and health services vendor personnel.

All patients newly diagnosed with HCV who appear on the HCV Comprehensive Log shall be reported to the Executive Director of Behavioral Health for Addiction Recovery Services. This shall be reported on a weekly basis.


VI. APPLICABILITY:

This HCSD is applicable to all facilities providing health services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
INFECTION CONTROL

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the required components of Infection Control Practices.

II. GUIDELINES (See Facility Directive):

A. Epidemiologist

The Department's Epidemiologist is responsible for the management of infectious diseases in correctional facilities through comprehensive infection control measures including, but not limited to, disease identification, classification, surveillance, monitoring, testing, screening, and education dissemination.

B. Health Services Vendor's Regional Infection Control Nurse

1. The Epidemiologist shall coordinate with the Health Services vendor's Regional Infection Control Nurse (ICN). The Regional Infection Control Nurse shall work closely with contracted Health Services personnel to guide infection control measures and treatment planning.
2. The Regional Infection Control Nurse (ICN) shall ensure there are systems in place to include surveillance, prevention, and control of communicable illnesses. The ICN shall ensure that patients receive health care in a clean, safe, and healthy environment.
3. When problems are identified, the ICN shall work with the Epidemiologist to identify solutions and monitor implementation for success.

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C. Facility Infection Control Program

Each facility shall develop a written program to address communicable and infectious diseases. The program shall include:

1. Prevention to include immunizations, when applicable;
2. Surveillance (identification and monitoring);
3. Incarcerated individual education and staff training;
4. Treatment to include medical isolation, when indicated;
5. Follow-up care;
6. Reporting requirements to applicable local, State and federal agencies;
7. Confidentiality/protected health information;
8. Appropriate safeguards for staff and the incarcerated population; and,
9. Post-exposure management protocols, particularly for HIV and viral hepatitis infection.

D. Infection Control Meetings

1. The Epidemiologist and Regional Infection Control Nurse shall coordinate quarterly Infection Control Meetings to help monitor the presence and transmission of infections in the facility, with special attention to nosocomial and reportable infections.
2. Infection Control Meetings, held quarterly, shall include Regional Managers, Health Services Administrators, Nursing Directors, and Executive Director of Physical Health, security and administrative representatives.

E. The Epidemiologist and ICN shall monitor and address sexually transmitted infections (STI), HIV, TB, Hepatitis C, and other communicable illnesses, beginning at Intake. This monitoring shall include continuous review of disease reports so that trends and problems can be identified promptly.

F. The Epidemiologist and ICN shall review the provision of care regarding the annual Influenza control plan and pandemic plans.

G. The Dental Services Unit shall establish a Facility Directive describing dental infection control practices. This Directive and any updates shall be discussed by the ICN during the Infection Control Meetings.

H. The Health Services vendor shall periodically review facilities' infectious and biohazardous waste management.

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- I. Any infection control concerns and updates shall be reported by the Epidemiologist or ICN to the Regional CQI Committee.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title ECTOPARASITE CONTROL

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. **PURPOSE:**

This Health Care Services Directive (HCSD) establishes guidelines for the control of ectoparasites as a standard health intervention.

II. **GUIDELINES:**

- A. Routine “delousing” shall not be supported by Health Services staff unless epidemiological review demonstrates a high incidence of infestation requiring intervention. Any time that a facility’s administration determines that routine delousing may be necessary, implementation shall not occur until reviewed and approved by Central Office Health Services personnel. Such implementation, if approved, shall be for limited times and purposes only. Implementation of this provision shall be reported to the facility and Central Office Continuous Quality Improvement Committee
- B. Treatment of ectoparasites shall be determined by the on-site provider. If over-the-counter medications are used, the provider shall observe the manufacturer’s warnings.

Pregnancy must be considered in advance of treatment selection for incarcerated females.

- C. After treatment, the hair shall be checked and combed with a nit comb to remove nits and lice. The patient shall be rechecked in one (1) week and, if necessary, every two to three (2-3) weeks until all lice and nits are gone.
- D. When infestation is identified, management of the environment (including cleaning of bedding, clothing, etc.) shall be advised in accordance with the type of environment and the parasite identified. Screening of exposed patients may be carried out, but prophylactic treatment of exposed patients

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Title ECTOPARASITE CONTROL			

shall not be accomplished. Exposed employees must use outside providers if they desire screening. Worker's Compensation program rules apply to diagnosis and treatment following on-the-job exposures.


III. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title INTOXICATION AND WITHDRAWAL

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCS D) provides guidelines for the management of the chemically addicted patient who is in need of medical detoxification.

II. GUIDELINES:

- A. Patients shall be screened for potential withdrawal symptoms at intake in accordance with the guidelines established in Health Care Services Directive 2.02, "Reception Screening." When necessary, Medication Assisted Treatment (MAT) shall be considered to treat the patient in accordance with HCS D 2.16. For pregnant patients with a history of opiate use or currently using opiates the designated medical provider shall be consulted immediately. When necessary, MAT shall be used to maintain the patient throughout the pregnancy in accordance with HCS D 2.16, "Medication Assisted Treatment."
- B. Detoxification from alcohol, opiates, hypnotics, other stimulants, and sedative hypnotic drugs shall be conducted under medical supervision when performed at the facility or is conducted in a hospital or community detoxification center.
- C. The contracted medical vendor shall ensure a process is in place to assess and monitor all patients suspected of acute intoxication. This process shall be approved by the Health Services vendor's Regional Medical Director and the Regional Director of Nursing. When acute intoxication is suspected, qualified Health Services staff shall refer the patient for drug screening as clinically indicated. A complete assessment shall be documented in the EMR. The staff assessing the patient shall provide a detailed report to the clinician. If during business hours the clinician shall complete a face to face

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exam. The patient experiencing acute intoxication shall be placed under observations until released by the ordering clinician. These are the minimal guidelines for the treatment and observation of patients manifesting symptoms of intoxication or withdrawal from alcohol or other drugs. The patient shall be monitored using State Form 56392, "Clinical Institute Withdrawal Assessment (CIWA)," or State Form 56409, "Clinical Opiate Withdrawal Scale (COWS)." No patient shall be released from observation without the provider's assessment and order.

- E. Patients experiencing severe, life-threatening intoxication (an overdose) or withdrawal must be transferred under appropriate security conditions to a local emergency room or licensed acute care facility where specialized care is available.
- F. Patients treated by Health Services personnel for acute intoxication or withdrawal shall be referred for substance abuse assessment by the Health Services staff who remove them from intoxication/detoxification hold after appropriate assessment and when clinically indicated.
- G. Health Services vendor shall keep a log of all patients that are suspected of intoxication or monitored during withdrawal.

III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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Indiana Department of Correction

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3.08A

**HEALTH CARE SERVICES
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Title

MANAGEMENT OF HEAT RELATED ILLNESS

Legal References

(includes but is not limited to)

IC 11-8-2-5 IC 34-4-12.6

Related Policies/Procedures

(includes but is not limited to)

01-02-101

Other References

(includes but is not limited to)

www.cdc.gov

I. PURPOSE:

This Health Care Services Directive (HCSD) provides information and direction regarding Heat Related Illness (HRI) and avoiding HRI.

II. GUIDELINES:

A. Introduction

Heat related illness is any illness caused by high temperatures and humidity. HRI is preventable yet each year thousands of people are hospitalized for and according to the Centers for Disease Control and Prevention (CDC) an approximate 700 deaths were recorded where natural heat was a contributing cause of death. Morbidity rates detailing the number of people who incur an injury or illness as result of the heat are estimated at 3-5 times the mortality rate. Incarcerated individuals and staff at Department facilities are at risk for HRI, especially when temperatures and humidity are high and personal risk factors are present.

B. Factors affecting HRI

Body temperature normally is kept within the “normal” range by a balance of internal heat production and heat loss to the environment. Activities or actions that produce heat (general metabolic activity, physical exercise, use of clothes, sun exposure, etc.) must be balanced equally with activities or actions that promote heat loss (radiating heat into a cool environment, sweating with evaporative cooling, panting, etc.). When heat production exceeds heat loss, body temperature rises. If heat loss processes become seriously impaired, heat rises may be precipitous. Body temperatures above 104° F are dangerous, and brain damage will result if temperatures above 105° F are sustained more than briefly. Dehydration or loss of sodium

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balance may cause dysfunction in muscles and nervous tissue even at normal body temperatures.

The spectrum of HRI range from simple heat cramps through heat exhaustion and on to heat stroke. The mechanisms that cause HRI include dehydration, loss of electrolyte, and increased body temperature. Heat stroke is a true medical emergency may rapidly cause death if not emergently treated.

High relative humidity impairs the evaporation of sweat from the skin. (increased air movement increases evaporative cooling). When warm weather is accompanied by high humidity, and especially in still air, a normal body may have difficulty maintaining an acceptable body temperature. The relationship between humidity and evaporative cooling gives rise to the concept of “apparent temperature” (commonly called the “heat index”) often reported with weather forecasts.

There are many individual factors that affect a person’s susceptibility to HRI. Most are included in the following listing:

1. Those at greatest risk for developing HRI include infants and children up to four years of age, people 65 and older, people who are overweight and people who are ill or on certain medications.
2. Acclimation to heat occurs during continuing exposure to hot conditions over seven (7) to ten (10) days. Acclimated individuals are more resistant to HRI. However, acclimation should not be assumed unless all participants are known to be acclimated.
3. Loose clothing that does not completely cover the skin permits more cooling than does thick tight clothing. Multiple layers of clothing or clothing that is resistant to the flow of moisture impede heat loss.
4. Exposure to direct sun increases apparent heat by up to 15 degrees.
5. Different individuals in similar circumstances may exercise at different intensities, producing different amounts of heat that requires dissipation.
6. Certain medications impair the body’s ability to sweat or manage fluid balance. These include over the counter and prescription products, not limited to typical antipsychotic medications, cyclic antidepressant medication, antihistaminic medication, vasodilators, beta blockers, and diuretic medications. Tranquilizing medications

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(including drugs of abuse) may impair an individual's ability to recognize thirst or heat.

7. Certain health conditions may place an individual at increased risk for HRI. These include end stage kidney disease, especially if dialysis is used; congestive heart failure and other cardiac conditions; asthma, chronic obstructive pulmonary disease; poorly controlled diabetes mellitus, decompensated cirrhosis; and schizophrenia.
8. Prolonged exposure to heat, as in a heat wave, may predispose those at risk by reducing the general state of hydration or tiring those who are frail or have multiple risk factors.

Although this is an extensive list and includes the major risks for HRI, it is not a complete listing. It is provided to alert staff to the necessity to consider the entire patient when evaluating the risk for HRI and to underscore that individual HRI risk cannot be quantitated and can change over time.

HRIs are generally divided into four syndromes (descriptions are abstracted from the National Institute for Occupational Safety and Health):

1. Heat cramps usually affect those who sweat a lot during strenuous activity. This sweating depletes the body's salt and moisture levels. Low salt levels in muscles causes painful cramps. Heat cramps may also be a symptom of heat exhaustion. Heat cramps present as muscle cramps, pain, or spasms in the abdomen, arms, or legs. Heat cramps remit spontaneously with the cessation of exercise. They can be prevented by liberal water intake and eating a snack (carbohydrate or electrolyte replacement). These patients should seek medical treatment if the symptoms do not subside.
2. Heat exhaustion is the body's response to an excessive loss of water and salt, usually through excessive sweating. Patients most susceptible to heat exhaustion are those that are elderly, have high blood pressure, and those working in hot environments. These patients typically present with headaches, nausea, dizziness, weakness, heavy sweating, and extreme thirst. Heat exhaustion can be prevented by adequate intake of water and electrolytes. Patient or staff suffering from heat exhaustion should seek medical attention. Make sure to stay with the patient or staff and offer plenty of liquids.
3. Rhabdomyolysis is a health condition associated with heat stress and prolonged physical exertion, resulting in the rapid breakdown,

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rupture, and death of muscle. These symptoms may include muscle cramps/pain, dark urine (tea colored), exercise intolerance, weakness, and at times totally asymptomatic. This HRI requires medical intervention. Patients should be directed to stop activity immediately and increase water intake. Staff shall not leave the patient's side until medical attention is rendered.

4. Heat Stroke: This is the most severe HRI. It occurs when the body becomes unable to control its temperature; the body's temperature rises rapidly, sweating mechanisms fail, and the body is unable to cool down. When heat stroke occurs the body's temperature can reach 106° Fahrenheit or higher within 10 to 15 minutes. Heat stroke can cause death or permanent disability if not treated emergently. Although initial symptoms may be similar to those of exertional heat injury, heat stroke may present suddenly with loss of consciousness. Heat stroke is accompanied by disturbances of the clotting cascade, rhabdomyolysis, shock, and other abnormalities. Treatment must be immediate. Removal of clothing and spraying with cool water while ice is applied to the head, neck, armpits and groin will help lower core temperature. A fan aimed directly at the body will assist evaporative cooling and convective heat loss. Emergency services (911) shall be called for continued treatment.

In general, HRI can be avoided if individuals drink adequate fluid prior to hard or prolonged exercise, especially in hot environments, continue to drink fluid periodically while exercising (or while in extremely hot conditions even if not exercising), and take breaks (rest) on a regular basis. When extreme risks for HRI are present, additional measures may be required to promote cooling, including environmental fans, air conditioning, and presentation of cool water on a scheduled, periodic basis. Individuals whose health conditions place them at special increased risk may require more preventive measures, instituted at cooler temperatures. It is impossible to provide simple rules for individual persons.

The National Weather Service generally advises that a "Heat Advisory" should be issued when the daytime heat index is 105° F or greater and the night time minimum is 80° F or greater for a period of 48 hours or longer (A heat advisory indicates that there is increased risk for HRI). These criteria are not applied universally, and heat advisory declaration criteria vary around the country.

C. Actions:

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Each facility must devise a site specific HRI prevention facility directive based upon the information provided in this HCSD and the characteristics of the facility and its population. The plans should include, at a minimum:

1. Appointment of the Safety Hazard Manager (SHM) as the responsible person for design and implementation of the HRI prevention plan;
2. Establishment of a process for measuring heat and humidity (so that heat index can be calculated) in living spaces and the outdoor recreation and work areas;
3. Identification of those at special risk for HRI ;
4. Identification of activities likely to increase the likelihood of HRI during hot weather and of assignments on which risk is increased;
5. Identification of year-round hot work environments (e.g., laundries, kitchens) in which preventive measures may be necessary during all working hours;
6. Establishment of a process to educate staff and the incarcerated population about the risks of HRI and how to reduce them;
7. Establishment of a trigger temperature for organized and documented monitoring of the heat index;
8. Establishment of a process for declaring and establishing action levels (see below).
9. Establishing site and activity specific interventions to be implemented for each action level;
10. Establish heat index and temperatures for termination of organized and documented monitoring of the heat index;
11. Require notification of Central Office Operations staff when a level III heat action level is declared; and,
12. Develop measures for monitoring the process and report on them to the Safety Hazard Committee.

D. HRI prevention action levels are suggested as follows:

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1. Level I:

When the heat index is 85° or higher, prolonged exercise (whether recreational or work) should be undertaken with caution, especially by those who are not yet acclimated to heat. Cool water must be available as requested to those who are exercising, and they should be encouraged to drink before thirst is present. Prolonged time in direct sunlight should be avoided, as the relative temperature in sunshine is much higher. Rest periods of at least 10 minutes for every 30 minutes of activity (longer rest periods if the exercise is extremely hard) should be mandatory.

Those individuals at increased risk (described above) should be managed as if a Level II situation is present.

2. Level II:

When the heat index is 90°F or higher, prolonged exercise should be avoided by all except those who are already acclimated to heat. Cool water must be available at all times and those exercising must be encouraged every fifteen (15) minutes to drink water. Prolonged time in direct sunlight should be avoided. Rest periods equal to or longer than exercise periods must be mandatory.

Those at increased risk should not be permitted to exercise and should be managed as if a Level III situation is present.

3. Level III:

When the heat index is 95°F or higher prolonged exercise must be avoided. Brief periods of exercise may be permitted only if water is immediately available and encouraged. Prolonged exposure to direct sunlight should be avoided. Water breaks and water lines may be required in some settings.

Some patients may be at risk for water intoxication. Water intoxication is a potentially fatal syndrome characterized by obsessive water drinking and resulting in central nervous system dysfunction. Implementation of water lines in behavioral health settings may require that certain individuals have the specific gravity of their urine monitored in order to assure that electrolytes are not being washed out. Similarly, patients whose treatment requires mild dehydration (dialysis patients, congestive heart failure patients, and so on) may require similar monitoring (urinary specific

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gravity, blood pressure, weight, and so on) to ensure that adequate hydration is maintained.


IV. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss , MD
Chief Medical Officer

Date

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**HEALTH CARE SERVICES
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Title MATERNAL HEALTH CARE

Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

To establish guidelines and procedures for Operational, Health Services, and Program staff to use in providing healthcare services to the incarcerated mother population at Indiana Women's Prison. This HCSD describes processes for ensuring that pre-and post-natal mothers receive appropriate, timely, quality and holistic care.

II. DEFINITIONS:

- A. ACTIVE LABOR: Time when uterine contractions occur at regular intervals and cervix has dilated to 6 centimeters. Contractions last approximately 45 seconds and can be as close as 3 minutes apart.
- B. FALSE LABOR: Intermittent non-productive muscular contractions of the uterus during pregnancy. Contractions do not produce flattening (effacement) or dilation (opening up) of the cervix.
- C. HIV TESTING: Medical testing for Human Immunodeficiency Virus (HIV).
- D. INDIANA WOMEN'S PRISON (IWP): Maximum security female prison within the Department.
- E. ISOLATION: Single cell location restricted from contact with other persons while requiring extra personal protection equipment for staff.
- F. MATERNAL CHILD HEALTH COORDINATOR: Staff person responsible for the management of the Officer Breann Leath Maternal Child Health Unit.

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- G. MISCARRIAGE: Loss of a baby before the 20th week of pregnancy.
- I. NEONATAL DEATH: Death of an infant aged 0-27 days.
- J. OBSTETRICIAN/GYNECOLOGIST (OB/GYN): A physician who specializes in female reproductive health, pregnancy, and childbirth.
- K. PRETERM BIRTH: Baby born before thirty-seven (37) weeks of pregnancy have been completed.
- L. STILLBORN: Loss of a baby before or during delivery at 20 weeks of pregnancy and later.
- M. OFFICER BREANN LEATH MEMORIAL-MATERNAL CHILD HEALTH UNIT (MCHU): Voluntary program at Indiana Women's Prison for pregnant women that encourages family preservation and uses a holistic approach for the continuum of care. The housing unit designated by the Commissioner to provide a Residential Mother-Infant Nursery Program.
- N. PANDEMIC: An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.

III. MATERNAL HEALTHCARE PROCEDURES:

Incarcerated females who are or may be pregnant shall have access to pregnancy management services. Pregnancy management services includes:

- Pregnancy testing;
- Routine Services;
- High-risk prenatal care;
- Management of patients who are chemically addicted to substances;
- Post-partum follow-up; and,
- Birth certificates/registries that do not list the facility as the place of birth.

Incarcerated females who are pregnant while in the custody of the Department shall be provided pre- and post-natal physical health care and behavioral health services.

A. Prenatal Care:

1. All pregnant women shall be seen by the Health Services vendor's OB/GYN within the first thirty (30) days of arrival at the facility.

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2. All pregnant women shall be seen by the Health Services vendor's physical health department on a monthly basis during the first thirty-six (36) weeks of pregnancy unless advised by a physician to attend more frequently.
3. All pregnant women shall be seen by the Health Services vendor's physical health department on a weekly basis during weeks thirty-six to forty (36 to 40) of pregnancy unless advised by a physician to attend more frequently.
4. All pregnant women with a history of substance abuse before or during pregnancy shall be offered enrollment in the Addiction Recovery program at IWP by the Maternal-Child Health Coordinator.
5. Prenatal care for high-risk pregnancies shall be monitored by the Health Services vendor as clinically indicated.
6. The Health Services vendor shall provide pre-natal vitamins and ensure access to folic acid supplement for all pregnant women until delivery and/or until the cessation of breastfeeding. The Health Services vendor shall ensure that the approved pregnancy diet is also utilized.
7. A High-Risk Pregnancy Classification includes, but is not limited to:
 - a. Patient suffering from Serious Mental Illness
 - b. Addiction to substances;
 - b. Cardiovascular disease;
 - c. Hepatitis;
 - d. HIV/AIDS;
 - e. Lyme disease;
 - f. Polycystic ovary syndrome (PCOS;)
 - g. Pre-pregnancy weight under 100 pounds (45 kilogram) or obesity;
 - h. Previous neonatal death, stillborn, or miscarriage;
 - i. Previous preterm birth;
 - k. Syphilis during pregnancy; and,
 - L. As identified by the clinician.
9. Any pregnant mother not eligible for MCHU participation shall receive a behavioral health referral by the Maternal Child Healthcare Coordinator within seventy-two (72) hours of delivery of child.

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10. The Maternal Child Health Coordinator shall attempt to facilitate Family Preservation participation for those not eligible for MCHU.
11. Mothers not eligible for MCHU shall be authorized to obtain five (5) extra hours of visitation time per month with child and caregiver in attendance.
12. All pregnant women shall be screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) at regular intervals throughout their pregnancy by the Department's Maternal Child Health Coordinator.
 - a. Prenatal depression screening shall be completed by physical health and shall include screenings at the mother's first prenatal visit, during the second trimester, and during the third trimester, if applicable.
 - c. Any results indicating depression or suicidal ideation/intent shall initiate a referral to behavioral health services. Physical Health staff shall initiate the referral by completing State Form 46325, "Staff Referral for Medical Services."

B. Labor and Delivery:

1. Active and False Labor:
 - a. Active labor: Immediate referral to the contracted maternal health hospital.
 - b. False Labor: If pregnant mother is returned from hospital diagnosed by a physician as having false labor, she shall remain in the IWP Infirmary for observation by physician/nursing staff. She shall remain in the Infirmary until release is recommended by the physician.
2. Transportation to Hospital:
 - a. The Health Services vendor shall notify the Shift Supervisor to advise whether a facility vehicle or an ambulance is needed for transportation and what hospital the patient will receive treatment.
 - c. Each facility transportation vehicle shall be equipped with an Obstetric Kit (Delivery Kit) containing the following:

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- 1) Two pairs disposable sterile gloves;
- 2) One drape sheet;
- 3) Two umbilical clamps, sterile;
- 4) Two O.B. towelettes;
- 5) One O.B pad, sterile;
- 6) One receiving blanket;
- 7) Six gauze sponges, sterile;
- 8) One bulb syringe, sterile;
- 9) Four disposable towels;
- 10) Two nylon tie-offs;
- 11) Two alcohol preps, medium;
- 12) Two twist ties; and,
- 13) One plastic bag for placenta.

NOTE: Once a kit is used, it is the responsibility of the Trip Officer to notify facility Health Services for a replacement.

C. Hospital Labor and Delivery Procedures:

1. At no time shall the mother be notified in advance of her transportation date.
2. The mother's family is not authorized to visit her at any time during hospital admission.
3. Transportation staff shall adhere to Policy and Administrative Procedure 02-03-110, "Adult Offender Transportation," regarding the transportation and security of pregnant mothers

The use of restraints on incarcerated females during active labor and the delivery of the child is prohibited.

Any deviation from this prohibition requires approval by and guidance on methodology from the attending physician or in a medical emergency when no physician is physically present, the nurse attending the mother in labor, and is based on documented serious security risks. Prior to active labor and delivery, the attending physician shall provide guidance on the use of restraints on pregnant women. Custody staff may make recommendations regarding the use of restraints prior to active labor but the recommendations shall not supersede the attending physician's orders.

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D. Hospital Return:

1. Transportation staff shall ensure a hospital Car Seat Technician secures car seat and newborn inside vehicle.
2. MCHU participants: If mother was accepted into MCHU, the mother and infant shall be admitted to the MCHU housing upon discharge from the hospital in the event of no post-partum complications. Three (3) officers shall be used for the participants' return. At no time shall the mother or newborn be left unsupervised entering the facility.
3. Non-MCHU participants: If the mother was denied or declined participation in MCHU, the mother shall return to the facility upon discharge from the hospital if there are no post-partum complications. The infant shall be picked up by the person or agency designated as responsible for the guardianship of the infant while the mother is incarcerated before the mother is discharged from the hospital. Non-participants shall receive a behavioral health referral by the Maternal-Child Health Coordinator within seventy-two (72) hours of hospital discharge.

E. Post-Partum Care:

1. All mothers shall be medically evaluated by the Health Services vendor within seventy-two (72) hours of hospital discharge. Mothers who experience post-partum complications after hospital discharge must be housed in the infirmary if the physician determines that observation is needed.
2. Any woman who experiences a miscarriage or stillborn shall receive a behavioral health referral within twenty-four (24) hours of hospital discharge initiated by the Maternal-Child Health Coordinator.
3. After vaginal delivery, the mother shall receive a medical restriction for six (6) weeks, unless there were complications at delivery and the physician provides specific orders. After the six (6) weeks, mothers are expected to attend their program assignments, unless given other specific restrictions by the physician.
4. After cesarean delivery, the mother shall receive a medical restriction for eight (8) weeks, unless there were complications at delivery and the physician provides specific orders. After the eight (8) weeks, mothers are

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expected to attend their program assignments, unless given other specific restrictions by the physician.

5. Post-partum patients shall be seen within three (3) to six (6) weeks from hospital discharge by Health Services vendor's OB/GYN.
6. Post-partum patients shall have access to nursing pads, numbing spray, a water bottle, and mesh underwear for vaginal care after birth. Numbing spray shall be provided to the patient by the housing officer and adhere to the Indiana Women's Prison procedures regarding control of chemicals.
7. Post-partum patients shall be screened for depression using the Edinburgh Depression Scale at regular intervals after delivery:
 - a. Postnatal depression screenings shall be completed by physical health staff if the patient has an "A" mental health code and will be completed within four (4) weeks of delivery and at three (3), six (6), nine (9), and twelve (12) months' postpartum. Any results indicating depression or suicidal ideation/intent shall initiate a referral to behavioral health services. Physical health staff shall initiate the referral by completing State Form 46325, "Staff Referral for Medical Services."
 - b. Postnatal depression screenings shall be completed by mental health staff if the patient has a mental health code other than "A" and will be completed within four (4) weeks of delivery and at three (3), six (6), nine (9), and twelve (12) months' postpartum. Behavioral health staff shall be notified that the pregnant patient has given birth by receipt of State Form 46325, "Staff Referral for Medical Services." For patients who are not accepted to MCHU, initial postpartum depression screening shall occur within one (1) week of receiving the staff referral form.

IV. PANDEMIC PROCEDURES:

In the event of a pandemic, staff shall exhaust all efforts to limit pregnant women and mothers with baby's exposure to staff and other incarcerated individuals. All pregnant women shall be initially placed in the MCHU and moved as a cohort. Acceptance into the MCHU shall be decided prior to delivery.

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Upon arrival to IWP, the pregnant woman shall be isolated and tested in accordance with The Department's Pandemic Response Plan prior to movement into the MCHU. Access to the unit and movement must be approved by the Executive Director of Transitional Healthcare.

V. DISTRUBTION OF FEMININE HYGIENE PRODUCTS:

Feminine hygiene products such as sanitary napkins and tampons shall be provided to the female population without limitation or reprisal. At no time shall an incarcerated female be denied such product without approval of the Chief Medical Officer.


VI. APPLICABILITY:

This HCSD is applicable to the Indiana Women's Prison and the Department's Health Services Division.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title VISION SCREENING

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standard

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for provision of routine vision screening and specialized screening required in certain chronic health conditions.

II. GUIDELINES:

A. Introductory Comments

The United States Preventive Services Task Force carefully examined vision screening and concluded that adults with vision complaints should be examined for refractive problems or ocular disease, but that general screening was not required. Department practices shall be consistent with this stance.

B. Vision Screening at Transfer

Patients transferring from an Intake unit or facility to a receiving facility shall be provided with Snellen vision screening. If Snellen examination reveals combined visual acuity (corrected) of 20/50 or worse, referral to an optometrist shall be initiated. Those complaining of inability to read due to hyperopia or presbyopia shall be offered formal screening by an optometrist.

Once a patient has been referred to the optometrist, they shall be seen within thirty (30) days.

C. Vision Screening in Receiving Facilities

Incarcerated individuals who do not wear corrective lenses shall not be

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provided with additional vision screening unless they complain of vision difficulties. Those wearing corrective lenses may be re-screened upon the development of significant vision problems or every two (2) years upon request. The first vision screening provided to patients complaining of vision difficulties shall be a simple Snellen Acuity Test.

Those found to have combined (corrected) visual acuity 20/50 or worse, or an inability to read standard printed material due to vision difficulties shall be referred for refractive screening by an optometrist. For incarcerated adults, such referrals will generally be restricted to once every 2 years or as clinically indicated.

D. Contact Lenses

Only “medically necessary” contact lenses shall be supported by Health Services resources. Medically necessary contact lenses include contact lenses necessitated by deformed corneas (e.g., keratoconus), inability to correct vision to 20/40 (single eye) with standard glass lenses, or extreme anisometropia.

If the Warden elects to permit a patient to use contact lenses for cosmetic purposes, Health Services shall not provide ongoing support for them.

E. Replacement of Existing Glasses

A patient who loses or destroys their glasses shall be provided with a replacement at their own expense. In the event that they are indigent, a replacement shall be provided and the individual’s Inmate Trust Fund shall be charged in accordance with governing rules and regulations.

Glasses that wear out (scratches, broken frames, etc.) through no fault of the patient shall be replaced at State expense every 2 years.

F. Chronic Care

The purpose of this screening is to identify the development of retinopathy so that vision preserving interventions may be offered. Diabetic and homozygous sickle cell patients shall receive annual screening including examination of the fundus through a dilated pupil, performed by a primary care provider, optometrist, or ophthalmologist. Patients with hypertension and those with HIV infection shall receive an annual funduscopy exam. All screenings shall be documented in the EMR and clearly labeled.

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III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title REGULAR AND THERAPEUTIC DIETS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101	ACA Standard: 4-4318M

I. PURPOSE:

This Health Care Services Directive (HCSD) provides general guidelines for the prescription of therapeutic diets.

II. DEFINITIONS:

- A. THERAPEUTIC DIET: A diet which deviates from the standard diet in preparation, type, or the amount and type of food provided, and is prescribed to treat or manage a health condition. Therapeutic diets do not include diets provided for religious or security reasons.
- B. FOOD ALLERGY: An adverse health affect arising from a specific immune response that occurs reproducibly on exposure to a given food.

III. PROCEDURE:

A. General Information

At each facility, a heart healthy diet using a written cycle menu is provided by the Food Services Division. The menu is reviewed for nutritional adequacy at a minimum twice yearly, and copies of these reviews are made available to all Health Services Administrators (HSA) upon request. Individual facilities are permitted to deviate from the formal menu cycle with substitutions developed and approved by the registered dietician when there is a disruption in vendor delivery, utilities, or during facility emergencies as declared by the Warden/designee. All substitutions are forwarded to the Director of Contract Compliance. Records of substitutions may be provided to the HSA on request.

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Therapeutic diets shall be initiated as clinically indicated. Therapeutic diets may be prescribed by physicians, dentists, clinical nurse practitioners, and may be recommended by clinical dietitians.

Clinical dietitians may be consulted for both for nutritional instruction and for advice in prescribing therapeutic diets.

A therapeutic diet manual from the Food Service vendor provider shall be made available for reference and information in the Health Services and Food Services areas.

The therapeutic diets that may be prescribed without a formulary exception request include the following:

1. Cardiac diet is prescribed only when the standard heart healthy diet is inadequate (i.e., the patient requires less than 3500 mg of sodium);
2. 1800 Diabetic diet (no snack);
3. 2200 Diabetic diet (no snack);
4. Pregnancy/High Protein (includes HS snack);
5. Broken Jaw/Full Liquid;
6. Clear Liquid (beyond three [3] days requires a formulary exception request);
7. Renal diet/Pre-/Post-Dialysis; and,
8. HS Diabetic snack.

All other therapeutic diets shall require the initiation and approval of a formulary exception request. In addition, all provider's orders for meal delivery to an incarcerated individual on a housing unit shall require an approved formulary exception request.

B. Food Allergies

True food allergies cause a systemic immune reaction. The majority of adults have food intolerance which causes unpleasant symptoms such as bloating, abdominal cramping, gas, and diarrhea, but no systemic immune reaction (i.e., angioedema, flushing, generalized urticaria, pruritis, hypertension, shock, throat swelling, etc.). While any food is a potential allergen, more than ninety percent (90%) of acute systemic reactions to food in adults are from crustaceans (shrimp, crab, lobster), tree nuts, peanuts, or fish. A food allergy may coexist with asthma, atopic dermatitis, and eosinophilic esophagitis. Conditions such as celiac disease, irritable bowel syndrome, or a lactase deficiency may sometimes mimic a food allergy.

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A thorough health history shall be obtained and documented for any incarcerated individual who reports a food allergy. The physician shall question the patient regarding the following:

1. Quantity of food ingested;
2. Whether the food was cooked or uncooked;
3. The timing of the symptoms;
4. If the food was taken with alcohol or the concomitant use of aspirin or NSAIDS;
5. Treatment previously given; and,
6. How long symptoms lasted.

A review of recent commissary purchases shall also be completed to determine whether the patient is purchasing food products to which the patient claims to be allergic.

Diagnostic options currently used at some facilities include Oral Food Challenge Test, Elimination Diet, and Serum Specific IgE allergy testing.

The Oral Food Challenge Test is a diagnostic test in which Health Services personnel present the suspect food to the individual for ingestion in gradually increasing amounts until the food-symptom relationship is established/not established. It remains a “gold standard” in food-allergy testing. During an oral food challenge, the patient is fed gradually increasing amounts of the suspected allergy-causing food over a period of time under strict supervision by a physician in the Health Services unit at a facility.

An Elimination Diet, in which the patient is advised to avoid the specific foods causing symptoms, shall be implemented unless the diet would adversely affect the patient’s body weight or health. If an elimination diet is not feasible, a specific diet for documented food allergies shall be requested through the formulary exception process.

Diagnostic tests may be helpful in establishing the presence of a food allergy. All IgE testing for food allergies shall be interpreted in the context of the patient’s clinical reactions. Many patients will have positive IgE tests to foods despite never having a clinical reaction. Because individuals can develop allergic sensitization to food allergens without having any clinical symptoms on exposure to those foods, an IgE mediated food allergy requires both the presence of sensitization and the

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development of specific signs and symptoms on exposure to that food. Sensitization alone is not sufficient to define a food allergy.

C. Means of Prescription of Therapeutic Diets

The necessity for a therapeutic diet must be documented in the EMR prior to the prescription being written (documented in progress notes, in the provider's orders, and in the treatment plan). When a therapeutic diet is initiated, the patient shall receive nutritional counseling to ensure that they understand the desired benefits of the diet and the obligation for compliance. This counseling shall be offered by a dietician, or other licensed health care professional(s).

Orders for therapeutic diets shall include the type of diet, the duration for which the diet is to be provided, and special instructions, if necessary. Diet orders for formulary diets shall not exceed one hundred-eighty (180) days. Approved formulary exception diet orders may not exceed ninety (90) days. Diet orders initiated from an approved nursing protocol may not exceed seventy-two (72) hours.

When a therapeutic diet is prescribed, the facility shall, in accordance with Policy and Administrative Procedure 04-01-301, "The Development and Delivery of Food Services," provide a means to generate a diet card. The diet card provides the patient access to the therapeutic diet in the Food Service facility.

If a patient is to refuse a therapeutic diet at the time it is prescribed, they shall be advised of the consequences of the refusal and the patient shall be offered a written refusal form in accordance with HCSD 2.12A, "Consent and Refusal."

D. Non-compliance and Refusal

Each facility's Food Service personnel shall inform Health Services via State Form 17481, "Weekly Record of Prescribed Diets," if a patient receiving a therapeutic diet is more than rarely non-compliant (Some facilities may find it simpler to report all non-compliance to Health Services personnel). Health Services personnel shall document the non-compliance in the health record and arrange for a nutritional counseling session for the patient. If the patient refuses the diet at this counseling session, the patient shall be advised of the health consequences of the refusal and the patient should complete a refusal form. If the patient elects to continue with the therapeutic diet the patient shall be informed that should non-compliance continue, the diet may be discontinued.

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If diets are discontinued due to non-compliance the patient shall be informed. This information may be transmitted in written form. The decision to discontinue the diet shall be documented in the EMR as an order by a clinician. If the patient is interested in receiving the therapeutic diet and it is still medically indicated, consideration shall be given to providing the diet again.

Practitioners are often faced with patients who comply with therapeutic diets in the facility dining room but defeat the therapeutic diet purpose through commissary use. When this is documented, education shall be provided for the patient. This shall be documented in the EMR.

E. Mechanical Modifications

Mechanically modified diets shall be prescribed only when necessary to permit continuing nutrition. The following comments shall be considered generally applicable. Justification for deviations shall be documented in the EMR.

Clear liquid diets are useful when patients cannot tolerate more complex food, usually due to nausea and vomiting. Clear liquid diets are nutritionally inadequate and should not be continued for more than brief periods (24-48 hours).

Full liquid diets may be useful in advancing patients from clear liquids to more complex diets or when an acute problem with mastication or swallowing has developed but should not be continued once the immediate difficulty has passed. Full liquid diets may be required for long term use when mastication and swallowing cannot be relied upon to move food to the stomach.

When liquid nutrition supplements are prescribed for patients in general population, the supplements shall be provided at the medication line and consumed in the presence of Health Services personnel.

Pureed diets are nutritionally superior to full liquid diets and should be provided preferentially to patients who cannot chew but can swallow. This type of patient should not be provided with a full liquid diet.

A dental soft diet may be prescribed, in lieu of a full liquid diet, if the patient has mild chewing or swallowing problems, or when necessary, after oral surgery. Dental soft diets should not be provided for long periods unless there is an unusual condition resulting in continuing jaw instability or pain. After oral surgery gums will toughen and become capable of mastication despite the absence of teeth. In

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fact, this toughening must be permitted to occur in order for gums to mature and be properly fitted with dentures.

Absence of teeth is not an indication for a permanent mechanically modified diet.

F. Calorie Controlled Diet

Calorie controlled weight loss diets will not generally be available in the Department unless the weight loss diet is necessary to manage a serious health condition. Similarly, high calorie diets shall not be prescribed for weight gain unless prior weight loss is due to a health condition and failure to regain weight on the regular diet despite its ingestion (approximately 2800 calories per day) has been documented in the health record. In this circumstance, as soon as weight gain is back to the normal range has been documented, the extra calories should be discontinued (unless the hypermetabolic or malabsorptive state is present). Consultation with a dietician regarding necessary caloric content may be helpful. "Double portion," or four thousand (4,000)-calorie diets shall not be provided.


IV. APPLICABILITY:

This HCSD is applicable to all adult facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title ASSISTIVE DEVICES

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) describes the circumstances in which the Health Services Division provides assistive devices.

II. GUIDELINES:

- A. Assistive devices run from the routine (eyeglasses, dentures, etc.) to the unusual (prosthetic limbs, motorized wheelchairs, etc.). When assistive devices are necessary to address significant impairments in ability to perform activities of daily living, relieve pain, or otherwise significantly improve the health of a patient, they will be provided.
- B. On occasion these devices will be brought with a patient upon arrival to prison. When such a device is received, its necessity shall be reviewed by Health Services staff and a recommendation regarding its use made.
 1. If Health Services staff recommends its use, the device shall be inspected by Operations staff. If Operations staff has questions regarding the specific item, Operations and Health Services staff shall review the item and determine whether the item is necessary or whether a different assistive device will be provided.
 2. If Health Services does not recommend its use, the device will be considered property and Operations staff will determine whether or not it will be permitted.
- C. On occasion assistive devices will be provided by Vocational Rehabilitation Services or other outside agencies. When outside agencies provide devices, they will be reviewed as described in subsection B.

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- D. If assistive devices are necessary as in subsection A, they shall be provided and supported by the Health Services vendor. If questions regarding the necessity for provision of assistive devices arise, the HSA shall attempt to resolve the questions locally.
- E. Preventive maintenance, adjustments, modifications, and repairs shall be performed on assistive devices as necessary to ensure that they remain functional. Services shall be provided in a timely manner so as to prevent deterioration of patients' health conditions.
- F. In general, assistive devices should be replaced when:
 - 1. The patient's health condition changes to the extent that the current assistive device no longer meets the patient's needs;
 - 2. Weight gain/loss, growth, or surgical revision renders the current assistive device useless;
 - 3. Initial assessment, measurement, or fabrication was incorrect;
 - 4. Normal wear and tear renders an assistive device unsafe or incapable of addressing the health or ambulatory needs of the patient;
 - 5. Loss or damage to an assistive device through no fault of the patient's; or,
 - 6. When repairs to the device are no longer cost-effective.
- G. Release planning shall include arrangements that ensure the patient's need for an assistive device will continue to be met through the immediate post-release period. Physical Health Staff shall work with Transitional Health care to ensure that release planning is collaborative in nature and that the patients' needs are met.


III. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
OFF-SITE MEDICAL, HOSPITAL, AND SPECIALTY CARE REFERRALS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) presents information and guidelines on the types of interventions that are appropriate for treating certain types of conditions seen in patients committed to the Department, and which cannot be provided on-site. Additionally, this directive presents a review mechanism for the provision of off-site medical services so that unnecessary or duplicative interventions can be avoided.

II. GUIDELINES:

- A. No correctional health care system can provide all necessary care through its own on-site providers and equipment. The use of specialists, off-site emergency facilities, and off-site equipment will always supplement the Department's on-site capabilities. The Department's responsibility to the public requires it to make certain that the off-site services purchased are both necessary and obtained in a cost effective fashion.

Specialized services will generally fit one of the following categories:

- Emergency care
 - Diagnostic services
 - Hospital services
 - Specialized ambulatory care
- B. Each facility must plan in advance for the delivery of these services. These plans may reflect arrangements made on behalf of all or a group of facilities or may be

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local, and must be reflected in written plans and contracts, as appropriate. The plans shall also identify the manner in which 24-hour support from on-call staff (physician, dentist, and behavioral health) will be provided.

- C. Emergency services must be provided when needed. When a patient requires a trip to the emergency department the EMS should be the main mode of transportation. A State vehicle may be used for joint dislocations, stable orthopedic injuries (i.e., fractures, noncomplex clean breaks). The determination to use a State vehicle is the sole determination of the sending clinician and must be clearly documented in the EMR. State vehicles should not be used in emergency situations that may pose an immediate risk to the health and safety of the patient. A State vehicle shall never be used for patients that require access to immediate health interventions such as: uncontrolled bleeding, head injury, altered mental status, unstable vital signs, systolic blood pressure <90 or >200, Pulse <40 or >200, requiring oxygen, chest pain or shortness of breath, unstable abdominal pain, or with any noted changes on an EKG. The determination of the type of transportation used is a clinical decision that must be made by the person who decides that off-site services are emergently necessary and documented in the electronic medical record (EMR).

Physicians, mid-level practitioners, and dentists shall determine whether emergency off-site services are necessary. On occasion, circumstances shall preclude contacting a physician or dentist for authorization, but a nurse will recognize the need for emergency care. If, or when, this occurs, the nurse is authorized to send the patient off-site for care and must document the reason that care was provided without an order from a physician or dentist. Following the emergent send-off, the nurse shall contact the on-call clinician within one (1) hour.

Off-site emergency transfer shall be accompanied by copies of health records or other material that is obviously useful to the receiving facility. Notification shall be made to the appropriate Quality Assurance Manager (QAM), Executive Directors and Chief Medical Officer (CMO) of all emergency transfers at time of event.

- D. Off-site diagnostic services or off-site specialty care may be required and may be reviewed and scheduled. The practitioner requesting services is expected to document in the EMR the need for the proposed diagnostic intervention and to request approval from the Health Services vendor's regional medical director or designate. The review shall result either in approval or suggestions regarding alternative interventions within seventy-two (72) hours. Alternative treatment interventions/plans must be acknowledged and documented in the EMR.

For the safety of transporting staff and the public, staff **shall not** inform the patient

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of the date and time of any off-site appointment.

When the patient is sent for care, certain preparations may be necessary or clinical information may be useful. Such preparation shall be accomplished, or information provided in order to maximize the efficiency of the off-site referral process.

- E. Hospital admission may be scheduled as part of a planned procedure or unscheduled as a result of an emergency. When patients are hospitalized at off-site facilities, they must remain under direct supervision by Department Custody officers.
- F. Upon return from off-site travel, the patients should be accompanied by photocopied health records, clinic encounter forms, discharge summaries, or other clinical material. This material shall be reviewed immediately by clinical staff, with physician staff informed regarding the results immediately or later, as may be clinically appropriate. Care must be provided in a continuous manner. All patients shall follow up with the clinician within 24 hours following inpatient admission and ER runs. Patients shall be seen within 7 days following all offsite visits.

The essential health records must be scanned into the EMR within 48 business hours. These documents must be acknowledged by the signature or electronic signature of a clinician.

- G. If a request for off-site referral is not approved and the on-site provider believes that the denial and alternate suggestions are inappropriate, the on-site provider must act on the patient's behalf. Depending upon the urgency of the problem, the provider may write or telephone the Health Service vendor's Regional Medical Director or designated individual to discuss the patient. All such contacts shall be documented in the EMR and decisions explained to the patient.
- H. All alternative treatment plans shall be recorded at the site level and forwarded to the QAM. A monthly roll up shall be forwarded to the Executive Director of Physical Health and the CMO.
- I. Off-site providers are used as consultants, it is the on-site provider who must determine whether the course of care suggested by the consultant will be implemented. This determination must be documented in the health record and the treatment plan must be explained to the patient.
- J. Scheduling elective services is the responsibility of the Health Services staff. Managing scheduled transportation (including providing security to accompany

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travel) is the responsibility of Operations staff. Both groups must work cooperatively in order to assure that services are provided in an efficient manner.

When security considerations lead to potential cancellation of a scheduled off-site medical trip, the Operations staff must inform the Health Services staff as soon as possible. The Health Services staff shall advise Operations staff regarding the urgency of the travel and assist to ensure that necessary care is timely provided. The site medical director or designee shall be notified of the potential cancellation in order to intervene if clinically necessary.

- K. At facilities lacking space or equipment, off-site travel for imaging studies, dental services, optometry services, etc., may be minimized by arranging for mobile services through private contractors.
- L. When specialized ambulatory care is provided through telehealth, the health professionals providing the consultation must be appropriately licensed in Indiana, credentialed, and privileged to provide specialized care. On-site Health Services staff must adhere to the following:
 - All on-site personnel who use the telehealth equipment must be trained in equipment operation and trouble shooting.
 - When peripherals are used, the manufacturer's infection control procedures must be implemented in between patients.
 - Patient privacy and confidentiality must be maintained in accordance with the provisions of HCSD 2.01A, "Access to Care."
 - Patient consent, when necessary, is obtained in accordance with Health Care Services Directive 2.12A , "Consent and Refusal."
 - Documentation of the telehealth encounter is generated, either directly into the patient's health record or through a paper consultant's report. When the consultant provides a paper report, the report shall be scanned into the EMR.


III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
NURSING PROTOCOLS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6 Indiana Nurse Practice Act	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) establishes guidelines under which nursing assessment protocols are to be developed, implemented, and monitored.

II. DEFINITIONS:

- A. NURSING PROTOCOLS: Written instructions or guidelines that specify the steps to be taken in evaluating a patient's health status and providing interventions.
- B. CLINICIAN : A physician, dentist, advance practice nurse (APN), or any other person allowed by law to independently prescribe medication or a course of treatment.
- C. STANDING ORDERS: Written orders that specify the same course of treatment for each patient suspected of having a given condition.

III. PROCEDURE:

A. General Information

Protocols are not synonymous with standing orders. Standing orders require that the same course of treatment be provided in each situation. In circumstances when there is a well-defined patient population with predictable health care needs, standing orders can be an acceptable method of helping to ensure that appropriate care is provided. Standing orders may be used to promote identified health screening (such as HCV, HIV, and TB screening programs) and prevention activities (such as immunizations).

The Health Services vendor shall use nursing protocols to:

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1. Provide guidance for nursing personnel to implement certain therapeutic and diagnostic procedures in their clinical work;
2. Facilitate the management of some acute and chronic health conditions; and,
3. Provide a framework for patient management in certain emergency situations.

In the absence of a protocol, standing order, or other practitioner order (e.g. telephone or verbal), nursing personnel are not permitted to:

1. Administer any medication, including over-the-counter medications (OTC);
2. Renew medication orders; or,
3. Perform diagnostic tests such as laboratory studies or x-rays (excluding test used for patient assessments such as urine dipsticks and finger stick blood sugars).

Nursing protocols shall reflect an effective and appropriate standard of care based upon prevailing standards of clinical practice. Nursing protocols must be appropriate to the educational preparation and skill level of the nursing staff implementing them, and they must comply with the Indiana Nurse Practice Act.

Nursing protocols may not include the use of prescription medication without a referral to the practitioner and a verbal order, except for those covering emergency, life-threatening situations (e.g., nitroglycerin, epinephrine, Narcan, etc.). Emergency administration of these medications requires a subsequent clinician's order.

Nursing protocols may include over-the-counter (OTC) medication necessary for the treatment of a serious medical condition. If the condition is not a serious medical condition, the patient shall be referred to the OTC products available on commissary. Nursing triage guidelines and patient instruction sheets which provide information on self-management including instructions for purchasing and using OTCs medications are acceptable.

B. Scope of Practice

Nursing protocols may be utilized by RNs and LPNs. RN's must provide

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oversight for LPN's conducting nursing protocols and a 5% review must be completed monthly by a supervising registered nurse or director of nursing (DON).

Nursing protocols are not necessary for Advanced Practice Nurses (APNs) with prescriptive authority.

Practitioners may not use nursing protocols to delegate interventions which are clearly beyond the scope of nursing practice, or which are beyond the nurse's education or training. Nursing personnel are not permitted to perform a service, task, or clinical intervention that exceeds their scope of practice.

C. Implementing a Nursing Protocol

The decision to proceed with any plan or strategy for care including nursing protocols is dependent upon several factors:

1. The accuracy of the assessment or clinical evaluation;
2. What is known about the patient's health history and physical condition; and,
3. The nurse's comfort with implementing the particular therapeutic intervention.

Nurses may not deviate from the nursing protocol. When a nurse determines it necessary to vary or not implement the protocol, the nurse shall consult with a practitioner for guidance. Additionally, there are times when the presenting pattern is ambiguous, the findings from the assessment are contradictory, the interpretation of the clinical evaluation is beyond the scope or ability of the nurse, the best approach to treatment is debatable, or the nurse cannot decide which protocol is the most appropriate. In such circumstances, the nurse must discuss with, or refer to, a practitioner.

D. Nursing Protocol Design

Nursing protocols designed for use within a facility will be established in collaboration with the Health Services vendor's Regional Medical Director, Regional Director of Nursing, or RN nurse educator, the Chief Medical Officer (CMO), and the Executive Director of Physical Health. Nursing protocols must comply with relevant State statutes and administrative codes. Nursing protocols may be written in the style of an algorithm or a decision tree.

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Each nursing protocols shall contain the following categories:

1. Subjective and objective data to be collected by the nurse;
2. Nursing assessment or patient symptomatology which forms the foundation for therapeutic intervention; and,
3. Specific treatment plans to be implemented, including the specific circumstances when the nurse shall contact a higher level practitioner.

Once developed, approved, and implemented, each nursing protocol must be reviewed annually by the facility's HSA, DON, and the site Medical Director. In a facility without a DON, the RN nurse manager or the facility's RN must review the nursing protocols in conjunction with the Site Medical Director or physician.

E. Staff Training

All nursing staff responsible for nursing protocol implementation must receive annual training. Documentation of training must include:

1. Evidence that all new nursing staff members are trained;
2. Demonstration of knowledge and skills;
3. Evidence of annual review of skills; and,
4. Evidence of retraining when protocols are introduced or revised.

F. Health Record Documentation

Implementation of a nursing protocol shall be documented on the appropriate template in the EMR. All sections of the template must be completed and the plan clearly defined.

G. Implementation and Monitoring

Nursing protocols designed by the Health Services vendor may only be implemented after approval by the CMO or the Executive Director of Physical Health.

Any modification to a written nursing protocol requires the initiation of a new protocol (including Department Health Services Division approval). Nursing protocols must be signed by the current Site Medical Director, the DON or nurse manager, and the HSA.

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The facility's DON or RN nurse manager shall routinely monitor the use of nursing protocols. The DON or RN designee shall complete a five percent (5%) review of all nursing protocols used at least monthly. These reviews shall include the following indicators:

1. Nursing personnel were authorized to treat the identified health condition;
2. Acuity level of the patient or condition was consistent with that of the protocol used;
3. Nursing personnel using the nursing protocol followed the treatment regimen contained in the nursing protocol, including notification of the on-call physician as required; and,
4. Nursing personnel complied with required or customary follow-up applicable to the health condition treated.

When nursing protocols involving the use of emergency or lifesaving medications are employed, a clinician must review the usage, with the review documented by an entry in the EMR and must sign off all verbal orders.


IV. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss MD
Chief Medical Officer

Date

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<p>Title</p> <p>INFIRMARY MANUAL</p>

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the contents and review of Infirmary Manuals in Department facilities.

II. INFIRMARY CHARACTERISTICS:

- A. Although Department inpatient units (infirmaries) are not licensed, they serve the same role as that of licensed units in the community. For this reason they shall be professionally designed, maintained, and managed.
- B. Infirmaries are areas in which patients are maintained for periods of twenty-four (24) hours or more for clinical health reason, under the supervision of licensed, registered nurses and clinicians. Each infirmary shall maintain an infirmary manual which describes its operation. The physical plant must be consistent with the program statement in terms of space, equipment, and supplies.
- C. Infirmaries must be maintained in a clean and sanitary manner with running water and electrical outlets sufficient for clinical use. Supplies shall be adequate to the tasks performed and equipment appropriately supplied and maintained. Fire extinguisher adequate to promote safety and meeting all applicable fire and safety codes shall be present in the infirmary.
- D. Each infirmary shall have clean and soiled utility rooms adequate to support the unit.

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- E. Nursing staff shall be present on the unit twenty-four (24) hours per day, seven (7) days per week. Supervision of the nursing staff shall be from a registered nurse (RN) present in the infirmary daily. Physician staff shall be available on site Monday through Friday and shall be on-call when not on site.
- F. Patients must be within sight or sound of clinical staff at all times. A call system may be used to satisfy this requirement.
- G. Patients shall have access to showers, washbasins, and toilet facilities and shall be encouraged to bathe daily.
- G. Admission to, and discharge from, an infirmary is only completed on order of a physician, dentist, or an advanced practice nurse. This does not preclude the occasional use of an infirmary bed by Operations staff for specific purposes, outlined in the facility infirmary manual. Such uses shall be the significant exceptions.
- H. No infirmary may be referred to as a “hospital”.

III. INFIRMARY MANUAL GUIDELINES:

A. Program Statement

The program statement defines and describes the role of the infirmary, the population served, and describes the types of care provided, including capabilities for isolation and restrictive status.

B. Scope of Practice

Scope of Practice describes the process governing which staff member can perform specific tasks in the infirmary.

C. Staffing Pattern

The staffing pattern defines the minimum staffing patterns and the staffing modifications to be made as population and patient needs vary. The staffing pattern shall be reviewed annually.

D. Available Nursing Services

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Available nursing services describes the approach to the delivery of nursing services.

E. Position Descriptions and Shift Responsibilities

The infirmary manual shall include position descriptions that are shift-specific, an organizational chart defining infirmary management responsibilities, and identification of a responsible physician director.

F. Service Arrangements

1. Off-site

Service arrangements with other facilities describe existing relationships with other Department Health Services Units, community hospitals, and other outside services (e.g., radiology, vision, emergency transportation, etc.).

2. On-site

Services not typically provided (such as physical and occupational therapy, speech therapy, specialized rehabilitative interventions, blood product administration, etc.) but necessary for the care of infirmary patients must be planned and arranged in advance of need. If additional unanticipated needs arise, patients shall be sent off-site to receive the services, unless arrangement can be made in a timely manner.

G. Special Equipment

Special equipment describes any special equipment (X-ray unit, air beds) used on-site on a continuous or occasional basis.

H. Preventive Maintenance

Preventive maintenance provides a description of an organized preventive maintenance service program, including the responsibility for monitoring implementation.

I. Pharmaceutical Management

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Pharmaceutical management identifies the manner in which pharmaceuticals are obtained, stored, and delivered, including individually dispensed supplies, nursing supplies, emergency drug kits, starter drugs, etc. Also, this section identifies the service provider for medications needed on an emergent basis and must be obtained off-site.

J. Infection Control

Infection control describes a program that:

1. Monitors the unit for nosocomial infections;
2. Assists in the implementation of general departmental infection control requirements (e.g., Tuberculosis Control Plan, Bloodborne Pathogen Control Plan, and Pandemic Response Manual);
3. Describes the use of isolation rooms;
4. Describes disinfection of rooms, showers, and tubs;
5. Describes management of contaminated waste (including linens); and,
6. Describes hand hygiene.

K. Universal Precautions

Universal Precautions shall be utilized and followed. The facility's infirmary manual shall define and/or describe Universal Precautions.

L. Security and Disaster Planning

Security and disaster planning describe how security is maintained and clarifies the relationship between Custody and Health Services staff, including how disagreements are resolved. The infirmary manual shall include a formal disaster plan and the manner in which it will be rehearsed/drilled.

M. Sample Chart/Forms

This section of the infirmary manual shall include a description of the health record and provides a blank chart example for review and training purposes.

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N. Problem Lists and Treatment Plans

The infirmary manual shall describe the manner in which problem lists are to be initiated and maintained, including changes that may be made upon admission, during the inpatient stay, and upon discharge from the inpatient unit.

O. Admission to the Infirmary

The infirmary manual shall include a section that provides a detailed description of the admission process. This shall include, but is not limited to, standard, short stay, and administrative admission types. The infirmary manual shall include requirements and information for the following:

1. Authorization to order admission;
2. The production of admission orders;
3. The frequency of provider contacts;
4. Admission orders and progress notes;
5. The review and reestablishment of the problem list and treatment plan;
6. Local custodial requirements;
7. Performance of a formal nursing assessment;
8. Performance of admission history and physical; and,
9. Clarifies varying requirements for different admission types.

P. Patient Management Requirements

This section of the infirmary manual describes the frequency of contact and documentation expected of nurses, physicians, and other facility staff members, including variations based on admission type or patient need, and how these differences are documented. The section shall include reliance upon the Multidisciplinary Treatment Team and general documentation of progress towards discharge.

The section shall describe general unit activities including, but not limited to, meals, recreation, bathing, day room privileges, telephone privileges, and educational involvement for long-term patients.

The following are examples of minimum default documentation frequencies which shall be described in the infirmary manual. Deviations from these

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frequencies must be directed by orders in accordance with the treatment plan:

1. Vital signs obtained every shift;
2. General nursing note completed each shift (except for the shift with the comprehensive nursing note);
3. Comprehensive nursing note with full assessment once daily; and,
4. Daily (Monday through Friday, excluding State holidays) visit and progress note by the attending physician, psychiatrist, advanced practice nurse, or dentist unless otherwise documented by the responsible provider.

Q. Discharge and Release from Infirmary

This section shall limit the authority to discharge to those authorized to admit. The infirmary manual shall describe the requirement for discharge planning, discharge orders, and discharge summaries. It shall describe the requirement that discharges be accompanied by an updated problem list and treatment plan. It shall address actions to be taken if a discharged patient does not have an available bed in general population. The infirmary manual shall provide for provider contact when the discharge is to another health care facility. Discharge planning shall begin at time of admission (i.e., Goals to meet prior to discharge shall be well defined).

R. Multidisciplinary Treatment Team

This section of the infirmary manual shall establish a Multidisciplinary Treatment Team to meet and review patients on a routine and continuing basis, meeting weekly and including representatives from all disciplines working in the unit.

S. Additional Facility Directives

This section of the infirmary manual shall include additional facility directives necessary for the smooth, orderly operation of the unit and includes, but is not limited to:

1. Discharge to a long-term care facility;
2. Death;

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3. Suicide;
4. Assault;
5. Sexual assault;
6. Commissary;
7. Unit Team and Religious Services support;
8. Advance Directives;
9. Do Not Resuscitate Order;
10. Visitation;
11. End of Life services;
12. Patient property; and,
13. Use of restraints.

T. Nursing Procedure Reference

This section shall reference a standard nursing procedure manual or includes nursing procedures in detail.

U. Contact Information

This section of the infirmary manual shall list contact information necessary for infirmary operation and management in the form of an on-call calendar.


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing inpatient services to incarcerated adults.

signature on file

Kristen Dauss , MD
Chief Medical Officer

Date

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Title RESTRAINTS IN GENERAL MEDICAL USAGE (NON-PSYCHIATRIC)

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the use of restraints in the treatment of medical and surgical patients.

II. DEFINITIONS:

For the purpose of this HCSD, the following definitions are presented:

- A. **ACUTE MEDICAL RESTRAINT:** The application of any physical or mechanical device which limits the patient's mobility and the restraint supports the medical healing of the patient.
- B. **CLINICAL CARE RESTRAINT:** The use of a physical or mechanical device, material or equipment, for certain specific clinical procedures or for the treatment of medical conditions (e.g., delirium, post-traumatic brain injury, etc.) to protect the patient from harm or to ensure a necessary medical procedure can be performed safely.
- C. **EMERGENCY:** A situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff, or others.
- D. **PHYSICAL RESTRAINT:** The direct application of physical force to a patient, without the patient's permission, to restrict freedom of movement. Physical force may be human, mechanical, or a combination of these interventions which are attached to the patient's body so that they cannot easily remove. Holding a patient in a manner that restricts their movement constitutes physical restraint.

III. GUIDELINES:

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Mechanical devices which are used to support proper body position, alignment or balance, orthopedic devices, protective helmets or mittens, and other durable health equipment which support activities of daily living are not considered restraint. Devices which are customarily employed during nursing, medical or diagnostic procedures that are considered routine safety measures (e.g., lap belts in wheelchairs, arm boards for peripheral IVs) which are standard practice for the procedure or intervention are not considered restraints.

On occasion the safe management of a patient with a medical or physical disorder may require restrictive and/or intrusive interventions to protect the patient, a staff member or others from harm. Acute medical restraints may be applied when they are necessary to support the healing of the patient. Clinical Care Restraints are used when the patient does not have rational decision making capability and there is significant danger to the patient if they dislodge or terminate a line, catheter, or tube. The type of restraint is not specific to the setting the patient is in, but to the situation the restraint is being used to address.

Physical or mechanical restraint must be used as an intervention of “last resort” only when the intervention is necessary to ensure the physical safety of the patient and other less restrictive interventions have been tried and found ineffective or interference or resistance is reasonably anticipated.

During the use of restraints, the patient’s dignity and well-being must be protected and respected. Health care personnel are absolutely forbidden to utilize restraints for purposes of retaliation, punishment or for any disciplinary purpose.

In order of increasing restrictiveness, the interventions available are:

- A. An evaluation to rule out the possibility that the symptoms represent a significant change in clinical status;
- B. Increased surveillance by staff;
- C. Additional pain relief or other comfort measures;
- D. Physical activity or exercise;
- E. Meaningful distraction;
- F. Environmental modification;
- G. Placing the patient on close observation with regular fifteen (15)-minute checks;
- H. Assign a companion or sitter for the patient;
- I. Mittens;
- J. Soft restraints for one (1) or two (2) extremities;
- K. Soft restraints for three (3) to four (4) extremities; and/or,
- L. Leather restraints.

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Movement should be restricted only so far as necessary to maintain safety. Restraints should be individualized, applied for the patient's benefit, afford as much dignity to the patient as the situation allows, and should be humanely and professionally administered. Restraint usage must be terminated as soon as clinically feasible.

A patient should never be restrained face-down, hog-tied or spread-eagled and no restraints should be used around the patient's neck.

In an emergency, a patient who lacks capacity for decision making is at risk for loss of life or limb if treatment is not provided may be restrained in order to permit care to be provided.

IV. PROVIDER'S ORDERS FOR RESTRAINTS:

Restraint may be implemented only on the order of a physician, nurse practitioner or physician assistant. Orders for restraint must contain date and time, reason and type of restraint, duration of order, specific criteria for which the restraint may be removed, and the name of the provider and nurse if a verbal order.

For acute medical restraint, the duration of the order may not exceed 24 hours. At 24 hours, the nurse must perform a comprehensive assessment and obtain a new order. The order may be renewed every 24 hours up to a maximum of 72 hours. At the end of 72 hours, if restraint is still necessary the treating provider must conduct a face to face evaluation of the patient. The treating provider must consult with the Health Services vendor's Regional Medical Director for guidance on ongoing management.

For clinical care restraint, the time frame for the order is limited to the duration of the clinical need. Clinical care restraint must be discontinued when criteria is no longer met either by removal of the tube, invasive lines, catheters, etc., or the patient's decision making capacity has been restored.

If the restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying restraint.

Orders for the use of restraint must never be written as a standard order or on an as needed basis (i.e., PRN). When an on-call provider is not the patient's primary care provider, the order for restraint the patient's primary care provider must be consulted as soon as possible.

In emergency situations, when restraint is necessary to preserve the patient's life or is necessary for the management of aggressive or combative behavior, a licensed nurse may initiate restraint and obtain a verbal or telephone order from the primary care or on call provider within one (1) hour.

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V. APPLICATION OF RESTRAINTS:

Restraints must be applied in the least restrictive manner possible, in accordance with safe and appropriate restraining technique, and ended at the earliest possible time. Restraints may only be applied by personnel who have been trained in their use. A Registered Nurse must be present to witness the application and ensure appropriateness.

VI. MONITORING OF RESTRAINT:

The frequency of monitoring should be determined based on the assessed needs of the patient. At a minimum, the following assessments and services shall be provided and documented in the EMR:

- An immediate assessment must be done after the patient is restrained to ensure the restraint was properly and safely applied
- At 15 minute intervals, staff must observe the patient for any signs of injury or physical distress.
- Within one hour after the patient is placed in restraint, the patient must be seen face-to-face by a Registered Nurse to determine if the patient still meets criteria for the restraint.
- Obtain vital signs every 2 hours
- Assess the patient's mental status (i.e., orientation and cognitive function) and level of distress every 2 hours
- Assess circulation including an assessment of capillary refill, the patient's ability to move fingers and toes and the presence or absence of edema. The last circulation check should be done two (2) hours after restraints have been removed
- Conduct range of motion activities for the restrained extremities every 4 hours
- Assess skin integrity to the extent possible with the range of motion activities
- Attend to hydration needs every 2 hours while awake
- Provide an opportunity to attend to elimination and personal hygiene needs every 2 hours while awake
- Support nutritional needs as prescribed

Health Services personnel shall obtain vital signs, conduct the 15 minute checks, conduct range of motion activities, and assist the patient with hydration, nutritional support and elimination with oversight by a RN. The RN is responsible for completing and documenting all assessments.

At each assessment the patient should be evaluated for the opportunity to remove the restraints. Restraints should be discontinued at the earliest possible time when the

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patient's actions no longer warrant the use of restraints or the clinical treatment is discontinued (i.e., I-V lines, catheters, etc., has been removed).

When restraints are used for emergency treatment, the restrained patient must be continuously monitored.

VII. HEALTH RECORD DOCUMENTATION:

Health record documentation shall include:

- A. The patient's behavior prior to restraint;
- B. All attempts to gain the patient's cooperation or that making such attempts would delay the necessary emergency treatment and further jeopardize the patient's life and safety;
- C. A description of the failure of less restrictive methods of restraint including verbal reminders or verbal attempts to convince the patient to cooperate;
- D. Information that was provided to the patient when the reasons for restraint were explained;
- E. The patient's understanding of the criteria that must be met for the removal of restraint;
- F. A description of the type of restraint (soft, leather, mechanical) used
Identification of the limbs or body part restrained;
- G. A description of any injuries that occurred before, during or after the restraints were applied;
- H. Descriptions of the patient's mental status and behavior before and after the restraints were applied;
- I. Documentation regarding the patient's status at least every fifteen (15) minutes;
- J. Assessments including vital signs and mental status, and skin integrity;
- K. Range of motion activities and notations regarding the provision of hydration and nutrition and how and when elimination needs were met; and,
- L. With each new order for restraint, the results of the comprehensive assessment and the rationale for the continued use of restraint.

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VIII. STAFF TRAINING:

Health Services staff with direct patient contact must have continuing education and training in the proper and safe use of restraints. At a minimum, the following topics are to be included in staff training:

- A. Underlying causes of aggressive or combative behaviors (e.g. hypoglycemia, postictal state following a seizure, delirium with fever);
- B. De-escalation techniques;
- C. Safe use of restraints including the application and removal of restraints;
- D. Signs and symptoms of physical distress in restrained patients;
- E. Frequency of vital signs, circulation checks, and range of motion activities;
- F. Addressing hygiene and elimination needs;
- G. Components of the comprehensive assessment; and,
- H. Recognizing the patient's readiness for discontinuation of restraints.


IX. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title ORGAN AND TISSUE DONATION

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This directive provides guidelines for patients wishing to donate tissue or organs for transplantation and for staff assisting these patients.

II. GUIDELINES:

- A. From time to time patient's request to participate in organ or tissue donation procedures. While it is reasonable for patient's to be permitted to donate organs or tissues, it is not reasonable for the Department to use its funds to support these procedures. Organ donation is not a necessary health care service.

The donation process includes several major steps:

1. Personal decision to participate;
2. Blood samples for tissue typing, including examination for histocompatibility;
3. Meeting with surgeon or other operator;
4. Donation procedure, often as a hospital inpatient; and,
5. Follow up.

- B. If a patient wishes to participate as a donor, all associated costs must be borne by outside agencies, by the family, or by another third party, and none borne by the Department. Associated costs include costs of officer coverage (including overtime if that is used and including associated fringe benefit expenditures), costs for vehicles, costs for blood tests or other evaluation procedures, costs for the donation process, and costs for any required follow up care.

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The Warden shall:

1. Confirm that an outside agency is considering the patient as a source of tissue or organs;
 2. Review the individual patient's history with regards to escape risk or other risk to the public. (If there is any unacceptable concern for escape risk or the public's safety, the Warden may require additional security (also funded by a party other than the Department) or determine that no off-site trips are acceptable); and,
 3. Ensure that funds adequate to cover security and transportation are transferred to Department in advance of any off-site trips.
- C. The outside agency considering a patient as a tissue or organ source and the patient must be informed regarding these costs and security considerations in advance of initiating the donation process.
- D. The Chief Medical Officer (CMO) must be informed regarding donation procedures that are carried out. The CMO retains the authority to deny permission to participate, if good cause for this denial is present.
- E. If patients or outside groups wish to consider a patient participation's in general organ transplant registries, permission from the Commissioner shall first be obtained.

III. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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HEALTH CARE SERVICES DIRECTIVE -ADULT Manual of Policies and Procedures

Title

ADDICTION RECOVERY SERVICES

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References:
IC 11-8-2-5(a)(8) IC 11-10-3-4(a)(1) IC 35-50-6-3.3	01-02-101 01-04-101 01-02-106 01-07-101 01-02-107 03-02-104 01-03-103	National Correctional Healthcare Standards

I. PURPOSE:

Adult patients with substance use treatment needs shall have access to comprehensive addiction recovery treatment services. This Health Care Services Directive (HCSO) provides an overview of the way addiction recovery services shall be provided in Indiana Department of Correction (IDOC or "the Department") adult facilities.

II. POLICY STATEMENT:

The Department recognizes that a significant portion of the patients committed to the Department have been involved in some form of problematic substance use. In order to address this problem, the Department has established coordinated addiction recovery services (ARS) that provide education, treatment, and support programming for patients within the Department's facilities.

III. DEFINITIONS:

For purposes of this Health Care Services Directive the following definitions are presented:

- A. **ADDICTION RECOVERY SERVICES (ARS):** The entire continuum of services and programming offered at Department facilities for the treatment of problematic substance use.

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- B. ADDICTION RECOVERY SERVICES FACILITY DIRECTOR (ARS FD): The ARS staff at each location responsible for coordinating and providing addiction recovery services at their location. This individual may or may not supervise other ARS staff.
- C. ARS STAFF: The employee(s) at each location responsible for direct delivery of Addiction Recovery services. Staff must have an Addiction Consultant in Training (ACIT) credential at minimum, with eligibility to obtain the CADAC I certification or higher within eighteen (18) months of the date of hire. Credentials such as Licensed Addiction Counselor (LAC), Licensed Clinical Addiction Counselor (LCAC), and Licensed Clinical Social Worker (LCSW) may also qualify as Addiction Recovery Staff.
- D. CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the IRAS and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.
- E. COMPREHENSIVE SUBSTANCE USE ASSESSMENT (CSUA): The formal assessment process used with newly referred patients to establish eligibility for participation in ARS and determine the appropriate Level of Care.
- F. CO-OCCURRING DISORDERS: A condition in which a patient has at least one diagnosable mental illness along with one or more substance use disorders.
- G. DIRECTOR OF ADDICTION RECOVERY SERVICES (D/ARS): The Central Office employee responsible for the oversight, coordination, and direction of the ARS program within the Department.
- H. EARLIEST PROJECTED RELEASE DATE (EPRD): The date on which a patient would be entitled to discharge or release from a Department facility.
- I. ELECTRONIC MEDICAL RECORD (EMR): The secure electronic system used to record all health care information for a patient, including ARS treatment records.
- J. IDOC RECORDS MANAGEMENT SYSTEM (IRIS): The Web-based program that facilitates the digital capture and storage of document images along with associated indexing data.
- K. INDIVIDUALIZED TREATMENT PLAN (ITP): The document that specifies a patient's personal Addiction Recovery needs, goals, and measurable objectives that will be addressed, and interventions that will be implemented, during their participation in ARS.

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- L. LEVEL OF CARE (LOC): The clinically indicated intensity and frequency of services that the patient needs to meet their individualized treatment goals. There are three (3) active levels of care in the Recovery While Incarcerated (RWI) treatment program to which a patient can be assigned: 1) Residential Level of Care (RES); 2) Intensive Outpatient (IOP); and 3) Outpatient Level of Care (OP).
- M. MEDICATION ASSISTED TREATMENT (MAT): The use of FDA-approved medications that may be used in combination with counseling and behavioral interventions for the treatment of substance use disorders.
- N. MONTHLY SERVICE REPORT: The monthly report sent to the D/ARS providing information regarding ARS staffing, treatment changes, and census and outcomes data.
- O. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspective and treatment modalities in the management of patients' needs.
- P. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team staff to record, store, and review patient data, including Case Plan and Progress Reports.
- Q. OFFENDER CASE MANAGEMENT SYSTEM NOTE: A documentation entry that includes information necessary for the continuity of patient care management throughout the Department which does not include information that is protected by the Health Insurance Portability and Accountability Act (HIPAA) confidentiality guidelines and 42 CFR.
- R. PATIENT: Any incarcerated individual receiving Health Services.
- S. PROGRAM MANAGEMENT REFERRAL SYSTEM (PMRS): The electronic referral system housed within OCMS that tracks patient Program/Course participation.
- T. PROTECTED HEALTH INFORMATION (PHI): Individually identifiable information including demographic information that relates to past, present, or future physical or mental health conditions of, or provision of health care to, an individual.
- U. PURPOSEFUL INCARCERATION (PI): An initiative by which a sentencing authority (a judge or the Indiana Parole Board) agrees to consider a modification to the patient's sentence pending completion of a Department-recognized ARS program.

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- V. RECOVERY ORIENTED COMMUNITY (ROC): A dedicated housing unit set aside for participants in the Recovery While Incarcerated program designed to facilitate mutual support for patients during their recovery. All patients in Residential Level of Care will be required to live in a ROC while those in other levels of care may not.
- W. RECOVERY WHILE INCARCERATED (RWI): The Department's comprehensive addiction recovery treatment program.
- X. REGIONAL DIRECTOR OF ADDICTION RECOVERY SERVICES: The contracted employee responsible for collaborating with the Director of Addiction Recovery Services for the purpose of providing oversight, coordination, and direction of all Addiction Recovery Services within the Department.
- Y. REGRESSION: A clinical treatment decision to require a patient to repeat or complete a more intensive Level of Care based on current clinical needs being exhibited.
- Z. SUBSTANCE ABUSE MANAGEMENT SYSTEM (SAMS): The computerized system that provides for program and system administration for patients participating in ARS.
- AA. SUPPORT GROUPS: Programs including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery, and other groups designed to assist patients in maintaining recovery from substance use. These groups can be conducted by volunteers, peer recovery coaches, or patient-led self-help groups.

IV. TREATMENT STANDARDS:

- A. The overall operation of the Department's addiction recovery services (ARS) treatment, known as Recovery While Incarcerated (RWI), shall be in accordance with Policy and Administrative Procedure 01-02-106, "Addiction Recovery Services."
- B. The Department's ARS shall include assessment, treatment (including medication assisted treatment [MAT]), and referral for post-release recovery support for patients with substance use disorder(s). Continuity of care must be provided from admission to discharge from the Department, including referrals to appropriate community-based providers, in collaboration with Transitional Health Care staff.
- C. All ARS, including assessment, and treatment, shall be conducted by ARS staff within the scope of their professional credential(s), competency, and training.

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- D. All treatment interventions provided by ARS staff shall conform to accepted national professional standards, utilize standardized curricula approved by the Department, and be delivered in accordance with an Individualized Treatment Plan (ITP).
- E. Regardless of housing assignment, patients must have access to ARS assessment and treatment. ARS must be provided in a manner in which affords the patient confidentiality and provides physical protection for the staff.
- F. Each facility shall identify an ARS Facility Director (ARS FD) who functions as the coordinator for the ARS provided within the facility.
 - 1. The ARS FD shall collaborate with the Health Services Administrator (HSA), Warden, and other facility staff to ensure the facility's ARS program is properly managed and appropriate for patients who require addiction treatment.
 - 2. The Regional Director of Addiction Recovery and Regional Director of Mental Health shall identify an ARS FD and Psychologist from another facility who shall provide leadership and direction as necessary at facilities without an ARS FD or Psychologist on site.
- G. ARS is a voluntary treatment program, and a patient always has the right to refuse to participate without punishment or reprisal (unless under a court order for involuntary treatment for substance use).
 - 1. If the patient refuses the recommended Level of Care, they will be offered other engagement opportunities such as attending support groups (AA, NA, Celebrate Recovery), completing the Foundation Curriculum, utilizing recovery coach services, and all Tablet-Based Resources. These resources will not be a part of a treatment plan or time-cut eligible programming but instead allow the patient to stay engaged and encourage future participation in the recommended Level of Care.
 - 2. Every attempt must be made by the person receiving the refusal to obtain the patient's signature on State Form 9262, "Refusal and Release From Responsibility for Medical, Surgical, Psychiatric and Other Treatment."

V. RWI PROGRAM COMPONENTS AND DESCRIPTION:

- A. Independent Study
 - 1. The Foundations Curriculum consists of independent study by the patient of the Department-approved substance use education, resources, and information manual.

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The Foundations Curriculum is multifunctional in that it may be used for those who refuse to complete the recommended Level of Care, those who do not wish to participate in any organized ARS treatment programming, those seeking educational resources without the need for addiction treatment, or those who are restricted from participating in a group setting at that time due to administrative/housing restrictions (e.g., patients in restrictive status housing).

2. Facilities shall keep a sufficient stock of Foundations Curriculum at the facility to provide to patients and are responsible for re-ordering the material when inventory runs low.

B. Active Treatment / Level of Care (LOC)

There are three (3) Levels of Care in RWI in which the treatment modality consists of group sessions led by ARS staff and peers. Individual sessions should only be conducted for Individualized Treatment Plan (ITP) review or as clinically indicated.

1. Residential Level of Care (RES): the most intense Level of Care reserved for patients who need stabilized. Patients in RES will receive twenty plus (20+) hours of group treatment each week spread over five (5) or more days. This Level of Care will require a patient to live among their peers in a Recovery Oriented Community (ROC). RES Level of Care may not participate in other programs or be employed for the duration of time in RES.
2. Intensive Outpatient (IOP): The next level of services offered in the continuum for patients who are stable or have successfully completed the RES Level of Care if that was the initial treatment recommendation. Patients in IOP will receive a minimum six (6) hours of group treatment each week spread over two (2) or more days. This Level of Care is not required to live in the ROC but may if it is available and appropriate. IOP Level of Care is encouraged to participate in other programs concurrently and/or maintain employment.
3. Outpatient Level of Care (OP): Patients in OP shall receive a minimum of one hour of group treatment per week. This Level of Care is not required to live in the ROC but may if it is available and appropriate. OP Level of Care is encouraged to participate in other programs concurrently and/or maintain employment.

C. Aftercare

Enrollment in Aftercare is reserved for patients needing or desiring ongoing relapse prevention support without the structured services provided in RWI. Patients may enroll

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in Aftercare after successfully completing OP or may directly enroll in Aftercare with approval of the ARS Facility Director (ARS FD).

VI. COLLABORATION WITH OTHER FACILITY DIVISIONS:

- A. Collaboration and exchange of information across treatment and facility operational divisions is essential to providing quality care within a correctional environment. Every facility shall create and maintain a Multidisciplinary Team (MDT) in order to review conduct, safety/security concerns, Case Management needs, physical health needs, and mental health needs of patients participating in ARS. The facility MDT shall include representatives from each clinical, operational, and administrative division within the facility.

The facility MDT shall meet at a regular frequency determined appropriate by the facility, but no less than once per month, to discuss and make decisions regarding:

1. Circumstances (other than clinical assessment) that may affect patient's appropriateness for admission into ARS; and,
 2. Removing a patient from ARS for behavior such as treatment non-engagement, repeated minor conduct violations, or a pattern of violation of ARS rules and expectations.
- B. The management and treatment of mental health and psychiatric disorders is the responsibility of the contracted medical provider's Behavioral Health Services Division and is supervised by the contracted Regional Director of Behavioral Health Services. When mental illness symptoms are recognized or suspected, ARS staff must ensure the patient is referred for mental health services in accordance with current behavioral health procedures and referral guidelines. ARS and Behavioral Health staff are required to hold, at minimum, a monthly staffing of patients with co-occurring behavioral health and substance use disorders. These meetings shall be documented and kept on file with the site Health Services Administrator (HSA) for auditing purposes.
 - C. The management of acute intoxication and withdrawal is primarily the responsibility of Health Services personnel in accordance with HCSD 2.32A, "Intoxication and Withdrawal." However, consultation with ARS staff may be needed to manage acute intoxication and withdrawal, and ARS staff shall collaborate as needed with facility Health Services personnel. Patients treated by Health Services personnel for acute intoxication or withdrawal shall be referred for substance abuse assessment by the Health Services staff who place them on intoxication/detoxification hold.

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- D. Patients newly diagnosed with Hepatitis C (that is, the diagnosis was made after the patient was committed to the Department) or being treated for Hepatitis C shall be referred for substance abuse assessment by Health Services staff.
- E. ARS staff shall collaborate as needed with facility Unit Team staff for the purpose of identifying treatment goals to be documented on the Clinical Review Form for patients who are participating in the Case Plan Credit Time process and who have been identified as needing addiction treatment. A copy of the Clinical Review Form with identified goals shall be shared with the patient's Unit Team staff to coordinate treatment plan and case plan goals. Annual reviews, or reviews at the completion of addiction recovery treatment, documenting the patient's progress in addiction recovery treatment shall be completed on the Clinical Review Form and shared with the patient's Unit Team staff for consideration in their Case Plan Credit Time review.

VII. REFERRING A PATIENT FOR ARS:

- A. In routine cases, a patient begins the assessment and enrollment process for ARS via a "Refer to Substance Abuse Assessment" assignment entered in the Program Management Referral System (PMRS). However, a referral in PMRS is not required for an assessment to be initiated in urgent cases (for example, a patient who has recently overdosed or referred by Health Services).
- B. Only Case Management staff can enter a "Refer to Substance Abuse Assessment" assignment in PMRS. This assignment must be entered in PMRS in the following circumstances:
 - 1. When the "ARS Screening Note" or "Initial Assessment Note" in the Offender Case Management System (OCMS) states that a referral to ARS is indicated;
 - 2. When a patient is written up on any conduct charge related to illegal substances;
 - 3. When a patient has a positive urine drug screen (UDS) or fails to comply with a UDS request;
 - 4. When a referral is requested by ARS staff, other facility staff, or Central Office staff; and,
 - 5. Per the patient's request.
- C. The **ONLY** substance use option to which a patient should be referred in PMRS is "Refer to Substance Abuse Assessment."

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- D. Once the “Refer to Substance Abuse Assessment” assignment is entered in PMRS, Case Management’s responsibility has ended. ARS staff are tasked with managing the patient’s addiction treatment program assignments going forward. Case Management staff should not close or otherwise modify any ARS-related assignment in PMRS unless specifically requested to do so by the ARS FD. Unit Team staff will be a point of contact for ARS staff completing Clinical Review Forms for patients who are participating in the Case Plan Credit Time structure. Copies of Clinical Review Forms with newly identified goals at Intake and at each review, and reviews completed annually, or at the conclusion of a patient’s addiction treatment shall be shared with the patient’s Unit Team.

VIII. DETERMINING CLINICAL ELIGIBILITY:

- A. Establishing clinical eligibility for ARS most often begins when a patient is referred for “Substance Abuse Assessment” in PMRS. However, the clinical assessment of a patient demonstrating an urgent need for ARS intervention must not be delayed while awaiting a formal referral in PMRS. In these cases, ARS staff shall initiate the clinical assessment as soon as possible, and follow up with Case Management staff to have the formal referral entered in PMRS.
- B. Facility ARS staff shall schedule a Comprehensive Substance Use Assessment (CSUA) with all patients referred.
1. The CSUA shall take place within twenty (20) business days from the date the referral was entered into PRMS.
 2. The CSUA consists of five (5) mandatory components:
 - a. Patient Packet Review to gather pertinent information related to the patient’s biopsychosocial history, substance use history and patterns, criminal charges, and prior participation in treatment for addiction. Particular attention should be given to the patient’s pre-sentencing investigation (PSI), the mental health and nursing Intake, and the Classification Intake Summary. The packet review should include a review of the IDOC Records Management System (IRIS), patient’s hard copy, and review of the Electronic Medical Record (EMR).
 - b. A comprehensive face-to-face clinical interview with the patient, to include administration of the Department-approved behavioral health assessment tool.

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- c. Safety and Security Review to determine if there are recent conduct violations or historical involvement with trafficking, gang affiliation, or other undocumented activities that would disqualify the patient from participating in group treatment or the ROC.
 - d. Urine Drug Screen per Health Services vendor policy and procedures.
 - e. Treatment Level of Care Recommendation. Using information gathered from the CSUA and MDT, appropriately trained ARS staff shall determine the appropriate RWI Level of Care for the patient. Whenever possible or necessary, ARS staff completing the CSUA should consult with other ARS staff and/or the ARS FD regarding the appropriate treatment Level of Care for a patient.
3. ARS staff must document the completion of the CSUA in both OCMS and the EMR. The content of the documentation in each system differs, based on the information needs of the targeted reader and the requirement to safeguard protected health information (PHI). Sample language for the OCMS note and a template for the EMR entry are provided by the Department's contracted medical services provider.

IX. PROGRAM MANAGEMENT REFERRAL SYSTEM (PMRS) USE BY ARS STAFF:

- A. ARS staff are responsible for managing a patient's referral for "Substance Abuse Assessment" and for entry and management of all subsequent addiction recovery-related assignments in PMRS.
 1. It is essential that the information entered in PMRS be correct and timely to accurately convey a patient's current participation status in addiction treatment.
 2. When ending a patient's ARS-related assignment, staff must be mindful that the completion type may have different meanings depending on the patient's assignment.
- B. ARS staff shall refer to the "PMRS Use by ARS Staff" document for specific instructions on accessing the functions in OCMS.

X. SUBSTANCE ABUSE MANAGEMENT SYSTEM (SAMS):

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- A. The Substance Abuse Management System (SAMS) shall only be used for administrative management of patients participating in RWI. No clinical documentation shall be entered in SAMS.
- B. Administration tasks executed in SAMS include patient Level of Care assignments (including start and end dates for each level and completion code), ARS staff member caseload assignment, and time cut request submissions for those that opt-out of the Case Plan Credit Time (CPCT).
- C. ARS staff should refer to the “SAMS Counselor Manual” for specific instructions on accessing the functions in SAMS.

XI. ADMISSION PRIORITY AND PROCESS:

A. Admission Priority Management

Admission priority is, by necessity, a fluid situation that requires constant monitoring due to the various criteria that must be considered when determining who will next be admitted. The following guidelines will help inform admission priority but should not be considered a substitute for clinical judgment.

1. First priority regarding access to treatment will always consider clinical need above all other policies/guidelines. If the clinical presentation is severe and urgent enough (e.g., recent overdose) that immediate access to treatment is warranted, the decision to bypass the waiting list and admit a patient at the next opening, must be determined by a facility MDT meeting or by the ARS FD.
2. Admission to the program is at the discretion of the ARS FD based upon the following circumstances:
 - a. A patient who transferred into the facility while in active treatment; and,
 - b. A patient who is no more than twelve (12) months from their EPRD.
3. The remaining enrollments of patients who do not meet the previous criteria will be admitted based upon the date that their referral was entered into PMRS. PI patients will not be given special priority for enrollment; however, the ARS FD should attempt to enroll PI patients within a reasonable amount of time to allow completion of their treatment and notice provided to their sentencing judge.

B. Enrollment Procedure and Requirements

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1. After completion of the CSUA and decision about Level of Care, an individualized orientation session shall be held within twenty (20) business days of the CSUA. During this orientation session, the following activities must occur:
 - a. Review the results of the CSUA;
 - b. Create an initial Individualized Treatment Plan (ITP) that is comprehensive of goals for each Level of Care needed;
 - c. Completion and signing of State Form 46494, “Informed Consent,” and State Form 46490, “Notice of Confidentiality Guidelines;”
 - d. Signing the RWI Participation Consent; and,
 - e. Signing the contracted medical provider’s UDS Consent Form.

Patients who refuse to sign any of the required forms or otherwise participate in any component of the individual orientation session should not be admitted to treatment, and their refusal communicated to Unit Team.
2. Patients who had a waitlist date entered prior to treatment shall have another Safety and Security Review prior to enrollment in a ROC Level of Care to ensure they have not incurred any disqualifying conduct or Intelligence and Investigations involvement since their initial assessment.
3. Documentation requirements and PMRS management
 - a. ARS staff shall enter a Start Date for the patients who have a referral with a waitlist date program assignment in PMRS.
 - b. A brief note is entered in OCMS stating that the patient has begun RWI programming.
 - c. An Admission/Orientation Note is entered in the EMR using the contractor-provided template.
4. In the event that the patient was enrolled in “Foundations” and decided to enroll in treatment upon completion, or are now administratively able to participate in treatment, they shall have another Safety and Security Review prior to enrollment.

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- a. ARS staff shall enter an End Date for the patient's "Foundations" assignment in PMRS using the completion type "Transferred to Program". ARS staff shall enter an "Active" program referral assignment in PMRS and enter the Start Date;
- b. A brief note is entered in OCMS stating the patient has begun RWI programming; and,
- c. An Admission/Orientation Note is entered in the Electronic Medical Record (EMR) using the contractor-provided template.

XII. CASELOAD ASSIGNMENT AND MANAGEMENT:

- A. The ARS FD is responsible for assigning newly admitted patients to a primary ARS staff member. With limited exceptions, the expectation is that the patient will remain on that staff member's caseload throughout their participation in each Level of Care in RWI, to maximize continuity of care and ability of staff to recognize and facilitate change as the patient progresses.
- B. The ARS FD is responsible for evaluating and approving any reassignment of a patient to another ARS staff's caseload. This should only be done in rare circumstances, such as when issues of countertransference arise, or when the safety of a staff member becomes jeopardized.

XIII. RECOVERY ORIENTED COMMUNITY (ROC) MANAGEMENT:

- A. The occupancy mix of the Recovery Orientated Community is designed to be fluid, in order to meet the needs of the RWI program at each facility. There is no minimum, maximum, fixed number, or ratio of ROC beds that must be filled by patients in each Level of Care.
- B. Priority assignment of ROC beds shall be for patients in Residential Level of Care, with any remaining beds assigned to patients in the IOP or OP Level of Care. A limited number of ROC beds may be assigned to RWI graduates serving as mentors or Peer Recovery Coaches.
- C. Safety and Security Considerations
 1. Patients who represent an immediate or significant threat to the health and safety of themselves, other patients, ARS staff, or other facility staff should be removed from the ROC immediately.

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2. Patients who do not represent an immediate health or safety risk but may be engaged in other dangerous or prohibited behavior should be staffed by the MDT at the earliest opportunity, and the MDT shall determine future participation. These behaviors include active substance use, possession of illegal substances, STG activity, inappropriate sexual contact, and other behaviors that are significantly disruptive to the ROC or potentially interfere with other patients' treatment.
3. Removal from the ROC for safety and security reasons does not automatically constitute removal from RWI program but will require MDT discussion and decision about the appropriateness of continued participation in another level of RWI.

XIV. INDIVIDUALIZED TREATMENT PLAN (ITP):

The Individualized Treatment Plan (ITP) is an essential piece of clinical documentation, forming the foundation of a patient's participation in RWI. It documents the patient's strengths, resources, and protective factors as well as problem areas, treatment needs, and measurable objectives which will help the patient reach their identified goals. Goals and objectives on the ITP must be relevant to the individual and be sensitive to and respectful of cultural differences and values.

A. ITP Development Requirements

1. The ITP shall, by definition, be specific to each patient.
2. Because the creation and management of the ITP is a collaborative process between the patient and their treatment team, the development, review, and update of the ITP must only be conducted during an in-person individual session with the patient. A patient shall be provided a copy of their ITP upon request at any time and at no charge.

B. Initial ITP Development and Review/Update Timeframes

1. A patient's initial ITP shall be developed at the individual orientation session and entered in the EMR within five (5) business days of the orientation.
2. The ITP shall be reviewed a minimum every thirty (30) calendar days while in Residential Treatment and every ninety (90) calendar days while in IOP or OP Level of Care. The ITP shall be updated as necessary. The ITP for patients in After Care are required to be reviewed/updated annually. These treatment plan reviews should include a clinical note summarizing treatment goals completed, setbacks, and success during that review period.

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3. Other circumstances for which an ITP review/update is required include:
 - a. When a patient successfully completes a Level of Care;
 - b. When a patient is regressed in treatment or moved to a more intensive Level of Care; and,
 - c. When new treatment needs, goals, and/or measurable objectives are identified.
4. All ITPs (initial and review) shall be entered into the EMR using the contractor-provided template.
5. An ITP is not required for a patient enrolled in “Foundations”; however, staff shall review those enrolled every six (6) months to determine if “Foundations” referral can be closed in PMRS.

XV. PROGRESSION COMPLETION SUMMARY AND TREATMENT SUMMARY:

A Completion Summary

1. A Completion Summary is entered in the EMR, using the contractor-provided template, when a patient completes a Level of Care. In the case of a patient’s successful completion of Outpatient Treatment, the Treatment Summary (see Section B below) takes the place of the Completion Summary.
2. The Completion Summary’s purpose is to document the staff member’s clinical determination that the patient met the required competencies for a given Level of Care and summarizes the patient’s participation in treatment activities and provides a subjective observation of the patient’s behavior. The Completion Summary must also include specific measurable evidence that the patient met their identified treatment goals and objectives established for that Level of Care and the ITP must be reviewed and updated.

B. Treatment Summary

1. A Treatment Summary is completed when a patient’s participation in RWI ends, whether through successful completion, voluntary or involuntary termination, release from Department custody, or transfer to another facility.

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2. The Treatment Summary is an essential piece of clinical documentation, which serves as the record of a patient's entire participation in RWI and is sometimes made available to persons outside of the Department as a verification and clinical summary of a patient's involvement in addiction treatment. It must effectively communicate to the reader (who is often not a behavioral health professional) the growth and successes attained by the patient, ongoing concerns, and areas for continued clinical attention, and prognosis and recommendations for further addiction recovery treatment.
3. The Treatment Summary must contain information about a patient's overall participation and growth during their entire enrollment in RWI. It must document specific evidence that the patient met or did not meet the most significant identified treatment goals and objectives established on the ITP.
4. The primary ARS staff who provided treatment to the patient shall complete the Treatment Summary in cases where that is possible. If the primary ARS is unable to complete the Treatment Summary, it shall be completed by the ARS FD. The Treatment Summary is entered in the EMR using the contractor-provided template.
5. When a paper copy of the Treatment Summary is produced, it shall be signed and dated by the ARS staff that completed the summary, or the ARS FD if that staff member is unavailable.

B. Case Plan Credit Time

Patients who are participants in the Case Plan Credit Time process shall have a review of treatment goals identified on the Clinical Review Form reviewed annually; when a patient is removed from RWI treatment prior to completion; or when a patient successfully completes RWI treatment. The patient's progress or lack thereof should be documented on the Clinical Review Form and the form shall be sent or scanned to the participant's Unit Team staff.

XVI. CLINICAL DOCUMENTATION DESCRIPTION AND REQUIREMENTS:

Accurate and timely clinical documentation is an essential part of the delivery of quality clinical services. Clinical documentation shall include a patient's participation in treatment from referral through the end of their participation in services. It shall identify the patient's needs, treatment involvement, outcomes of treatment, and post-treatment recovery plans and prognosis. In addition, information contained in the clinical documentation for a patient participating in RWI becomes part of that patient's Department record, and is used by other health services providers, other

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Department divisions, the court system, and other entities to make health care and custody decisions.

A. Treatment Notes (EMR)

1. Treatment Notes document a clinical intervention or activity that takes place with a patient. Treatment Notes are entered into the EMR only, since they contain protected health information (PHI) which is subject to protections under the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR.
2. Treatment Notes must be entered within five (5) business days of the date the activity occurred, or in the case of Weekly Progress Notes, within five (5) business days of the end of the seven- (7-)day period covered by the note.
3. Treatment Note types and descriptions
 - a. CSUA Note – entered when a CSUA is completed with a patient and the orientation session has been concluded.
 - b. Weekly Progress Note – entered for every patient enrolled in Residential and Intensive Outpatient treatment, summarizing their participation in all treatment interventions during a 7-day calendar period. A Weekly Progress Note is required even if a patient does not participate in any treatment activities during the 7-day period, so any gaps in treatment are appropriately documented and the reason made clear to a reviewer.
 - c. Treatment Plan Review – entered following an individual session with the patient. It shall determine if they completed the current LOC and can be progressed, or document the reason(s) why the patient should remain in the current LOC.

B Administrative Notes (EMR)

Administrative Notes are entered as needed to document activities other than treatment sessions or interventions that are relevant to the patient's participation in RWI, such as:

1. Communication with outside offices or agencies pertaining to the patient's participation in ARS (e.g., phone calls and/or letters to a court or the Indiana Parole Board).
2. Outcome from a facility MDT meeting.

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3. Temporary interruptions in treatment, such as the patient being out to court, extended facility lockdown, long-term medical treatment for the patient, etc.

C. OCMS Notes

1. In addition to entering clinical documentation in the EMR, ARS staff are also responsible for entering various non-treatment administrative documentation into OCMS. These OCMS Notes are vital for communicating information necessary for the continuity of patient holistic case management to Department staff who are not treatment providers.
2. OCMS Notes must be entered within five (5) business days of the date the activity occurred. Since OCMS Notes are intended for use by Department staff, contractors, and other persons who are not health care or treatment providers, they must not contain PHI or information that is protected by HIPAA and 42 CFR.
3. OCMS Note types and description
 - c. Initial Assessment Note – states the CSUA was completed and provides information about the disposition and/or recommendations for RWI. In the event this was completed before a referral was placed by Case Management staff, this will give the direction for them to enter a referral for assessment as well.
 - d. Enrollment Note – provides the date a patient was admitted into RWI and whether the patient is able to participate in another time cut-eligible program or employment.
 - e. Refusal Note – states a patient refused to participate in any component of RWI.
 - f. Discharge Simple Note – states the date patient was discharged from RWI.

XVII. ADMINISTRATIVE REPORTING:

A quantitative Monthly Service Report shall be submitted via email no later than the tenth (10th) of each month to the contracted Regional Director of Addiction Recovery Services and the Department's Director of ARS. All clinical and administrative documentation must be completed prior to submission of the Monthly Service Report. The Monthly Service Report shall be

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completed using the ARS contractor-developed (-or provided) templated approved by Director of ARS.

XVIII. DRUG AND ALCOHOL TESTING/ILLCIT SUBSTANCE POSSESSION:

- A. The RWI program shall include drug and alcohol testing as an integral part of patient accountability. Routine drug and alcohol testing shall be conducted in accordance with the contracted medical vendor's policy and procedures.
- B. A positive test for drugs or alcohol, admission of use, or a conduct charge related substances shall not automatically cause a patient to be dismissed from ARS. Substance-related incidents involving ARS participants shall be reviewed by the facility MDT to determine the appropriate response and intervention. Immediate termination from the program, removal from the ROC, clinical regression to an earlier Level of Care, or other sanctions shall all be considered within the scope of response.

XIX. REMOVAL OF PATIENTS FROM RWI:

Terminating a patient from RWI is almost always a last resort, especially when there is no serious conduct violation or other obvious justification for removing the patient. There are significant clinical and administrative ramifications to consider before deciding to terminate a patient from addiction treatment. For this reason, it is strongly recommended that all applicable clinical interventions be attempted first, including, but not limited to extra assignments, treatment plan revision, referral to additional services such as Behavioral Health, and regression in treatment level. Clinical interventions to address problematic behavior must be documented thoroughly, as well as the patient's response to those interventions. This provides valuable information for the MDT to consider when deciding whether to terminate a patient.

- A. In many cases, a conduct report is not generated as a result of a patient's actions. Other times, the conduct report is rescinded, dismissed, or overturned at appeal. Therefore, a patient may be removed and terminated from treatment after a facility MDT consensus decision or after consultation with the Director of ARS or higher-ranked employee.
- B. No matter the reason for termination the RWI termination form must be signed by the facility RWI/ARS Director and maintained on file by the Addiction Recovery Department and documentation for the reason placed in EMR.
- C. If the patient is removed from RWI, they will continue to be offered other engagement opportunities such as attending support groups (AA, NA, Celebrate Recovery), completing the Foundation Curriculum, utilizing recovery coach services, and all Tablet-Based Resources.

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XX. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing adult patients.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title THERAPEUTIC RESTRAINT

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References:
IC 11-8-2-5 IC 34-4-12.6	01-02-101 02-01-112	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidelines for the therapeutic use of highly restrictive interventions in the treatment of patients with mental illness. This HCSD is not applicable to restraints used for security reasons for the movement of patients from place to place, prevention of escape, etc.

II. DEFINITIONS:

For the purposes of this HCSD, the following definitions are provided:

- A. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.
- B. QUALIFIED MENTAL HEALTHCARE PROFESSIONAL (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- C. RESTRAINT: Any manual method, physical or mechanical device, material or equipment that restricts body movement by immobilizing or reducing the ability of the patient to move his or her arms, legs, body or head freely. Orthopedic devices, surgical dressings, protective helmets, or other devices used to provide support or to protect the patient during activities of daily living are not considered restraint. "Fixed restraints" refers to restraints that are attached to a fixed object (for example, top of bed), while "ambulatory

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restraints” refers to restraints that are only fixed to the person (such as handcuffs).

III. GUIDELINES:

The safe management of patients with mental disorders may, on occasion, require restrictive and/or intrusive interventions. Restraint is a safety intervention of last resort, to be used only when an individual poses an imminent danger to self or someone else.

When establishing the mental health treatment plan, mental health staff shall consider the patient’s risk of violence, previous restraint history, emotional triggers, and environmental stressors which may lead to self-destructive behavior. Staff should also establish de-escalation strategies or safety plans with patients to help reduce the need for restraint in the future. This plan shall be included as part of the treatment plan.

Therapeutic restraint shall be used in mental health treatment only when the intervention is necessary to ensure the physical safety of the patient or the safety of others. These interventions must not be used simply because a patient is loud, rude, non-violently disruptive, or non-compliant.

Health Services personnel are absolutely forbidden to utilize restraints for purposes of retaliation, punishment, or for any disciplinary purpose.

Emergency and involuntary psychotropic medication shall be used only when it is necessary to ensure the physical safety of the patient or the safety of others. Administration of emergency psychotropic medication shall meet the guidelines and follow the procedure established in Health Care Services Directive 4.04A, “Emergency Involuntary Psychotropic Medications.” Administration of non-emergent psychotropic medications shall meet the guidelines and follow the procedure established in HCSD 4.05A, “Involuntary Psychotropic Medication Administration—Non-Emergent.”

Restraints may be used only after less restrictive documented interventions have failed to protect the patient and others from harm or less restrictive measures have been considered and determined to be ineffective. Documentation of efforts for less restrictive treatment alternatives shall be entered into the electronic medical record (EMR) as soon as possible.

In order of increasing restrictiveness, the interventions available for addressing dangerous and destructive behavior by patients with mental illness or altered mental status are:

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- A. Verbal intervention and increased surveillance by staff;
- B. Close Observation or Safety Precautions;
- C. Constant Suicide Observation
- D. Short-term physical or mechanical restraint;
- E. Emergent involuntary medication used to manage severe behavioral manifestations of mental illness; and,
- F. Emergent involuntary medication use in combination with any of the measures listed above.

A Registered Nurse (RN) must be physically present, on site, whenever restraints are used.

When restraint is necessary, it must be:

- A. Implemented in a written modification to the patient's plan of care in the EMR; and,
- B. Implemented in accordance with safe and appropriate restraint techniques.
- C. Discontinued when clinical parameters or specific behavior goals are met that support the removal of restraints, regardless of the amount of time identified in the restraint order.

The use of therapeutic restraint may be implemented **only** on the order of a physician after reaching the conclusion that less restrictive measures would not be successful. Orders for the use of restraint must never be written as a standing order or on an as-needed basis (i.e., PRN). When an on-call physician, who is not the patient's attending psychiatrist, initiates the order for restraint, the attending psychiatrist shall be consulted as soon as possible, but no later than the next business day.

In emergency situations, when restraint is necessary for the management of violent or self-destructive behavior which jeopardizes the immediate physical safety of the patient or others, an RN, psychiatric nurse practitioner, psychologist, or other licensed independent practitioner may initiate restraint and obtain a verbal or telephone order from the attending or on call physician as soon as possible. This order must be obtained within one (1) hour after the patient is placed in restraint.

Whenever restraint is used, the nurse responsible for obtaining the order must document the following information in the EMR:

- A. Events leading up to the use of therapeutic restraints;
- B. A description of the patient's behavior;
- C. The other methods of management attempted or the reasons other methods were not attempted first;

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- D. The type of restraints used;
- E. The initial one (1) hour face-to-face evaluation and any subsequent evaluation(s) which were completed;
- F. All contacts with the attending psychiatrist or physician; and,
- G. The length of time restraints were ordered.

The prescribing physician or on call physician must identify the clinical parameters or specific behavior changes that support the removal of restraints.

The order for restraint may not exceed four (4) hours without being renewed by the attending psychiatrist or on call physician.

Restraints must be discontinued at the earliest possible time when specific behavioral criteria have been met. For this reason, periodic assessment of the patient's mental status and adherence to behavioral objectives must be completed on the following schedule:

Within one (1) hour after the patient is placed in restraints and every two (2) hours thereafter, the must be seen face-to-face by qualified mental healthcare professional (QMHP) or a Registered Nurse trained to perform mental status assessments to determine:

- The patient's current mental status;
- The patient's reaction to the restraint;
- The patient's medical condition
- The patient's behavioral condition; and,
- The need to continue or terminate the restraint.

After four (4) hours, the RN must obtain a new order to continue the intervention. The order may be renewed every four (4) hours up to a maximum of twenty-four (24) hours. At twenty-four (24) hours, before a new order for restraint may be implemented, either a QMHP (during regular business hours) or RN (if after business hours) must perform a comprehensive mental health assessment, completing the mental status exam in the behavioral health progress note or behavioral health suicide observation templates of the EMR and the assessment must be shared with the attending psychiatrist. Restraint may be continued if the patient remains acutely suicidal or poses a threat of serious physical harm to self or others and less restrictive interventions will not provide adequate safeguards.

At the end of seventy-two (72) hours, if restraint is still necessary for the safety of the patient or others, the treating psychiatrist must conduct a face-to-face evaluation of the patient. The treating psychiatrist must consult with the Health Services

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vendor's Regional Director of Psychiatry for direction regarding ongoing management.

The use of restraints, including all monitoring and support activities, must be documented in the EMR and on applicable State forms.

V. RESTRAINTS:

A patient is to be therapeutically restrained in situations in which serious violence or injurious acts to their selves have occurred, or are determined to be imminent, and other interventions have not been effective or have been determined to be inadequate or clinically inappropriate.

Therapeutic restraint is contraindicated if the patient has significant health problems requiring immediate care.

A notice shall be posted by the Health Services Administrator (HSA) in the Health Services area and in the Control Center indicating the location of therapeutic restraints in the facility.

The types of restraints that may be applied are:

1. Mittens;
2. Helmet;
3. Four-point restraints on a bed; and,
4. Restraint chair

Padded leather or other soft medical restraints shall be used unless there is reason to believe that soft restraints will not achieve restraint, **and** such reason(s) is (are) documented by the ordering physician. Security restraints, such as leg irons, waist chains, handcuffs, etc., shall generally not be used as therapeutic restraints unless ordered by the attending psychiatrist or on-call physician for protection from harm under extreme circumstances. This is applicable both to ambulatory and fixed restraints. When fixed restraint is used, the patient shall be restrained on a bed face-up in a relaxed position with arms at the sides or in a seated position in the restraint chair.

A patient shall never be face-down, hog-tied, or spread-eagled.

Therapeutic restraints shall be applied by Custody staff who have been trained, with documentation of training, in appropriate methods for applying therapeutic restraints. The application of therapeutic restraints must be conducted under the supervision of Health Services staff. In health settings when delay may be dangerous, Health Services staff are permitted to make the initial application of

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restraint, even using gauze ties as necessary, provided they have documented training in restraint application. Such application shall be very short term and requires continuous supervision.

The patient's clothing shall be removed only if ordered for clinical or security reasons. If clothing removal is ordered, the reasons for this order must be documented in the EMR. Minimally, the patient shall be allowed to wear appropriate underwear.

Once the patient is restrained, Custody staff who have received documented mental health training must physically observe the patient every fifteen (15) minutes, at staggered intervals. Camera monitoring is allowed but staff must continue the physical observation at fifteen (15) minute intervals until the restraints are removed.

Vital signs including blood pressure, radial pulse, and respiratory rate must be obtained and documented every four (2) hours while the patient is restrained.

Range of motion activities shall be conducted jointly by Custody and Health Services staff, for each limb, one (1) limb at a time, every two (2) hours. When possible, skin integrity shall be assessed when range of motion is performed.

Nursing staff shall assess circulation to all four (4) extremities every two (2) hours including an assessment of capillary refill, the patient's ability to move fingers and toes, and the presence or absence of edema. The last circulation check shall be completed two (2) hours after restraints have been removed.

The patient shall be offered liquids and the opportunity to attend to physical needs (i.e., use of toilet facilities, personal hygiene, etc.) every two (2) hours. This may be accomplished by providing the patient with a bedpan or urinal or partially removing the restraints to fulfill the necessary functions.

Medication shall be administered only as needed and as ordered by the psychiatrist or other physician on a voluntary basis unless the patient meets criteria for involuntary medication.

Therapeutic interventions, other than medication should be continued by behavioral health staff to the extent possible.

A no-utensil/no-packaging diet may be offered if the patient is in restraints for longer than six (6) hours.

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Restraints must be discontinued when clinical parameters or specific behavioral goals identified by the prescribing psychiatrist or on-call physician are met. Trained Custody staff shall remove the restraints under the supervision of Health Services staff. Following the removal of the restraints, the patient may be placed under close or constant observation until it is determined by a QMHP that this level of supervision is no longer necessary.

After being released from the therapeutic restraints, should the patient renew the behaviors that led to the application of therapeutic restraints, the patient may be placed in therapeutic restraints again, with a new order. At this point, the twenty-four (24) hour limitation begins again, and the situation is treated as a new incident.

Therapeutic restraints must be removed immediately, in their entirety or in part, in an emergency so that timely emergency services may be provided.

Custody and Health Services staff must adhere to the reporting requirements including the completion of any use of force forms found in Policy and Administrative Procedure 02-01-112, "The Use of Restraint Equipment with Adult Offenders."

Once restraint has been discontinued, the treatment plan shall be updated and a debriefing with the patient must be completed by a QMHP on the next business day and on State Form 56887, "Individual Debrief." This debriefing and the completed form shall be documented in the EMR. There should be a focus on symptom recognition, triggers that led to the crisis, and problem solving or conflict resolution skills that could have been used. There should also be a focus on strategies to manage emotions effectively through de-escalation and the interventions implemented to avoid placement in restraints in the future. A copy of State Form 56887 should be shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance Manager, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the date restraint use was discontinued.

A second debriefing with the Multidisciplinary Team including the psychiatrist, a representative from the Department's administration, Behavioral Health staff, and Custody staff, must be completed within one (1) week of the use of restraint on State Form 56888, "Multi-Disciplinary Team Debrief." This formal debriefing/after-incident review must review environmental stressors, staff responses, and whether the de-escalation or safety plan(s) was (were) appropriately implemented to identify and implement any modifications to the environment, unit procedures, processes, or staff training to reduce the chance of restraint being necessary in the future. A summary of this team debriefing and the completed form shall be documented in the patient's EMR. A copy of State Form 56888 should be

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shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance Manager, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the Multidisciplinary Team meeting.

VI. STAFF TRAINING:

All staff that are expected to manage patients in restraints must be trained at new employee orientation and annually. Successful completion of training and demonstration of competency must be documented in staff training records.

Custody staff must be sufficiently trained on:

- A. All provisions of this HCSD;
- B. The proper use of restraint;
- C. The application of restraints;
- D. Required monitoring activities;
- E. Maintaining nutrition and hydration during restraint;
- F. Range of Motion activities; and,
- G. Release from restraint procedures.

Health Services staff must be trained on:

- A. Techniques to identify actions, circumstances, events, and environmental factors that may trigger behaviors which result in the use of restraint;
- B. The use of nonphysical intervention skills which may reduce the need for restraint;
- C. Selecting the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition;
- D. The safe application and use of all types of restraint used including training in recognizing and responding to signs of physical and psychological distress (e.g., positional asphyxia);
- E. Monitoring, assessment, and the provision of care for a patient in restraints including the expectations and parameters of face-to-face evaluations; and,
- F. Identification of specific behavioral changes that indicate restraint is no longer necessary.

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Health Services staff who are expected to apply therapeutic restraints in an emergency shall be trained in the appropriate use and application of therapeutic restraints.

VII. OUTCOME MONITORING:

On the day that restraints are initiated, the HSA or designee shall notify the CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health on the use of restraints, including but not limited to the patient who was restrained, episode of restraint and duration of each use of restraint.

A copy of State Form 56887 "Individual Debrief" should be shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance Manager, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the date restraint use was discontinued.

A copy of State Form 56888 "Multi-Disciplinary Team Debrief" should be shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance Manager, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the Multidisciplinary Team meeting.

Every time that restraints are used, the usage shall be reviewed by the site's Quality Assurance Manager to ensure that the usage was carried out in accordance with this HCSD and that all requirements were met. Restraint usage that does not comply with the requirements in this directive shall be reviewed as a sentinel event during the Clinical Critical Incident review in accordance with HCSD 2.24, "Clinical Critical Incident Review." Use of restraints shall be documented on the facility's monthly Health Services Report and shall be reviewed for quality assurance.


VIII. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Behavioral Health Standards

I. PURPOSE:

Incarcerated adults with mental health needs shall have access to comprehensive mental health services. This Health Care Services Directive (HCSD) provides an overview of the delivery of mental health services in adult facilities.

II. DEFINITIONS:

For the purposes of this Health Care Services Directive, the following definitions are presented:

- A. APPRAISAL: An act of assessing or evaluating someone or something.
- B. ADDICTION RECOVERY SERVICES (ARS): The entire continuum of services and programming offered at IDOC facilities for the treatment of problematic substance use.
- C. CAPACITY EVALUATION: The assessment of one's ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.
- D. CASE PLAN CREDIT TIME (CPCT): CPCT is an earned credit time cut structure that is driven by the needs indicated in the IRAS and incentivized through the individual case plan to provide each individual the opportunity to earn the maximum credit time as allowed by law.

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- E. CO-OCCURRING DISORDERS: A condition in which an IDP has at least one diagnosable mental illness along with one or more substance use disorders.
- F. GRAVELY DISABLED: A condition in which a patient, as a result of a mental illness, is unable to independently and successfully perform activities of daily living.
- G. INDIVIDUAL TREATMENT PLAN (ITP): A series of written statements specifying a course of mental health services for a patient and the roles and responsibilities of staff in carrying out the course of mental health services.
- H. IPAS SETTLEMENT: A settlement between the Department and the Indiana Protection and Advocacy Services Commission (IPAS) that states incarcerated individuals who are classified as Seriously Mentally Ill may not be housed for more than thirty (30) consecutive days in restrictive status housing, other than under the rare exceptions as detailed in HCSD 2.21A, "Evaluation of Incarcerated Individuals in Restrictive Status Housing."
- I. MENTAL HEALTHCARE PROFESSIONAL (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- J. MENTAL HEALTH SERVICES: The use of a variety of psychosocial and pharmacological therapies, provided individually or in groups, including biological, psychological, and social interventions to alleviate symptoms, eliminate maladaptive behavior, attain appropriate functioning and prevent relapse.
- K. MENTAL HEALTH UNIT: A housing unit dedicated to the provision of mental health services to incarcerated individuals who are unable to function in a standard prison environment as a result of a mental illness.
- L. MENTAL ILLNESS: A psychiatric disorder that substantially disturbs an individual's thinking, feeling, or behavior, and impairs the individual's ability to function.
- M. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.

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- N. PSYCHIATRIC PRESCRIBER: A physician or nurse practitioner authorized to prescribe medications for the treatment of mental illness.

III. GUIDELINES:

- A. Mental Health Services within the Department shall include screening for mental illness, evaluating mental illness, and treating patients with mental illness.
- B. Each facility must have a sufficient number of QMHPs to complete the above. QMHPs are expected to provide these services as well as prepare for discharge planning by communicating these needs to the Transitional Healthcare Division for continuity of care into the community. .
- C. QMHPs are also expected to assist in training all staff in Suicide Prevention and Intervention for new employee and annual in-service training, the treatment component of the Certified Treatment Specialist training for all staff who work in mental health units and participate in the training for Suicide Watch Companions and mentors.
- D. Each facility shall have identified a lead QMHP who functions as the coordinator for the mental health services provided within the facility. The lead QMHP shall collaborate with the Health Services Administrator, Warden, and other facility staff to ensure the facility's mental health services are properly managed and available. At facilities without a psychologist, the contracted vendor's Regional Director of Behavioral Health or designee, shall identify a psychologist and psychiatrist from another facility who shall provide leadership and direction as necessary.
- E. Mental Health Intake Appraisals, and diagnostic testing shall be carried out by QMHPs as appropriate to their professional scope, competency, and training. Such functions may include interviews and behavioral observations as well as administering, scoring, and interpreting instruments for assessment, diagnosis, and treatment planning.
- F. All treatment interventions by QMHPs must inform patients, in writing, of the limits of confidentiality at the initiation of mental health treatment.
- H. Regardless of housing assignment, patients must have access to mental health services necessary to screen for, evaluate, and treat mental illness. Mental health services must be provided in a manner which affords the patient confidentiality and provides physical protection for the staff.

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- I. All incarcerated individuals shall be screened for mental illness and suicide risk by a mental health trained nurse or QMHP at Intake, within twenty-four (24) hours of admission to a restrictive status housing unit (HCSD 2.21A, "Evaluation of Incarcerated Individuals in Restrictive Status Housing"), or upon transfer to a new facility (HCSD 2.07A, "Inter-Facility Transfers,") and annually (HCSDA 2.08, "Annual Health Screen").

All incarcerated individuals shall be assessed for mental health needs by a mental health provider at Intake, within seventy-two (72) hours of admission to a restrictive status housing unit, and within one (1) business day of admission to a mental health unit.
- J. Mental health services shall be provided to all incarcerated individuals who need mental health treatment in accordance with an ITP. Psychiatric services shall be provided, when necessary, in accordance with the ITP.
- K. Mental health staff shall identify treatment goals to be documented on the Clinical Review Form for clients who are participating in the Case Plan Credit Time process and who have been identified as needing mental health treatment. Annual reviews documenting the client's progress in mental health treatment shall be completed on the Clinical Review Form annually during the client's regularly scheduled 90-day or 180-day mental health appointment. A copy of the Clinical Review Form with feedback on goal progress shall be shared upon request with the client's Unit Team staff to be considered in the client's Case Plan Credit Time review.
- L. Diagnosis of mental illness must be coded using the most current standard of care outlined in the Diagnostic and Statistical Manual of Mental Disorders. Current diagnoses must be listed on the "Problems," or "Diagnosis" tab within the electronic medical record (EMR). In addition, the "Treatment Plan" template must be kept current, with problems entered as "new" and noted as "resolved" when appropriate.
- L. Each facility shall maintain an accurate roster of patients with mental health needs. Patients with identified mental health needs shall be seen at a minimum of one (1) time each ninety (90) day period by a QMHP to monitor their mental health needs, and progress toward goals identified on their treatment plan. Patients who have been prescribed psychotropic may be seen, no less than every one hundred eighty (180) days by a prescriber only, per the ITP.

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- M. A patients with a serious suicide attempt or self-injurious behavior shall be identified as a “D” Behavioral Health code and shall remain in treatment for a minimum of one year post incident to ensure appropriate treatment and monitoring. Additionally, patients who present to the Department upon Intake with a serious suicide attempt history prior to their incarceration will be monitored as a “D” Behavioral code for one year to ensure stability of mental health needs, appropriate adjustment to incarceration, and provide education to patients of behavioral health services available during their incarceration. Following the year, in both cases, the treating clinician can determine the client’s risk for continued suicidal ideation and behavior and identify which Behavioral Health code most accurately represents the patients continued behavioral health needs.
- N. Incarcerated individuals found guilty but mentally ill in accordance with IC 35-36-2 shall be screened, evaluated, and treated in the same manner as all other patients.
- O. The management and treatment of substance use is the responsibility of the Director of Addiction Recovery Services and the Health Services vendor’s Regional Director of Addiction Recovery Services. Incarcerated individuals are screened at Intake for the presence of substance use (acute intoxication, withdrawal, and history) including alcohol and other drugs. When substance use is recognized as a need by anyone within Behavioral Health Services or Custody, the incarcerated individual shall be referred for addiction recovery services in accordance with current ARS procedures and referral guidelines. QMHPs and ARS staff shall work collaboratively to address the needs of patients with co-occurring disorders.
- P. The management of intoxication and withdrawal is the responsibility of Health Services personnel who address physical needs. However, psychiatric consultation and services may be needed and, when necessary, they shall be provided in collaboration with the physical health primary care provider. A referral shall be made to Addictions Recovery Services in every instance of intoxication and a referral to mental health as clinically indicated by Health Services staff personally treating the patient.
- Q. The management and treatment of incarcerated individuals who are convicted of sexual offenses and required to participate in programming as a result is the responsibility of the Sex Offender Monitoring and Management (SOMM) Program staff. If there are co-occurring disorders present, QMHPs and ARS staff shall work in collaboration with the staff from the SOMM Program to provide appropriate treatment.

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R. In order to prevent dual relationships, professional conflicts of interest, adversarial relationships with other governmental entities, and/or other ethical/professional dilemmas, QMHP's shall not provide the following services:

- Competency evaluations requested by the judiciary or other third parties;
- Pre-sentence psychological evaluations regardless of the referral source;
- Employee assistance assessment or counseling; or,
- Special assessments (e.g., prediction of violence, recidivism, or other future behavior) requested by an entity outside the Department.

IV. CONTINUUM OF CARE:

Clinical mental health services including intake services, routine interventions, crisis management and special needs services shall be available to all patients. Mental health services shall be provided in the least restrictive setting in which the patient's mental illness may be managed. When specialized mental health services are required, the patient shall be transferred to a mental health unit which is most suitable for the patient's treatment needs. Acute stabilization services (e.g., emergency psychotropic medication) shall be provided, when necessary, prior to any transfer to a mental health unit as appropriate.

Intake services are available at all facilities that accept transfers from outside the Department. These services include mental health screening, Intake appraisal, and evaluation to determine mental health needs and plan for treatment in accordance with HCSD 2.02A, "Reception Screening."

Routine services are available at general population facilities and, to a limited extent, at work release centers. These interventions include screening, evaluation, treatment planning, individual and group therapies, psychoeducation, and discharge planning. Routine psychiatric interventions include evaluation, medication management, and the use of involuntary medications in accordance with Health Care Services Directive 4.05 "Involuntary Psychotropic Medication Administration – Non Emergent."

Crisis management services are available at general population facilities, work release centers, and mental health units twenty-four (24) hours per day. These services include evaluation and stabilization to ensure safety. Psychiatric crisis management includes evaluation, stabilization, and the use of emergency involuntary psychotropic medications in accordance with HCSD 4.04A, "Emergency Involuntary Psychotropic Medication."

Specialized mental health services are available at mental health units located at the New Castle Correctional Facility, Wabash Valley Correctional Facility, and Pendleton Correctional Facility for male patients and the Indiana Women's Prison for female patients.

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Services provided include all of the above, as well as increased individual and group therapy, behavioral modification, and psychoeducation services in a highly structured environment. . Discharge planning for patients receiving intensive mental health services shall involve a comprehensive multidisciplinary treatment team approach.

V. CLINICAL SERVICES:

A. Intake Services

Staff working at Intake units processing new intersystem arrivals and parole violators shall obtain information from the transporting officer regarding the incarcerated individual's conduct and demeanor during transport. Incarcerated individuals who are lethargic or difficult to arouse or acting strangely or in a bizarre manner shall be seen immediately by the nursing staff.

1. Nursing Screening

All incarcerated individuals shall be screened by a mental health-trained nurse as soon as possible after arrival. When emergency mental health needs are identified, the patient shall be immediately evaluated by a QMHP. If a QMHP is not on site, the nurse shall contact the appropriate QMHP for direction. For patients who are potentially suicidal, the patient must be placed under direct visual observation until an evaluation by, or consultation with, a QMHP has been completed.

2. Mental Health Intake Appraisal

Within fourteen (14) days of an incarcerated individual's arrival to an Intake facility (inter-system transfer), or as a parole violator (intra-system transfer), a QMHP must perform a Mental Health Intake Appraisal.

The comprehensive Mental Health Intake Appraisal shall include use of a structured interview that addresses and documents the following areas:

- Current mental status, symptoms, and condition including orientation to person, place and time, and response to incarceration;
- Review of available historical records of inpatient and outpatient psychiatric treatment and treatment with psychotropic medications;
- History of or current suicidal potential and person-specific circumstances that increase suicide potential;
- Past psychiatric hospitalization and outpatient treatment including

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psychotherapy, psychoeducational groups, and classes or support groups and treatment with psychotropic medication;

- Assessment of Drug and alcohol use, history, and treatment;
- Educational history including special education placement;
- History of sex offenses or sexual abuse-victimization and predatory behavior;
- Assessment of violence potential and person-specific circumstances that increase violence potential;
- History of traumatic life events and losses;
- History of violent behavior directed towards others or property
- History of victimization;
- History of prior suicide attempts or self-injurious behavior;
- History of cerebral trauma or seizures;
- Emotional response to incarceration;
- Estimation of overall intellectual abilities
- Need for referral for further mental health evaluation and treatment, as indicated;
- Development and implementation of a treatment plan, including recommendations concerning housing and job assignment and program participation; and,
- Use of additional assessment tools, as indicated.

B. Mental Health Transfer Screen

Patients transferring from one Department facility to another Department facility with a behavioral health code of “B” or higher shall be evaluated by a QMHP to include the following information within fourteen (14) days of arrival:

- Mental Status Examination
- Suicide Risk Assessment
- Review of current Behavioral Health code, diagnosis, Treatment Plan, and Clinical Review Form when applicable for accuracy. These shall be developed or updated as needed.
- Consent for Treatment and Limits of Confidentiality
- Referral to Psychiatry, if indicated
- Referral to Addiction Recovery Services, if indicated

C. Routine Services

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Routine services are available at general population facilities and to a limited extent work release centers.

1. Consent and Confidentiality

QMHPs are responsible for obtaining patient's informed consent prior to providing treatment by completing State Form 48429, "Consent for Treatment and Limits of Confidentiality," located in the EMR document library, prior to undertaking any therapeutic intervention other than crisis management.

2. Requests and Referrals for Service

All patients, regardless of Behavioral Health code, may access mental health services by submitting State Form 45913, "Request for Health Care Services (HCRF)" and seen in accordance with the provisions of HCSD 2.01A, "Access to Care." Nursing staff shall collect HCRFs daily and screen for needs requiring emergent or urgent attention. Patients requiring crisis stabilization services or who have an urgent or emergent mental health concern shall be identified and seen immediately by a QMHP. If Behavioral Health staff are not on-site nursing staff shall contact a QMHP for direction.

For routine Behavioral Health needs, nursing shall properly triage. As HCRFs often contain incomplete information, it may be necessary to conduct a face-to-face interview before establishing a priority for subsequent individual or group treatment. This Behavioral Health screening shall be completed within seven (7) calendar days of receipt of State Form 45913 unless there is a documented justification otherwise.

In some situations, patients may repeatedly request to be seen for unnecessary services. As long as there is not a new concern or a change in circumstances the QMHP may document that the appropriate assessment or review has already been completed, there is no need for another assessment or treatment, and notify the patient of that decision by responding on State Form 45913. Care must be taken to ensure new problems are assessed when reported.

All staff referrals shall be seen by mental health within 7 days as outlined in HCSD 2.01A, "Access to Care."

3. Treatment Planning

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Individual Treatment Plans (ITP) are formal written plans that identify serious mental health conditions referenced from the list of diagnoses in the EMR and include treatment modalities and interventions to be used to address the problem(s).

ITPs must be unique and specific to the patient and include the problem being addressed, a list of goals and objectives specific to the problems, and a description of the specific interventions to be provided. The treatment plan shall include the staff responsible for the interventions to be provided and the frequency or interval of follow up encounters.

Patients receiving mental health services must be seen in accordance with the time frames established in the ITP. Mental Health staff responsible for implementing the treatment plan must chart the patient's progress at each treatment plan review.

Treatment plans must be reviewed and revised at a minimum in accordance with the following time schedule:

- General population units, every six (6) months;
- Specialized mental health units, every three (3) months;
- Restrictive status housing units, every six (6) months.

ITP goals will also be used in the Case Plan Credit Time (CPCT) process for patients who have opted in prior to January 1, 2022 or entered the Department on or after January 1, 2022. Goals shall be documented on the Clinical Review Form when a patient is participating in the CPCT process. A copy of the Clinical Review Form with identified goals shall be uploaded in the EMR. Annually during the patient's regularly scheduled 90- or 180-day contact, mental health staff shall complete a review of the established Clinical Review Form, documenting progress the patient has made toward goals. A copy of the completed Clinical Review Form shall be provided to the patient's Unit Team staff upon request. A new Clinical Review Form with newly identified or continued goals shall be completed at Intake at each review unless mental health services are no longer required.

5. Mental Health Therapies

QMHP's shall provide individual and / or group therapies as appropriate to the mental health needs of the patient and in accordance with the patient's ITP.

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6. Psychoeducation

QMHP's and bachelor's degree-level staff shall provide psychoeducational groups to the patient as appropriate to the mental health needs of the patient and in accordance with their ITP.

7. PREA Follow-Up

If at any time during incarceration the patient indicates they have experienced prior sexual victimization or perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, mental health staff shall be notified. Mental Health staff shall ensure the patient has been offered services previously for this victimization and/or perpetration or is offered mental health services in line with other referrals and seen within seven (7) days.

8. Psychiatric Evaluation and Treatment

Psychotropic medications are to be used for the management of symptoms of a mental illness when such medication is the accepted treatment.

A patient who has been referred for routine psychiatric evaluation shall be seen within seven (7) days of the referral. At a minimum, the psychiatric evaluation shall include:

- The patient's current complaint or reason for the evaluation;
- A notation regarding the symptoms the patient is experiencing including comments regarding severity, associated features and precipitating and aggravating factors if indicated;
- A review of the patient's past physical and mental health history;
- An inquiry into the patient's alcohol and substance use;
- Outcome of a mental status exam; and,
- A functional assessment.

The patient who requires psychotropic medication shall complete an informed consent for treatment with psychotropic medication form. The medical provider's specialized consent forms may be used upon approval of the Chief Medical Officer (CMO), or Executive Director of Behavioral Health. No psychotropic medication shall be provided if the patient declines to sign the consent unless the patient is considered gravely disabled or dangerous and the involuntary psychotropic medication process has been initiated in

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accordance with the provisions of HCSD 4.04A, “Emergency Involuntary Psychotropic Medication,” or HCSD 4.05A, “Involuntary Psychotropic Medication Administration – Non-Emergent.”

Psychotropic medications should be prescribed judiciously for the management of distinct target symptoms and treatment goals and initiated with the patient’s consent, only after reviewing the potential risks, benefits, side effects, and alternatives with the patient. The use of psychotropic medication should be voluntary unless a psychiatric emergency exists or the patient is receiving treatment under involuntary psychotropic medication guidelines. Psychotropic medications should never be prescribed solely for disciplinary reasons.

Once medication therapy has been initiated, the patient must be seen by a prescriber and reassessed within thirty (30) days, even if the patient is noncompliant with the treatment plan or refuses other mental health services. Any patient who is prescribed a psychotropic medication shall be seen at a minimum of one time each one hundred eighty (180) day period by a prescriber to monitor their mental health needs and response to psychiatric intervention. The patient must be monitored for desired and adverse effects of psychotropic medication including extrapyramidal symptoms (EPS). Patients prescribed neuroleptic drugs must be screened for movement disorders using the Abnormal Involuntary Movement Scale (AIMS). AIMS testing shall be done:

- Before the first dose is administered
- Every six (6) months following initiation unless more frequent testing is indicated
- If AIMS testing is positive, the patient shall be monitored every three (3) months
- If medication is stopped due to positive AIMS testing, the patient shall be monitored as clinically indicated for symptoms that persist.

Patients receiving second generation / atypical antipsychotics (e.g., risperidone, ziprasidone, olanzapine, etc.) must have a body weight, blood pressure, fasting blood glucose and lipid panel obtained at baseline and follow current American Psychiatric Association (APA) guidelines regarding metabolic monitoring parameters for atypical antipsychotic medications. Prescribers may defer the orders for these tests if the patient is followed in Chronic Care Clinic for diabetes or heart disease and the parameters are already being measured and monitored by the provider.

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Serum drug levels (e.g. Lithium) should be obtained within the time frames established in national standards.

Patients housed in mental health units, but are not prescribed psychotropic medication, must be seen by a prescriber at least every one hundred eighty days (180) days.

Patients requesting psychiatric evaluation are first screened by the QMHP to determine mental health symptoms, clinical significance, and appropriateness of referral to psychiatry. In the event the QMHP does not believe a referral is appropriate and the patient continues to request psychotropics while engaging in services, the QMHP shall consult with psychiatry at minimum and document such consultation and plan of care.

10. Prescribing Guidelines

Prescribers are expected to adhere to the current evidence-based treatment guidelines of psychiatric disorders.

11. Capacity Evaluations

Psychiatry staff shall conduct Capacity Evaluations for patients being considered for advanced directives in accordance with HCSD 2.13A, "Advanced Directives."

12. Discontinuation of Mental Health Services

It is appropriate for a QMHP to discontinue mental health services when:

- The goals and objectives of treatment have been met and the QMHP determines mental health services are no longer required;
- The patient is released from the Department;
- The patient has repeatedly refused to comply with the interventions recommended on the ITP and the QMHP has determined the patient is not at substantial risk of harm. A refusal form should be completed in accordance with the guidelines of HCSD 2.12A, "Consents and Refusals." However, if a patient who is at risk of harm to themselves or others, refuses to comply with the recommended interventions, the

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patient must be assessed for potential placement in an appropriate mental health unit or involuntary psychotropic medication

- When psychiatric medication is discontinued, either by the patient upon request or by the psychiatric prescriber due to change in clinical condition or nonadherence to the drug regimen, the patient should be seen for follow up by the psychiatric prescriber within thirty (30) days to determine if there is any further clinical action necessary. No further follow-up is required unless clinically indicated.
- Noncompliance with treatment may be taken into consideration in evaluating the patient's progress for the purpose of the CPCT review. Noncompliance should not be considered a lack of progress on the Clinical Review Form if the patient is not capable of engaging meaningfully in treatment, or if it is determined the patient is not in need of mental health treatment by a clinical provider.

D. Crisis Management Services

Every facility must have access to both a prescribing and non-prescribing QMHP to manage crisis situations. Crisis situations shall be managed at each facility as appropriate to ensure safety of incarcerated individuals, staff, and facilities. A mental health risk assessment shall be completed as soon as the incarcerated individual in crisis has been identified. Depending upon the severity of crisis due to mental illness, substance use, or dangerous behavior, increased intervention or crisis supervision may be required. Mental health clinicians should consider the risk of harm to self, others, or the facility when implementing special accommodations, from least to most restrictive.

- Patients displaying symptoms of psychosis, acutely altered mental status, adjusting to medication, exhibiting poor coping skills, or experiencing deterioration in functioning, physical health, or cognition, and who are not at risk of harm to self or others but would benefit from temporary removal from the general population may be relocated to a designated area of a housing unit which is quieter or in close proximity to an officer station on Safety Precautions. The patient must be seen at least once every business day by a QMHP until they are able to return to their assigned housing. A referral to physical health may be initiated by the evaluating QMHP prior to release from safety precautions to rule out clinical reasons for the change. The QMHP must determine and communicate to the Custody staff the type of clothing, personal property,

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bedding, and meals (e.g., no packing/no utensils if necessary) a patient may have while on safety precautions. .

- Narcan shall be used as a life-saving measure in situations of suspected or known overdose as outlined in HCSD 3.07A, “Intoxication and Withdrawal.” When substance use or overdose is suspected or known, the patient shall be tested to determine the type of substance used. Patients with a suspected or known overdose or intoxication shall be referred to Addiction Recovery Services as well as Mental Health as clinically necessary.
- Facility staff must intervene immediately whenever a patient attempts suicide or inflicts self-harm. Patients must be managed in accordance with the applicable Health Care Services Directive or Directives:
 - 4.06A, “Suicide Prevention and Self Injury”;
 - 4.04A, “Emergency Involuntary Psychotropic Medication”; and
 - 4.02A, “Therapeutic Restraint.”

E. Specialized Mental Health Services

A continuum of mental health services is offered in most facilities. In some cases, patients may require placement in specialized mental health treatment units for stabilization and treatment. Facilities shall identify and attempt less restrictive means of addressing the patients’ needs prior to referring to the mental health units for admission. This includes collaborating with the facility Multidisciplinary Treatment Teams, and attempting all reasonable interventions including psychotherapy, psychiatric referral, and psychotropic medications including involuntary medication, if appropriate.

1. Referral and Clinical Staffing Process

Patients who have been identified as needing a higher level of services can be identified by mental health teams at any facility. Once less restrictive interventions have been attempted unsuccessfully or with incomplete success, a referral to a mental health unit is appropriate. In the case that the transfer need is emergently, the site Lead QMHP shall contact either the Health Services vendor’s Regional Director of Mental Health or designee to staff emergency admissions to one of the three adult male mental health units and/or the Special Needs Unit (SNU) at Indiana Women’s Prison for women. Following a Serious Suicide Attempt or Serious Self Injury, the Director of Mental Health and the Health Services vendor’s Regional

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Director of Mental Health should be notified at the earliest possible time if admitting the patient to a mental health unit upon release from an outside hospitalization is preferable to returning them to their former facility.

In most Mental Health unit transfer cases, the facility's Lead QMHP, or designee from each adult male facility, including mental health units, shall participate in the Mental Health Movement Call. During this call, all patients being considered for admission to, or discharge from, a mental health unit shall be discussed. At this time, determination shall be made as to whether admission to a mental health unit is appropriate or if an alternative treatment plan shall be explored first. Determination of the appropriate mental health unit placement shall also be made at this time.

All female patients requiring mental health unit placement shall be housed at the Indiana Women's Prison Special Needs Unit (SNU). Due to the single mental health unit and the lower frequency of transfer needs, Mental Health Movement Calls for adult women may occur on an as needed, rather than weekly, basis.

New Castle Psychiatric (NCP)

- Further stabilization of acute psychotic symptoms
- Recent serious suicide attempts
- Recent serious, frequent, or extreme self-injurious behavior, including substance use
- Assessment and clarification
- High security risk patients requiring mental health unit placement

Pendleton INSIGHT (Intent on Shaping Individual Growth with Holistic Treatment) Treatment Unit (IRT)

- Additional need for either transitional treatment and/or structured environment
- Patients meeting criteria for Serious Mental Illness and currently housed in Restrictive Status Housing, who are security appropriate for an open milieu treatment environment
- Patients who require a transitional level of care and do not require placement at a facility with an infirmary for medical needs
- Patients who have co-occurring disorder behavioral health needs

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Wabash Valley Correctional Facility Special Needs Unit (SNU)

- Additional need for either transitional treatment and/or structured environment
- Patients for whom placement in a double cell is an appropriate and anticipated component to transition back into a general population setting
- Patients meeting criteria for Serious Mental Illness and currently housed in Restrictive Status Housing who are security appropriate for an open milieu treatment environment
- Patients who require a transitional level of care and require placement at a facility with an infirmary for medical needs
- Patients who are diagnosed with cognitive disorders who require some prompting or support to complete ADLs

Indiana Women's Prison Special Needs Unit (IWP SNU)

- Further stabilization of acute psychotic symptoms
- Recent serious suicide attempts
- Recent serious, frequent, or extreme self-injurious behavior, including substance use
- Assessment and clarification
- Additional need for transitional treatment and/or structured environment
- Patients meeting criteria for Serious Mental Illness and who would be placed in Restrictive Status Housing who are appropriate for an open milieu treatment environment

2. Mental Health Admission Transfer Process

Once a determination has been made as to the appropriate mental health unit placement, an authorization from the Health Services vendor's Regional Director of Mental Health or designee is sent to the Department's Director of Mental Health and Program Director for Behavioral Health Services. , Once final approval has been received from the Department's Director of Mental Health or designee, an email is sent to the Health Services and Mental Health staff of the sending and receiving facilities, as well as the Central Office Classification and Operational Support division. The QMHP shall then provide the facility Classification Supervisor a copy of the patient's updated Behavioral Health code. The QMHP shall complete the

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Electronic Medical Record (EMR) Transfer Summary template including the narrative Mental Health Treatment Summary.

3. Mental Health Unit Intake Process

A licensed nurse shall review SF 45998, “Record of Point of Entry” and complete the Intake screening template in the EMR to include the Suicide Risk Assessment. This template shall be completed within twelve hours of arrival. Patients admitted to a specialized mental health unit must be seen by a QMHP within one business day in order to assess for acute needs.

A Comprehensive Mental Health Appraisal shall be completed within seven (7) days of arrival to a mental health unit. Patients who are placed at NCP or IWP SNU must be seen within seven (7) days of arrival by a prescriber. Patients who are placed at IRT or SNU must be seen within fourteen (14) days of arrival by a prescriber. Newly admitted patients shall have an ITP established or revised by all appropriate QMHPs.

4. Mental Health Unit (MHU) Treatment and Documentation

Each patient in a MHU shall be seen at a minimum of once a month for individual therapy. If the patient refuses to attend an individual therapy session, they must be seen by a mental health QHMP on the day of the refusal. If a patient is determined to be inappropriate for individual therapy due to a mental health reason, the patient must be visited daily by a QMHP to assess for appropriateness to participate in individual sessions. If the patient is determined to be inappropriate for individual sessions for a safety or security reason, the patient must be seen daily by a QMHP only after they have been on that status for seven (7) days. Documentation should be entered as an EMR progress note.

Patients who are on psychotropic medications shall be seen at least every ninety (90) days by a prescriber. Patients on involuntary medications must be seen at least every thirty (30) days by a prescriber. Patients who are not on psychotropic medications shall be seen within thirty (30) days of arrival and then at a minimum of every one hundred eighty (180) days, or in accordance with the patient’s ITP. All interactions should be documented as EMR medication management notes.

Each patient must be offered the opportunity to participate in ten (10) hours of out-of-cell therapeutic programming per week unless the patient is

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determined to be inappropriate for mental health or safety or security reasons. If a patient refuses to attend a group session, they must be seen by mental health staff on the day of the refusal to encourage continued participation in treatment. If a patient is determined to be inappropriate for group sessions due to a mental health reason, the patient must be visited daily by a QMHP to assess for appropriateness to participate in group sessions. If a patient is determined to be inappropriate for group sessions due to a safety or security reason, the patient must be seen daily by a QMHP. Patients who are inappropriate for either mental health or safety and security reasons should be permitted to participate in group sessions as soon as they are stable or safe enough to attend. Weekly group notes should be entered in EMR and on weekly Out-Of-Cell Summary Reports. If less than ten hours of out-of-cell therapeutic programming was offered, appropriate documentation shall be made reflecting the reasons this did not occur.

Each patient's ITP must be reviewed at a minimum of every ninety (90) days or in accordance with the patient's ITP or the facility directive. ITP shall additionally be reviewed upon diagnosis or when a significant change in clinical status occurs; when a course of planned treatment is completed; and when the patient will be discharged from the MHU. ITPs reviews shall be documented in the EMR Treatment Plan Review Template.

5. Mental Health Unit Discharge/Transfer Process

A patient shall be discharged from a mental health unit when their mental health needs no longer are appropriate for placement in the unit. The reasons this may occur include, but are not limited to:

1. The clinical and behavioral goals and objectives of treatment have been met and the assigned therapist and Multidisciplinary Treatment Team determine that the level of mental health services is no longer required;
2. The patient has failed to progress in treatment and transfer to a higher acuity unit is required due to a worsening of mental health status after treatment plan updates and reasonable attempts to treat the patient's mental health needs have been documented;
3. The patient presents safety and security risks that cannot be managed in the unit; such as either a continued pattern of disruptive or destructive behavior in the unit, or engaging in assaultive

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behavior toward staff or other program participants **and** if removal does not pose a substantial risk to the individual;

4. The patient does not wish to participate in the mental health unit programming and removal from the unit does not pose a substantial risk to the patient.
5. The patient does not participate in individual and group therapy as required and has not engaged in treatment after treatment plan updates and reasonable attempts to gain the patient's treatment compliance have been made or documented. The patient may only be discharged for these reasons if removal does not pose a substantial risk to the individual.

When a MHU's Treatment Team determines a patient is appropriate for discharge, or no longer appropriate for that level of care, a Transfer Summary is prepared and sent to the Health Services vendor's Regional Director of Mental Health. The patient is then discussed on the weekly Mental Health Movement Call. If the patient is approved for discharge, the same process used for approving admissions into mental health units will be used to process the patient's discharge. Mental health staff shall continue to see the patient until they are transferred to a different site.

If a patient is being discharged to Restrictive Status Housing from a MHU, a Restrictive Housing Review should be completed by a QMHP at the discharging site and submitted to the Executive Director of Behavioral Health and the Director of Mental Health for review. If approved, the individual may be discharged directly to Restrictive Status Housing. If the patient meets criteria for classification as Seriously Mentally Ill, a safety and security exception for placement in Restrictive Housing shall be submitted, reviewed, and approved by the Executive Director of Behavioral Health Services. If approval is not received in either of these situations, the individual shall remain in the MHU until an appropriate placement can be determined.

After the transfer is completed, the patient shall be seen within one (1) business day of arrival at the receiving facility by Mental Health staff to assess for stability after transfer and adjustment to new facility. The patient shall continue to be seen weekly for the first month and once per month from the second to the sixth months, or more frequently as indicated by the ITP. One exception is if the purpose of the mental health unit was diagnostic

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clarification and clinical documentation clearly identifies that this follow-up is not clinically indicated.

F. Restrictive Status Housing

1. Admission

In accordance with the guidelines established in Health Care Services Directive 2.21, "Evaluation of Incarcerated Individuals in Restrictive Status Housing," the Health Services staff must be informed immediately when an incarcerated individual is assigned to Restrictive Status Housing. A health record screening and review must be completed by a nurse, nurse practitioner, or physician to determine if any contraindication to Restrictive Status Housing exists.

If the health record review show that the incarcerated individual is a "D" Behavioral Health code or is within the thirty (30) day period of post-release follow up after having been removed from suicide watch precautions, the reviewer must immediately conduct the suicide risk and mental health screening and contact the facility's lead psychologist or designee. During business hours, the psychologist or designee must assess the patient to determine if any immediate action is necessary. If placement and review occurs after normal business hours, the lead psychologist or designee must assess the patient on the next business day.

Regardless of Behavioral Health code, within seventy-two hours (72) hours of placement in a restrictive status housing unit, a QMHP shall conduct an evaluation of the individual placed in restrictive housing to determine if the patient meets criteria for classification as Seriously Mentally Ill or if there are other clinical reasons why extended restrictive status housing placement is contraindicated. This evaluation shall include a review of the patient's pertinent mental health history, a thorough review of all active and provisional diagnoses, a validation of current mental health diagnoses, and a determination of the severity of both the clinical symptoms and any resulting functional impairment.

Patients may be identified as meeting Serious Mental Illness criteria as a part of either the initial restrictive status housing review process (as noted above) or as part of a subsequent identification during mental health monitoring at any time during restrictive status housing placement. When a patient receives a new Serious Mental Illness-qualifying diagnosis, the

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QMHP shall notify the Health Services vendor's Director of Mental Health or designee, the Department's Director of Mental Health, and the facility SMI point of contact by email within one (1) business day of the patient's diagnosis. This shall be discussed with the facility Restrictive Status Housing Multidisciplinary Team and determination made by the Team as to the anticipated length of stay in restrictive status housing.

If a determination is made that the patient is unlikely to return to general population in thirty (30) days, the patient is not clinically appropriate to be permitted to consent to remain in restrictive status housing, and the patient is not clinically appropriate to be considered for a safety and security exception, the QMHP should complete and submit a Transfer Summary to the Health Services vendor's Regional Director of Mental Health to be presented on the Mental Health Movement Call for potential placement in an MHU.

If mental health needs are identified by the MHP during the evaluation, the QMHP must make a determination regarding the frequency of contacts necessary for maintenance during restrictive status housing placement and modify the treatment plan accordingly. Mental health services personnel must ensure that proper services and support continue to be provided during restrictive status housing placement by escorting the patient to the appropriate location for services or by providing services in an appropriate setting on the restrictive status housing unit. If at any time the patient's treatment needs cannot be met in restrictive status housing and they are not appropriate to return to a general population setting, the QMHP should complete and submit a Transfer Summary to the Health Services vendor's Regional Director of Mental Health to be presented on the Mental Health Movement Call for potential placement in a MHU.

2. Remainder of Stay

All incarcerated individuals in restrictive status housing must be evaluated by a QMHP within thirty (30) days of placement and every thirty (30) days after in accordance with HCSD 2.21, "Evaluation of Offenders in Restrictive Status Housing," even if no mental illness is present., Mental health evaluations of patients with an identified mental health need(s) must be done in a location which affords the patient confidentiality; the evaluation may not be done at the cell front unless patient refuses an out of cell visit. Follow up evaluations shall be done in accordance with the time frames noted in the ITP which may not exceed thirty (30) days.

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Unless mental health attention is needed more frequently, each incarcerated individual in restrictive status housing shall receive a weekly visit from mental health staff to ensure that offenders have access to the behavioral health system. The presence of a mental health staff in Restrictive Housing is announced and the announcement is recorded in the unit log. The mental health authority determines the frequency of mental health professionals to Restrictive Housing units.

In accordance with a Settlement Agreement between the Indiana Protection and Advocacy Services Commission (IPAS) and the Department, QMHPs assigned to restrictive status housing areas within the Department are required to fulfill unique assessment responsibilities. The attachment to HCSD 2.21A presents a matrix for the types of mental health contacts, frequency of contacts, location of contacts, and documentation required for patients in restrictive status housing.

3. Special Confinement Unit

QMHPs shall evaluate all incarcerated individuals referred for placement in a special confinement unit. This evaluation shall consist of a mental status examination and chart review for mental health needs. Findings including presence of a mental health diagnosis and risk of decompensation in a long term restrictive status housing environment shall be communicated to classification professionals.

Incarcerated individuals placed in a special confinement unit will be reviewed and evaluated by a QMHP to determine whether they meet criteria to be classified Seriously Mentally Ill and will receive the same follow-up and treatment as is required in other restrictive status housing placements.

G. Release/Discharge Planning

Transitional Healthcare staff identify patients who potentially have special needs upon release and triage them to be staffed by a Transitional Healthcare Facilitator and the Lead QMHP at their facility. If the facility does not have an assigned facilitator, a Transitional Healthcare Specialist shall work, as needed, directly with the Lead QMHP. Once special needs are identified, post-release care coordination is triaged and release planning continues until the IDP is discharged from IDOC.as directed in HCSD 5.01, "Transitional Health Care."

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H. Parole Board Evaluation Requests

All Parole Board requests for mental health evaluation shall be routed to the Department's Director of Mental Health or designee who shall, in turn, contact the appropriate QMHP.

The QMHP shall compile the information itemized below and forward to the Parole Board within thirty (30) days of the request.

- For individuals who are currently in treatment, mental health staff shall forward:
 1. A summary description of the treatment and/or interventions provided to the patient;
 2. The patient's response to treatment and/or interventions;
 3. A current mental status summary; and,
 4. Recommendations regarding continuity of care upon release.
- For patients who have a history of receiving mental health treatment, but are not currently in treatment, Mental health staff shall review and summarize for the Parole Board available treatment records including the mental health services discharge summary as well as the timeframe when the patient last received services.
- For patients with no known history of mental illness or of mental health treatment, mental health staff shall not be expected to provide evaluations or reports. The absence of mental illness or treatment history shall be communicated to the Parole Board.

If the Parole Board indicates that additional information beyond that described above is necessary, the Parole Board will submit a formal request to the Executive Director of Behavioral Health or designee.

Under no circumstances shall a QMHP recommend for or against release.

H. Civil Commitment Upon Release

Individuals nearing the end of their commitment to the Department, who are believed to pose a danger to themselves, others, or are gravely disabled as a result of a mental illness shall be considered for Civil Commitment. Cases shall be reviewed by the Health Services vendor's Regional Director of Psychiatry,

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Regional Director of Mental Health, Executive Director of Behavioral Health, Executive Director of Transitional Healthcare, and the Legal Services Division. Alternate release plans should be developed in the event a patient is not civilly committed.

VI. APPLICABILITY:

This Health Care Services Directive is applicable to all facilities housing incarcerated adults.

Kristen Dauss, MD
Chief Medical Officer

Date

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Title EMERGENT INVOLUNTARY PSYCHOTROPIC MEDICATIONS

Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101 01-02-106	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides direction regarding the emergent and involuntary use of psychotropic medications with adults. Emergent and involuntary psychotropic medication shall be used only when it is necessary to ensure the physical safety of the incarcerated individual or the safety of others.

II. DEFINITIONS:

- A. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.
- B. QUALIFIED MENTAL HEALTHCARE PROFESSIONAL (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.

III. GUIDELINES:

- A. Forced emergent psychotropic medications shall be used when:
 - 1. A patient is displaying symptoms of acute or chronic mental illness or is experiencing an acute change in mental status, **and**;
 - 2. Refuses to take the prescribed medication, **and**;

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3. Less restrictive or intrusive measures have proven inadequate or are clinically determined to be inadequate or inappropriate, **and**;
 4. The following exists as a clear and imminent substantial threat:
 - a. The patient is suicidal, as determined by a qualified mental healthcare professional (QMHP); and/or,
 - b. The patient will cause serious physical harm to self or others; and/or,
 - c. The patient is gravely disabled as a result of an acute change in mental status or due to displaying symptoms of acute or chronic mental illness; and/or,
 - d. The patient will cause serious property damage; **and**,
 5. The medication is a generally accepted treatment for the patient's condition; and,
 6. Details are specified about why, when, where, and how the medication is to be administered.
- B. Emergent involuntary psychotropic medication may not be used for behavioral control unless the above criteria are met.
 - C. Emergent involuntary psychotropic medication may not be used as punishment or for staff convenience.
 - D. Only a psychiatrist or other physician may order emergent involuntary psychotropic medication.
 - E. This process supersedes a patient's right to refuse psychotropic medication. Contemporaneous documentation regarding the use of emergent involuntary psychotropic medication must include:
 1. A full description of the acute symptoms experienced by the patient;
 2. The behavioral manifestations observed by Health Services staff;
 3. Description of any relevant incidents;

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5. Description of less restrictive interventions and why or how they have failed or been skipped in the decision to administer emergent involuntary medications;
 6. Evidence for suicidal, dangerous, or destructive behavior or intent; and,
 7. Support for the proposed involuntary medication usage, including the expected effects of the medication.
- F. If there is a psychiatrist on-site who can timely evaluate the patient, the psychiatrist must personally carry out a mental health evaluation in advance of provision of emergent involuntary psychotropic medication. As part of this assessment, the patient shall be offered a last opportunity to accept medication voluntarily.
- G. If there is no psychiatrist on-site, another QMHP must personally assess and personally discuss the patient with a psychiatrist over the telephone. The psychiatrist must confirm that all required criteria are met before providing an order for emergent involuntary psychotropic medication. The psychiatrist is limited to providing a single dose of involuntary medication per order. Each subsequent dose of emergent involuntary medication shall require either a psychiatrist personally assessing the patient or again reviewing the case with a QMHP who has been able to do so and who personally discusses the case with the psychiatrist.
- H. When there is no psychiatrist or no QMHP on site and the patient is at imminent risk of harm to self or others, the on-site physician may initiate a single dose of emergent involuntary psychotropic medication when necessary.
- I. When there is additionally no physician on-site, the on-site nursing staff shall contact the psychiatrist on-call for orders. The psychiatrist is limited to providing a single dose of emergent involuntary medication per order. Each subsequent dose of emergent involuntary medication shall require either a psychiatrist personally assessing the patient or again reviewing the case with an on-site nurse who has been able to assess the patient.
- J. After provision of an emergent involuntary psychotropic medication order, the psychiatrist shall review the chart and assess the patient during their next visit to the facility. If the ordering psychiatrist does not routinely work at the facility, the attending psychiatrist at the facility must review the record and assess the patient during the next business day that they are present at the facility.

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K. Actual administration of the ordered emergent psychotropic medication shall be carried out as follows:

1. Custody staff trained in the use of crisis intervention techniques shall be utilized to restrain and/or manage the patient while nursing staff administers the involuntary medication. Excessive use of force is never acceptable.
2. Nursing staff shall take vital signs after the administration of the medication, again one hour later, and at least once a shift for the next twenty-four (24) hours (or more often as clinically indicated or ordered by the psychiatrist). Nursing staff shall assess the patient for medication effects continuously for fifteen (15) minutes with careful attention to respiration and shall assess for behavioral effects at fifteen (15) minute intervals for the first two (2) hours. Any indications of adverse side effects shall be reported to the prescribing psychiatrist and/or site medical director immediately. After two (2) hours nursing staff shall report on behavioral effect to the psychiatrist.
3. If patient agitation precludes obtaining vital signs, nursing staff shall consult with the prescribing psychiatrist rather than risk injury to obtain vital signs. If this occurs, it shall be fully documented in the health record.

L. After involuntary administration of emergent psychotropic medication, the patient shall be placed on constant suicide observation to maintain constant watch of behaviors.

M. After involuntary emergency use of psychotropic medications, the psychiatrist shall:

1. Review the problem list and treatment plan, updating as necessary;
2. Ensure that appropriate follow-up visits are scheduled;
3. Consider whether the current location is appropriate; and,
4. Provide new orders as necessary.

N. Within one (1) business day following the administration of emergency involuntary medication, a QMHP shall meet with the patient and complete State Form 56887, "Individual Debrief."

VII. OUTCOME MONITORING:

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On the day that emergency involuntary psychotropics are initiated, the HSA or designee shall notify the CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance Manager, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health on the use of emergency IVM, including but not limited to the patient who was given the medication, medication dose and patient tolerance.

A copy of State Form 56887 "Individual Debrief" shall be shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, Quality Assurance, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the date emergency IVM was provided.

A copy of State Form 56888 "Multi-Disciplinary Team Debrief" should be shared with the Warden, CMO, Executive Director of Physical Health, Executive Director of Behavioral Health, Director of Mental Health, the Health Services vendor's Regional Director of Psychiatry, Regional Director of Behavioral Health, and Regional Director of Mental Health within five (5) business days of the Multidisciplinary Team meeting.

Every time that emergency involuntary psychotropic medication is used the usage shall be reviewed by the site's Quality Assurance Manager to ensure that the usage was carried out in accordance with this HCSD and that all requirements were met. Emergency involuntary psychotropic medication usage that does not comply with the requirements in this HCSD shall be reviewed as a sentinel event during the Clinical Critical Incident review in accordance with HCSD 2.24A, "Clinical Critical Incident Review." Use of IVM shall be documented on the facility's monthly Health Services Report and shall be reviewed for quality assurance.

III. APPLICABILITY:

This HCSD is applicable to all facilities providing health services to incarcerated adults.

Kristen Dauss, MD
Chief Medical Officer

Date



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**INVOLUNTARY PSYCHOTROPIC MEDICATION ADMINISTRATION – NON
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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101 01-02-106	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) outlines the procedures for the administration of psychotropic medications without the patient's consent when the patient is either gravely disabled or poses a likelihood of serious harm to self or others due to a mental disorder.

II. DEFINITIONS:

- A. **PSYCHIATRIC ORDER:** A medical order issued by a board certified or board eligible psychiatrist providing psychiatric services for the correctional facility.
- B. **MENTAL ILLNESS:** A psychiatric disorder that substantially disturbs an individual's thinking, feeling or behavior and impairs the individual's ability to function.
- C. **GRAVELY DISABLED:** A condition in which the individual, as a result of mental illness, is in danger of impending harm because the individual is unable to provide for his/her food, clothing, shelter or other essential human needs; or, has a substantial impairment or an obvious deterioration of judgment, reasoning or behavior that results in the individual's inability to function independently.
- D. **MULTIDISCIPLINARY TEAM (MDT):** A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.
- E. **QUALIFIED MENTAL HEALTHCARE PROFESSIONAL (QMHP):** A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians,

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psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.

- F. SEVERE DETERIORATION IN ROUTINE FUNCTIONING: Evidence of repeated and escalating loss of cognitive or volitional control over their actions and, therefore, not receiving such care as is essential for health or safety.
- G. LIKELIHOOD OF SERIOUS HARM: Evidence of substantial risk of physical harm to self, or physical harm to others, or to the property of others.
- H. DANGEROUS: A condition in which an individual, as a result of mental illness, presents a substantial risk to harm self or others.
- I. ASSISTING STAFF MEMBER: A staff member who is not a qualified mental healthcare professional but who has been provided with training in the process of assisting the patient and ensuring that the Treatment Review Committee addresses the basic questions regarding involuntary treatment.

III. GUIDELINES:

- A. Gravely disabled, mentally disordered patients who require medication to prevent severe deterioration in routine functioning and do not consent to treatment shall be provided a due process hearing. This hearing shall be conducted by a Treatment Review Committee to review the documentation which explains the need to initiate and continue involuntary psychotropic medication orders.
- B. A patient has a right to refuse psychotropic medications unless all of the following criteria are met:
 - 1. The individual suffers from a mental illness or mental disorder, **and;**
 - 2. The medication is in the best interest of the individual for health reasons, **and;**
 - 3. The individual is determined to be gravely disabled or exhibits severe deterioration in routine functioning or poses a likelihood of serious harm to self, others or the property of others.

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- C. The psychiatric orders for involuntary medications and the clinical evidence to support these orders shall be fully documented in the patient’s health record. The psychiatrist or psychiatric Nurse Practitioner (NP) shall meet with the patient to explain why the medications are recommended and discuss any concerns the patient may have.

- D. The administration of psychotropic medications as ordered by the psychiatrist has been reviewed and approved by the Treatment Review Committee after the completion of a due process hearing.

- E. Whenever a psychiatric emergency situation exists, and the patient poses an imminent threat of serious physical harm to self or others due to a mental disorder or significant change in mental status, no due process hearing is required prior to the administration of emergency forced psychotropic medication. In the case of a psychiatric emergency, the procedures outlined in HCSD 4.04A, “Emergent Involuntary Psychotropic Medications,” shall be followed.

- F. Treatment Review Committee Process:
 - 1. The Treatment Review Committee shall be comprised of three or more members. At least two members shall be physicians and at least one of those shall be a psychiatrist. Neither shall have been involved in the prescribing of the psychotropic medications under review.

 - 2. Members are not disqualified from sitting on the Committee if they have treated or diagnosed the patient in the past. The lead psychologist shall serve as Chairperson of the Committee. The members of the Committee shall have completed a training program approved by the Chief Medical Officer (CMO) or designee after consultation with the jurisdiction administration regarding the legal and health issues involved.

 - 3. The Warden shall identify one or more staff members to be available to act as an “assisting staff member” in the due process procedure. The role of this “assisting staff member” is to facilitate understanding and participation by the patient during the hearing and to ensure that the Treatment Review Committee addresses the basic questions regarding the necessity of involuntary treatment. All assisting staff members shall complete a documented training program which has been approved by CMO.

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4. The Treatment Review Committee Hearing shall be conducted as soon as possible after the determination of need for involuntary psychotropic medications has been made, and at maximum within three (3) business days.
5. The patient and assisting staff member shall receive written notification of the time and place of the hearing at least twenty-four (24) hours prior to the hearing. The notification shall include the tentative diagnosis and the reasons the psychiatrist and other mental health services staff believes the medication is necessary. State Form 48401, "Notice of Treatment Review Committee Hearing," shall be used for this purpose.
6. The patient has the right to attend the hearing, to present evidence, including witnesses, and to cross-examine staff witnesses unless the patient's attendance at the hearing poses a substantial risk of serious physical or emotional harm to self or poses a threat to the safety of others. The assisting staff member shall appear at the hearing on the patient's behalf whether the patient attends or not. The assisting staff member shall specifically request (at least) the following from the prescribing psychiatrist:
 - a. A summary of the evidence for serious mental illness, including the specific psychiatric disorder thought to be present;
 - b. An explanation why the psychiatrist believes that the recommended medication is in the patient's best interest, including specific goals for treatment;
 - c. A summary of the evidence for grave disability, severe deterioration in routine functioning, or the likelihood of serious harm to self, other, or property; and,
 - d. A description of what other interventions might serve to treat the patient's mental health condition.
7. The documentation in the health record shall be reviewed by the Treatment Review Committee and the Committee may require that the prescribing psychiatrist appear in person at the hearing. When the prescribing psychiatrist is not required to be present, a non-voting member of the Committee may read the documentation

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prepared by the prescribing psychiatrist of the above 4 questions (at minimum) that are the basis for the involuntary medication hearing.

8. Prior to the hearing, the patient and assisting staff member may request in writing to the Chairperson of the Committee that certain staff witnesses be present at the hearing or that specific questions be asked outside of the hearing and that certain information be available at the hearing.
9. Reasonable efforts shall be made to have any requested witness present at the hearing, unless the witness' testimony would be repetitive, irrelevant, or a threat to the safety of any of the persons involved, or to the security of the facility, or for other reasons, including, but not limited to, the unavailability of the witness, or matters related to the orderly operation of the facility.
10. In the event that the requested witnesses are unable to appear at the hearing, but are otherwise available, the witnesses shall be interviewed by a Committee member. The Committee member shall ask the witness(es) any relevant questions provided by the patient and the patient's assisting staff member. The patient and the assisting staff member shall be given a copy of the responses of any witnesses interviewed. The assisting staff member shall consult with the patient regarding any statements made by the witnesses interviewed by the Committee.
11. At the hearing, the patient shall be assisted by the appointed staff member and may make statements and present documents which are relevant to the proceedings.
12. The patient and assisting staff member may make statements and may direct relevant questions to any staff witness at the hearing unless the Chairperson finds the questions to be repetitious, irrelevant, or a threat to the safety of individuals, or the security of the facility.
13. The Committee shall conduct any investigations, which it deems necessary, regarding the issue of administering psychotropic medication to the patient. Any information obtained during an investigation must be presented at the hearing in order to be considered by the Committee. The Committee shall consider all relevant information and material which has been presented at the

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hearing in deciding whether to approve or disapprove the administration of the medication.

14. The Treatment Review Committee must make its decision by simple majority of voting members.
15. A written decision shall be prepared by the Chairperson and shall be signed by all members of the Treatment Review Committee. The decision shall include a summary of the hearing and the reasons for approving or disapproving the administration of the medication. State Form 48402, "Report of Treatment Review Committee Hearing," shall be used for this purpose. The written decision must include answers to the questions asked by the assisting staff member and described under number 6 above.
16. The administration of psychotropic medications on an involuntary basis shall begin immediately after the verbal agreement for this action by the appropriate number of members of the Treatment Review Committee. When administered, the following conditions shall be met.
 - a. The authorization is by a physician who specifies the duration of therapy;
 - b. Less restrictive intervention options have been exercised without success as determined by the physician or psychiatrist;
 - c. Details are specified about why, when, where, and how the medication is to be administered;
 - d. Monitoring is ordered and occurs for adverse reactions and side effects; and,
 - e. Treatment plan goals are prepared for less restrictive or less invasive treatment alternatives with return to voluntary treatment as soon as clinically feasible.
17. The original copy of the decision shall be placed in the patient's health record with copies provided to the patient, within five (5) business days of the hearing. The CMO has the authority to overturn a decision that affirms use of involuntary medication if the CMO determines that good cause for this action exists.
18. If the Committee approves administration of the psychotropic medication, the patient shall be advised of the opportunity to appeal the decision by filing a written request of appeal to the CMO within

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five (5) business days after receipt of the Committee’s written decision. The patient shall complete State Form 48403, “Appeal of Treatment Committee Decision,” and submit the form to the Chairperson of the Committee.

19. Within five (5) business days, the Chairperson of the Committee shall forward the appeal to the CMO, or physician designated by the CMO, the Director of Mental Health, and the Behavioral Health Services Program Coordinator. The CMO has five (5) business days to respond to the appeal.

G. Review by the Department’s Chief Medical Officer (CMO)

If the patient appeals the decision of the Treatment Review Committee, Health Services staff shall enforce administration of the medication as ordered by the psychiatrist and approved by the Committee while awaiting the decision on the appeal by the CMO or designated physician.

Within five (5) business days of receipt of the appeal, the CMO or designated physician shall review the Committee’s decision, either authorizing continued involuntary administration of medication or ordering that the medications be stopped by contacting the ordering psychiatrist and/or the facility. The CMO’s decision shall be in writing on State Form 48403, “Appeal of Treatment Review Committee Decision.”

The original copy of the appeal decision shall be placed in the patient’s health record with copies to the patient and others designated by the CMO.

H. Periodic Reviews of Involuntary Medication Orders

Once authorized, the involuntary medication treatment effect shall be reviewed by the psychiatrist within seven (7) days for newly-initiated involuntary medications; If orders are a renewal, they should be reviewed by the psychiatrist within fourteen (14) days. Full documentation shall be provided in the EMR health record by the psychiatrist to support the decision to continue involuntary medication orders.

The patient shall be evaluated in an interview by the on-site psychiatry provider every thirty (30) days. If the on-site psychiatry provider is not a psychiatrist, the patient shall be seen by the prescribing psychiatrist every ninety (90) days while the patient receives involuntary psychotropic medications. Full documentation shall be provided by the psychiatrist in the health record as long as involuntary medication orders are continued.

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The Treatment Review Committee shall conduct a hearing every six (6) months to review the need for involuntary medication administration for as long as the psychotropic medications are ordered on an involuntary basis.

I. Emergency Administration of Psychotropic Medications

If Emergent Psychotropic Medication is used per HCSD 4.04A and it is determined that the medications need to be continued beyond the limits of the protocol, and the individual will not agree to take the medications on a voluntary basis, a Treatment Review Committee hearing must be held as soon as possible, but no later than three (3) business days following the referral.

J. Grievances

A patient may submit a grievance concerning the involuntary administration of psychotropic medication in accordance with Policy and Administrative Procedure 00-02-301, "The Offender Grievance Process." When considering the grievance, the Warden shall confer with the CMO. The CMO shall be considered the final authority in matters relating to health decisions.

K. Inter-Facility Transfer

Involuntary medication approved by a Treatment Review Committee shall be continued when a patient is transferred from one Department facility to another. The same ongoing review requirements apply to the receiving facility.


IV. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title SUICIDE AND SELF-INJURY PREVENTION
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Legal References (includes but is not limited to) IC 11-8-2-5 IC 34-4-12.6	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) provides guidance regarding the identification and management of patients who are at increased risk for suicide or self-injurious behavior. .

II. DEFINITIONS:

- A. FACILITY STAFF: Any individual assigned to or permitted by the Warden to perform a job, including volunteers.
- B. QUALIFIED MENTAL HEALTHCARE PROFESSIONALS (QMHP): A person with professional training, experience, and demonstrated competence in the treatment of mental illness. QMHPs include physicians, psychiatrists, psychologists, social workers, mental health counselors, mental health nurse practitioners, mental health-trained nurses, or other qualified persons as designated by the Executive Director of Behavioral Health Services.
- C. MULTIDISCIPLINARY TEAM (MDT): A treatment team comprised of individuals from different disciplines that contribute a broad range of perspectives and treatment modalities in the management of patients' needs.
- D. PSYCHOLOGICAL AUTOPSY: A formal systematic review, conducted after a death presumed to be from suicide, to examine the mental and emotional state of the patient prior to suicide as well as a review of the other factors or circumstances including staff training, adherence to procedures, access to care, etc., to determine why the individual ended their own life.
- E. SELF-INJURIOUS BEHAVIOR: An intentional, self-inflicted act of bodily harm. Risk of lethality can range from small cuts with low lethality,

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head banging, swallowing foreign objects, insertion of foreign objects into the body, starvation, not complying with medical treatment for chronic conditions or allowing wounds to heal, to serious life-threatening mutilation and amputation. Self-injurious behavior may result in suicide, either intentionally or unintentionally. Patients who engage in self-injury must be evaluated by a QMHP who shall use their clinical judgment to determine appropriate intervention. Tattoos, decorative piercing, and similar markings are not considered self-mutilation for purposes of this HCSD. Self-injurious behavior which requires emergency medical treatment such as the level of care provided in a hospital or emergency department will be considered a serious self-injury.

- F. **SERIOUS SUICIDE ATTEMPT:** Serious self-injurious behavior with the intent to die by a patient which requires emergency medical treatment such as the level of care provided in a hospital emergency department.
 - G. **SUICIDE PREVENTION COORDINATOR:** A staff member assigned or appointed by the Warden or the Warden's designee to manage the Suicide Companion Program, including the training of the Suicide Watch Companions.
 - H. **SUICIDE WATCH:** The enhanced supervision or precautions taken for a patient who is at increased risk for suicidal behavior. One of two levels of Suicide Watch shall be implemented for a patient at risk for suicidal behavior; close or constant.
 - I. **SUICIDE WATCH COMPANION:** A patient who has satisfactorily completed specialized training to assist staff in the direct, constant, visual monitoring of a patient who has been placed on Constant Observation. A companion must not be placed in a supervisory, clinical or therapeutic role.
- III. **GENERAL GUIDELINES:**
- A. Suicide prevention is the responsibility of all staff.
 - B. Each facility must develop a written suicide prevention plan as a facility directive which includes all components of this HCSD as well as addressing the unique needs of the facility including the facility-specific process and chain of command for implementing safety measures and the responses to, and evaluation of, attempted and actual suicides. In addition, the facility-specific plan shall include a schedule for regular maintenance and inspection of the safety smocks, blankets, and intervention tools. The Warden or designee must review the facility-specific suicide prevention plan annually.

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- C. All facility staff with responsibility for supervision of incarcerated individuals must receive training regarding suicide prevention at the inception of employment and through annual in-service training. Facility staff must receive training on the facility's suicide and emergency plans as well as job-specific training regarding the responsibilities for suicide prevention and monitoring activities appropriate for the staff's assigned duties.
- D. All facility staff with direct patient contact must be trained in standard first aid and cardiopulmonary resuscitation (CPR) in accordance with HCSD 1.04A, "Credentialing of Employees," and HCSD 1.06A, "Health Related Training for Correctional Officers." An automated external defibrillator (AED) shall be readily available.
- E. The following supplies must be readily available, on every housing unit or in a common area immediately adjacent to every housing unit: a cut down or rescue tool, gloves, and a pocket mask for CPR. These supplies shall be inventoried daily.
- F. All reports of suicidal ideation, verbal threats of self-injury , or physical self-injury gestures, made by a patient shall be taken seriously. Close Observation shall be implemented when an MHP determines there is a clinical need for observation based on a patient's statement or presentation that they may be suicidal or may engage in self-injurious behavior that could result in death. QMHPs may use their clinical discretion to decide whether to place a patient on close observation, but the evaluation must occur and a treatment plan must be devised. When a QMHP is not on site, a shift supervisor or nurse trained in suicide-risk assessment in consultation with a QMHP may order the level of observation until the patient is evaluated by a QMHP.
- G. A patient placed on Suicide Watch shall be housed where the watch can be conducted properly, including the necessary observation checks. When restrictive status housing is the best available option for housing a patient at increased risk of self-injurious behavior, the cell must be as suicide-resistant as possible.
- H. The Shift or Housing Area Supervisor shall make periodic visits to the housing units where patients on Suicide Watch are housed to ensure that monitoring forms are being used and accurately completed. At a minimum, these visits shall occur once each shift.

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- I. When a suicide attempt occurs, staff shall not assume the patient is deceased. Staff must provide first aid or CPR, if appropriate, while waiting for facility Health Services staff or external emergency services to arrive. Scene preservation shall be secondary to the provision of immediate life-saving measures.
 - J. Critical incident reporting should be completed on State Form 46896, "Report of Clinical Critical Incident" and a review shall be completed for Serious Suicide Attempts and Serious Self-Injuries as clinically indicated in accordance with applicable critical incident reporting procedures. A summary of the critical incident debriefing or other post event analysis shall be submitted to the Chief Medical Officer (CMO), Executive Director of Behavioral Health, Director of Mental Health, Health Services vendor's Regional Director of Behavioral Health and Regional Director of Mental Health in accordance with HCSD 2.24, "Clinical Critical Incident Reviews."
- IV. STAFF TRAINING:
- All facility staff with responsibility for supervision of incarcerated individuals shall be trained, in pre-service orientation and annual in-service training, in the identification, referral, and monitoring of potentially suicidal patient. Training must address:
- A. The reasons the environment of correctional facilities is conducive to suicidal behavior including the demographic and cultural parameters of suicidal behavior and,
 - B. Identifying the situations, warning signs, and symptoms of impending suicidal behavior as well as how to access help for the patient including:
 1. Understanding the demographic and cultural parameters of suicidal behavior, including the incidence and variations in precipitating factors;
 2. High risk suicide periods;
 3. Responding to suicidal and depressed patients;
 4. Referral procedures;
 5. Housing observation and Suicide Watch level procedures;
 6. Procedures for initiating Close or Constant Observation;
 7. Communication and referral procedures between Custody staff, Unit staff, Nursing and Mental Health staff;
 8. Reporting and notification procedures;
 9. Follow-up monitoring procedures for patients who made a suicide attempt;

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10. Population-specific factors; and,
11. Review procedures.

The curriculum used for training must be approved by the Executive Director of Behavioral Health Services.

V. CLINICAL SERVICES:

A. Identification at Intake

All incarcerated individuals shall be screened for suicide risk at Intake immediately upon arrival in accordance with HCSD 2.02A, "Reception Screening" and HCSD 4.03A, "Adult Mental Health Services." In addition, facility staff receiving a new patient shall also obtain information regarding conduct and demeanor during transport from the transporting officer or staff. Facility staff in the intake area must not rely exclusively on a patient's denial that they are suicidal; any behavior or actions which suggest the patient is at risk of suicide or self-injurious behavior shall be documented and the nursing staff notified.

Mental health trained nursing staff shall assess each patient and complete the suicide potential screening template of the nursing intake section, on the suicide/behavioral health screen template in the electronic medical record (EMR). Whenever a patient responds "yes" to any bolded question or whenever the patient has answered "yes" to five (5) or more questions, the nurse shall immediately contact the designated QMHP for guidance regarding management.

No patient shall be assigned to a housing unit until the intake suicide risk assessment has been completed.

B. Identification and Referral

An incarcerated individual may become suicidal at any point during confinement and facility staff shall not assume that an individual's ability to successfully function in general population eliminates any risk of suicide. Facility staff that interact with patients shall be aware at all times while on duty of increased suicide risk.

Any employee who:

1. Observes an incarcerated individual engaging in self-injurious, suicidal, or unusual behavior which is believed to present a credible risk of self-injury;

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2. Hears an incarcerated individual make suicidal threats;
3. Is made aware of an incarcerated individual verbal comments expressing a desire or intent to commit suicide; or,
4. Observes an incarcerated individual behaving or displaying any concerning or unusual behavior which for any other reason is believed to demonstrate a credible risk of injury to themselves;

shall directly observe the incarcerated individual until the Shift Supervisor or designated Health Services staff contacts a QMHP and the QMHP gives orders for supervision.

The least restrictive intervention necessary to ensure the incarcerated individual's safety shall be implemented. However, in an emergency, when the incarcerated individual is engaging in physical acts of self-injury or there is imminent danger of self-injury, staff must take action to ensure the physical safety of the incarcerated individual.

The on-call system shall be used to contact a QMHP whenever the QMHP is not on-site. Telephone contact with the on-call QMHP should be limited to the decision about whether to place a patient on observation or the decision to raise the observation level from Close to Constant Observation. A patient's status shall not be downgraded and a patient shall not be discharged from Suicide Watch without a face-to-face assessment by an QMHP.

A QMHP shall provide mental health evaluation and treatment to patients with suicidal ideation or behaviors. When notified by facility staff that an incarcerated individual is suicidal, a QMHP must complete a suicide evaluation within the time frames required by HCSD 2.01, "Access to Care," but no later than the next business day.

An alert shall be placed in the patient's electronic medical record (EMR) whenever they have had a Serious Suicide Attempt or engaged in Serious Self-Injurious behavior.

C. Evaluation

Whenever a patient has been referred, a QMHP shall evaluate the patient's;

1. Behavior or factors resulting in the referral;

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2. Mental health status;
3. Current suicidal risk; ideation, intent to end life, plans, lethality of plan;
4. History of suicidal behavior / ideation: how often, when, precipitating stressors, method used or contemplated, circumstances surrounding rescue, consequences of prior attempts / gestures;
5. Recent stressors and other pertinent social or family history; and,
6. Likelihood of further self-injurious or suicidal behavior in the short-term.

The QMHP shall determine the patient's level of suicide risk, the level of supervision required, and the type of treatment that is needed including, if necessary, transfer to a facility with on-site mental health services or a mental health treatment unit.

Consultation with a psychiatrist and/or other staff shall be obtained to assist in the evaluation as needed.

A patient on Suicide Watch shall be re-assessed daily to identify any change in condition which would necessitate a change in level of supervision or a transfer to another facility. This reassessment shall be documented in the EMR and the results communicated to the multidisciplinary treatment team.

D. Housing

The level of suicide risk shall guide housing unit placement. Patients shall be housed in the least restrictive environment indicated by the level of risk for suicidal behavior, including general population close to staff, specific areas of designated housing units, medical infirmary, or a mental health treatment unit.

Rooms or cells used to house incarcerated individuals at risk of suicidal behavior must be free from significant protrusions, free from any loose or breakable objects, conditions, or fixtures with which the patient could harm themselves. The door shall provide for full visibility inside the cell. The cell shall not contain any object that provides an easy anchoring device for hanging, including but not limited to, any type of clothing hook or towel rack or toothbrush holder on sinks or desks. There shall be no live electrical switches or outlets. Before any patient at risk of suicidal behavior is housed in a cell, the cell shall be inspected using the Safe Cell Check List. When a cell does not meet all of the conditions listed on the Safe Cell Check List, facility staff shall identify and plan for accommodations or special precautions which shall have to be taken, up to and including Constant Observation.

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F. Monitoring

Interventions and monitoring including scheduled follow up shall be based on the patient's individual level of risk. Two levels of increased supervision shall be used for patients at increased risk of suicidal behavior: Close Observation and Constant Observation. Orders for Close Observation and Constant Observation shall be completed at the discretion of QMHPs, based on clinical need.

A patient on Close Observation shall continue to be provided with educational services, showers, visits, etc., commensurate with the patient's security level and treatment plan unless the QMHP determines these activities are contraindicated. Toileting and bathing may or may not be visually supervised, depending on the provisions of the treatment plan.

The Shift Supervisor or designee or mental health trained nurse may raise the observation level of a patient, if circumstances warrant, until the QMHP is consulted. However, only a QMHP may downgrade or discontinue Close or Constant Observation.

A patient at increased risk of suicide or intentional or unintentional death by self-injury shall remain on Suicide Watch until they are removed from this status by a QMHP. Once a patient has been released from Suicide Watch, unless justified otherwise in an assessment and documented in the EMR, the patient shall remain on the mental health caseload and shall receive follow-up assessments by Mental Health staff at the following intervals: within twenty-four (24) hours of the watch being discontinued, once a week for two (2) weeks, and again within thirty (30) days. Follow-up monitoring may occur at more frequent intervals in accordance with the patient's Individualized Treatment Plan (ITP).

ITPs must be unique and specific to the patient and include the problem being addressed, a list of goals and objectives specific to the problems, and a description of the specific interventions to be provided. The treatment plan should include the staff responsible for the interventions to be provided and the frequency or interval of follow up encounters.

A patient who has made a Serious Suicide Attempt while incarcerated in a correctional setting shall remain on the mental health case load for a minimum of one year and be seen by a QMHP every ninety (90) days, at a minimum, or at intervals specified in the Individualized Treatment Plan. After one year, a QMHP may assess the individual's risk and provide

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documentation in the EMR to change the behavioral health code to something more appropriate at that time

G. Levels of Observation

1. Close Observation

Close Observation shall be implemented when a QMHP determines there is a clinical need for observation based on a patient's statement or presentation that they may be suicidal or may engage in self-injurious behavior that could result in death. QMHPs may use their clinical discretion to decide whether to place a patient on close observation, but the evaluation must occur and a treatment plan must be devised.

At this level of observation, staff shall conduct regular visual checks at varying intervals not to exceed fifteen (15) minutes (e.g., 5, 11, 8 minutes). Camera surveillance or a Suicide Watch Companion may be used to supplement staff monitoring but not replace it. When cameras are used, regular checks shall be conducted at regular random intervals no longer than fifteen (15) minutes apart. All visual checks shall be documented.

The patient on Close Observation shall be provided with bedding dependent upon their level of safety as determined by the mental health staff who writes the observation order.

One set of clothes without belts, shoelaces, or similar item(s) that can be easily used for hanging may be provided as determined by the QMHP. The patient shall have no additional personal property unless authorized by a QMHP in writing.

Regular meals shall be provided unless the QMHP specifies no utensils/no packaging diet. When special diets are provided, the number of calories must be equal to the number of calories in the regular diet. For patients on a therapeutic diet, the special diet shall equal the restrictions or accommodations of the prescribed diet if possible. When it is not possible to accommodate the therapeutic diet, the provider shall be contacted and an alternative diet prescribed for the duration of the observation period; the dietician shall be consulted when necessary. Water shall be offered every two (2) hours while the patient is awake if the water has been turned off due to intentional flooding of the observation area, the patient is being observed for water intake, or the cell has no water in it.

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Re-evaluation by a MHP shall be completed daily on business days. When the QMHP is not on site, a mental health trained nurse shall complete a mental status assessment once per day. Telephone contact with the on-call QMHP shall not be required except for initial placement on either Close or Constant Observation, or the decision to raise the observation level from Close to Constant Observation. Close Observation shall not be downgraded without a face-to-face assessment by a QMHP.

2. Constant Observation

Constant Observation shall be implemented in situations where a patient has attempted suicide or when there is an imminent risk of self-injury that may intentionally or unintentionally result in death.

Staff or Suicide Watch Companions shall perform continuous, one-to-one, line-of-sight, direct visual observation while a patient is on Constant Observation. At no time shall a cuff port/food slot be used as a means for observation. Cuff ports/food slots are to remain closed at all times unless being used to place / remove cuffs or deliver / remove food trays. An appropriately selected and trained Suicide Watch Companion may be used to carry out the Constant Observation procedures. When a staff member is used for Constant Observation, the staff member must document observations at least once every fifteen (15) minutes. When a Suicide Watch Companion is utilized, an assigned staff person shall confirm that the Suicide Watch Companion maintained the visual watch by conducting routine visual checks at staggered intervals not to exceed thirty (30) minutes and noting if any problems occurred.

Unless otherwise specified by the QMHP, a patient on Constant Observation may not have personal property or clothing other than underwear and a safety smock for modesty. The cell shall be empty and stripped with only a mattress and approved suicide blanket.

If the patient's risk of suicidal or self-injurious behavior escalates due to the destruction of smock or other protective clothing or destruction of the bedding, a QMHP or, when the danger is imminent, the Shift Supervisor may order all clothing and bedding removed. When all clothing has been removed, a staff member of the same gender identity as the patient shall be assigned to constantly observe the patient. When these measures are not successful and the patient continues to engage in acts of self-

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injurious behavior, restraints may be used in accordance with HCSD 4.02A, “Therapeutic Restraint.”

At a minimum, nursing staff shall obtain vital signs and conduct a mental status assessment twice per day, with no less than six (6) hours between assessments. The nurse shall document the results of these assessments in the electronic medical record.

The provisions noted above in the Close Observation section shall be followed in regard to meals, therapeutic diets, and the client being offered water.

A QMHP must evaluate the patient at least daily on business days. When the QMHP is not on-site, a mental health trained nurse shall complete a mental status assessment twice per day and consult with the MHP, if clinically indicated. Suicide Watch may not be discontinued or downgraded unless an QMHP has evaluated the patient in person.

H. Intervention

1. General Population

Any facility staff that discovers a patient attempting suicide, bleeding profusely, or unresponsive shall respond immediately, alerting other staff to call for the facility’s nursing staff if available and bringing the emergency response bag to the cell (Signal 3000). When no nurse is on duty, facility staff must contact 911 and access external emergency medical services (EMS). The exact nature of the emergency (e.g., “hanging attempt”) and location of the emergency must be communicated to facility nursing staff or EMS personnel.

Once facility staff and, if indicated, external emergency medical services have been notified, the responding facility staff must respond as quickly as possible. Two (2) facility staff must be present before entering the cell or area where the patient is found. (At least one [1] of the staff must be Custody staff.) Facility staff must never wait for nursing staff or external emergency services to arrive before initiating appropriate life saving measures.

If a patient is hanging, facility staff must use necessary measures including the cut-down tool to release the patient from the ligature. Facility staff must assume a neck/spine cord injury and stabilize the neck with a cervical collar or other means (e.g., rolled blankets) and

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the spine with a backboard. When external emergency services are necessary, the Shift Supervisor or designee shall ensure emergency services personnel have unimpeded access to the patient. All life-saving measures must be continued by facility staff until on-site nursing staff or external emergency medical personnel assume care.

Any incarcerated individual attempting suicide shall receive a comprehensive psychological assessment as soon as medically feasible.

Each incarcerated individual attempting suicide or otherwise placed on Suicide Watch shall have a treatment plan that includes goals and specific interventions designed to address and reduce suicidal ideation and threats, self-injurious behavior, and suicidal threats perceived to be motivated by secondary gain. The plan shall be discussed with the patient.

2. Restrictive Status Housing and Specialized Mental Health Units

In restrictive status housing or on specialized Mental Health Units, activation of the cell extraction team is not required in an emergency situation when the patient is inside a cell and unresponsive, is already hanging, or is bleeding profusely. To ensure the safety of staff, at least two (2) staff persons must be present to enter a cell when a patient is hanging or bleeding profusely or for a non-responsive patient.

When a patient is found hanging , the following procedures shall be implemented:

- a. The first staff person on the scene shall conduct a visual assessment of the patient from outside the cell and quickly determine if the patient has an article around their neck and is in fact attempting to or has completed connecting it to an object in an effort to hang themselves.
- b. The first staff person on the scene shall remain at the cell front for observation and summon a correctional officer on the radio to come to the cell for assistance. In addition, the first staff person on the scene shall contact Control and announce a Signal 3000 on the radio. While waiting for assistance the staff person on the scene shall observe the patient's hands for any objects that may be a possible weapon.

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- c. Immediately upon the arrival of at least one (1) correctional officer (minimum of two [2] staff must be present), staff shall enter the cell. Both staff shall lift the patient up and one (1) staff member shall cut the patient down with the designated cutting device (this device is to be located in all secured control rooms and on official stations in individual housing units). The first responders' Officer-In-Charge (OIC) shall be responsible to ensure the cutting device is ready for use at incident area. The patient shall be laid on the floor (hard surface if possible) and the article around his neck shall be removed. The correctional officers/staff shall begin basic life saving techniques. When medical assistance arrives, the Health Services staff shall assume the lead role in life saving techniques assisted by the correctional officers/staff if necessary.

When a patient is found unresponsive:

- a. The first staff person on the scene of an unresponsive patient in a cell shall conduct a visual assessment from outside the cell to determine if the patient is in fact not responding to any questions about their condition and appears either to be unconscious or experiencing a medical emergency.
- b. The first staff member on the scene shall remain at the cell front for observation and shall call Control and announce a Signal 3000. While waiting on assistance the staff person shall observe the location of the patient's hands and if they hold any objects that may be used as weapons. While waiting for staff assistance, the staff person on the scene shall call the Shift Supervisor on the radio, if possible, and request to go to specified Tac Channel to inform them that they have a patient that is unresponsive along with the patient's condition and location. The Shift Supervisor shall quickly make a determination of the appropriate response. If the Shift Supervisor's directions are different than those stated in the following paragraph, a written justification shall be required after the incident is over.
- c. Once a minimum of two (2) staff persons (at least one [1] correctional officer) have arrived at the cell, the door shall be opened and the staff shall enter the cell. Staff shall enter the cell with caution and be prepared to use an O/C streamer

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but they shall move quickly to secure a hold on the patient's arms. Restraints shall not be applied to the patient's hands, instead one (1) of the staff shall secure the patient and the other staff person shall assess the patient and begin life saving measures.

I. Communication

Facility staff shall converse with a patient whenever a critical event such as the death of a loved one has occurred or whenever loud arguments occur during family visits to identify feelings of hopelessness or suicidal intent. Facility staff shall encourage family and friends of the patient, including other patients to notify facility staff if they believe a patient is at risk of suicide or self-injurious behavior.

All facility staff shall share pertinent information and make appropriate referrals to Health Services staff whenever a patient is suicidal or is suspected to be at increased risk for self-injurious behavior. Facility staff must use various communication skills with the patient including active listening, staying with the patient when imminent danger is suspected, and maintaining contact through conversation.

Each facility must have a mechanism to notify the Warden, the Health Services staff and incoming shift's custody staff of the status of each patient on Suicide Watch. Officers transporting a patient to another jurisdiction or to another facility shall also be advised of a patient's suicide risk. When an patient on Suicide Watch is transferred from one facility to another, the sending facility staff and the transporting officer must communicate the patient's level of Suicide Watch and the provisions of the safety plan to receiving officers and Health Services staff.

Whenever a patient is placed on Suicide Watch, the Shift Supervisor or designee shall notify designated facility staff including the caseworker or case manager of the specific level of observation and associated precautions or orders. The Shift Supervisor must keep a separate daily roster of all patients on Suicide Watch. The roster must be distributed to appropriate facility staff including nursing and mental health staff.

When a patient returns following transfer to another facility or local hospital for self-injurious or suicidal behavior, the Shift Supervisor must contact the on-site nursing or mental health staff and obtain direction regarding what measures or observations are necessary. The on-call system shall be used to contact an QMHP whenever the QMHP is not on site.

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All incidents of suicidal behavior including authorizations for Close or Constant Observation, reassessments, and any changes in Suicide Watch level must be documented on the suicide monitoring forms and in the electronic medical record.

J. Notification and Reporting

All appropriate facility staff including the Warden, nursing staff, site psychiatrist or psychiatric prescriber, and the QMHP shall be notified of a patient's suicide attempt.

For a completed suicide, the Warden, appropriate Department Executive Staff, including the Executive Director of Behavioral Health, the Chief Medical Officer, Director of Mental Health, and the Director of Physical Health Services must be notified in accordance with applicable procedures and directives.

K. Documentation

All facility staff involved in assessing suicide risk and suicide watches must record their observations and interventions on applicable forms and on appropriate templates in the electronic medical record. At a minimum, staff must record:

- Patient name and identifying data
- Date, time, location of events
- Description of behaviors of concern
- Identification of staff who were present or participated in the suicide watch
- Identification of QMHPs involved and direction received
- Interventions provided;
- Patient's response to interventions
- Updated orders

Personnel carrying out Close or Constant Observation Suicide Watch must document the checks as they are completed or as soon as possible after the check is completed. Staff must not defer documentation to the end of a shift and record all checks simultaneously. When Suicide Watch Companions are used, the designated staff person must verify and document that the companion maintained the visual watch and note if any problems developed.

Additionally, QMHPs shall provide documentation of:

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- Date, time, and location of situation
- Chronological account of the development and handling of the crisis
- Description of patient's behavior and mood
- Information gathered from other staff involved
- Psychiatric history review
- Rationale for the crisis status placement
- Current mental health status
- Current psychotropic medications, if any
- Individual Treatment Plan with clearly stated and relevant problems, goals, objectives, interventions, time frames, and staff responsible
- QMHP's orders

L. Review

Critical Incident Stress Debriefing (CISD) provides affected staff an opportunity to process their emotional reactions to and thoughts about the incident, develop an understanding of critical stress symptoms, and ways of dealing with those symptoms. In the event of a serious suicide attempt or suicide, all affected staff shall be offered CISD. Patient's shall be offered the opportunity to speak with mental health staff following a serious suicide attempt or suicide of an patient whom they lived close to or interacted with socially. For maximum effectiveness, the CISD process and other appropriate support services shall occur within seventy-two (72) hours of the critical incident when possible.

Every suicide shall be reviewed within thirty (30) days. A mortality review must be completed in accordance with procedures established by HCSD 2.24, "Clinical Critical Incidents." The Review Team must include representatives of both line and management level staff from the direct care, medical, and mental health divisions. The Review process shall comprise a critical inquiry of:

- Circumstances surrounding the incident
- Facility procedures relevant to the incident
- All relevant training received by involved staff
- Pertinent medical and mental health services/reports involving the victim
- Possible precipitating factors leading to the suicide
- Recommendations, if any, for changes in policy, training, physical plant, medical services, mental health services, and/or operational procedures.

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When appropriate, the Review Team shall develop a written plan (and timetable) to address areas that require corrective action.

In addition to the critical incident debriefing, facility Health Services staff shall conduct a mortality review and psychological autopsy for suicides that occur in Department facilities.

M. Suicide Prevention Committee

Each facility shall establish a suicide prevention committee which shall review the adequacy and effectiveness of suicide prevention practices.

Facility committees shall consist of the facility's Lead QMHP (chair), the Suicide Prevention Coordinator, and at least two (2) individuals appointed by the Warden from various services in the facility including Correctional Officers, Unit Team staff, Chaplains, other Health Services personnel, and volunteers. The committee shall review the following points quarterly:

1. Quality and extent of suicide prevention training;
2. Effectiveness of the Suicide Watch Companion program;
3. Quality and thoroughness of the mental health evaluations;
4. Completeness of observation records; and,
5. Quantitative measures and outcomes of Close and Constant Observations.

All meetings shall be held quarterly and meeting minutes shall be maintained with a copy forwarded to the Warden and the facility's Quality Assurance Manager.

N. Suicide Watch Companion

Each adult facility with a security level of 2 or higher shall establish a Suicide Watch Companion program to enhance and complement the facility's Suicide Watch procedures. Each facility shall establish a facility specific program for Suicide Watch Companions using the following guidelines:

1. Selection

Suicide Watch Companions must be carefully screened. Preference shall be given to those patients who have a record of positive responsible behaviors, such as serving as peer mentor in a treatment program. The Warden or designee shall select patients for the Suicide Watch Companion program.

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In order to be a Suicide Watch Companion, a patient must:

- a. Be a graduate of Purposeful Living Units Serve (PLUS);
- b. Have maintained a conduct record clear of any Class A or Class B guilty findings for at least one (1) year;
- c. Have maintained a conduct record clear of violence for at least four (4) years;
- d. Have volunteered or applied for the position as a job;
- e. Be free of medical or behavioral health issues which the medical/behavioral health staff believe would impair the patient's ability to perform the duties of a Suicide Watch Companion; and,
- f. Demonstrate measurable progress on their Case Plan.

Each facility operating a Suicide Watch Companion Program shall develop incentives for exemplary program participation. Such incentives may include, but are not limited to, the following:

- a. Public recognition ceremonies;
- b. Special media or other events;
- c. Certificates of Achievement; and,
- d. Community service "credit" for the PLUS Program.

2. Training

All Suicide Watch Companions shall complete training based on a curriculum, approved by the Executive Director of Behavioral Health Services or designee. This training shall include, but not be limited to, the following elements:

- a. Scope and limits of role and responsibilities;
- b. Methods for reporting emergencies to staff;
- c. Nature and etiology of suicide;
- d. Accountability (i.e., sanctions for malfeasance);
- e. Risk factors related to suicidal crises;
- f. Signs and symptoms of imminent suicidal ideation;
- g. Active listening skills;
- h. Prohibition of transmittal of food, drink, or other items;

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- i. Length of shift;
- j. Limits of confidentiality; and,
- k. Debriefing with Suicide Prevention Coordinator.

Suicide Watch Companions must complete this training prior to assisting staff in monitoring any patient on Constant Observation. In addition, Suicide Watch Companions shall receive four (4) additional hours of training every six (6) months. At the completion of the initial training and after the completion of the four (4) hour semiannual training, the Suicide Watch Companion must review and sign and receive a copy of the “Responsibility Agreement” form. The Suicide Prevention Coordinator shall maintain the original copy of this form and a copy shall be filed in the patient’s facility packet.

It is the responsibility of the Suicide Prevention Coordinator to maintain an updated record of Suicide Watch Companions who have been trained as well as who needs re-training.

3. Assignment of Suicide Watch Companion

When a patient is placed on Constant Observation, the Warden or designee shall determine, in consultation with the Suicide Prevention Coordinator, whether staff or a Suicide Watch Companion shall conduct the observation. If it is decided that a Suicide Watch Companion is to be used, the Shift Supervisor shall assign the Suicide Watch Companion based on a roster, continuously updated by the Suicide Prevention Coordinator, maintained in the Control Center. Suicide Watch Companion shall be positioned at a table, desk, or chair directly in front of the Constant Observation cell or room where they can maintain a line-of-sight, direct visual observation of the patient.

The Suicide Watch Companion on duty must complete the “Suicide Companion Program – Companion Watch Report.” Correctional officers shall document their twice-per-hour checks in the same record. At the conclusion of the watch, all logs shall be forwarded to the Suicide Prevention Coordinator for review and forwarded to Health Services to be uploaded to the EMR. Meals, showers, medication issuance, and similar activities shall be exclusively overseen and documented by staff. Visits by an QMHP, chaplains,

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and other staff shall be documented by those individuals at the time of their visit.

A correctional officer designated by the Shift Supervisor must check on both the incarcerated individual working as a Suicide Watch Companion and the patient on Constant Observation at least twice each hour, at varied intervals, which may not exceed thirty (30) minutes. The Suicide Watch Companion time “on duty” is limited to four (4) hours in any twenty-four (24) hour period.

In the event of an emergency or any other situation that requires immediate staff attention, the Suicide Watch Companion shall seek assistance by contacting the Control Officer and/or the designated correctional officer via a pre-determined method of communication, such as a telephone, bell, whistle, intercom, or panic button. If such an emergency involves self-destructive behavior and/or the application of restraints, the Suicide Watch Companion shall be immediately removed from the area and replaced by a staff person. At any point, the QMHP may determine an officer watch is clinically indicated. If that clinical decision is made, Suicide Watch Companion watch shall be discontinued, and a Custody officer will resume the watch.

The Suicide Watch Companion may engage in verbal interaction with the patient on Observation if the QMHP permits. However, at no time shall the Suicide Watch Companion attempt to compel the patient to talk or offer solutions to the patient’s current problems, nor shall the companion give any item to the patient on Suicide Watch.

The Suicide Watch Companion is not authorized to bring any item to the watch. They shall be thoroughly searched prior to and following each four (4) hour shift. Water shall be provided by staff for the Suicide Watch Companion at the beginning of and as necessary during each four (4) hour shift. Restroom breaks shall be afforded, preferably when the correctional officer conducts their checks. The Companion shall not consume a meal during the course of a Watch, although staff shall make certain that the Suicide Watch Companion is served a regular meal before or after any shift that occurs during meal time.

The Suicide Prevention Coordinator shall maintain a log documenting:

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Title SUICIDE AND SELF-INJURY PREVENTION			

- a. The name and DOC number of the patient placed on Constant Observation;
- b. The date and time Constant Observation was started and stopped;
- c. The names and DOC numbers of the Suicide Watch Companions; and,
- d. Any comments regarding issues or problems which occurred during the Constant Observation period.

If a Suicide Watch Companion refuses to report for an assigned shift, fails to adhere to the guidelines and expectations set forth in the Suicide Watch Companion Voluntary Service Form, or engages in behavior which jeopardizes the safety of a patient on Constant Observation, the Suicide Watch Companion shall be subject to any or all the following sanctions:

- a. Receipt of a Report of Conduct for Code 356, "Refusing an Assignment;"
- b. Expulsion from the PLUS program and Unit, if applicable;
- c. Assignment to "Idle" (no-pay) status for a ninety (90) day minimum if employed as a Suicide Watch Companion; and/or,
- d. Other administrative actions deemed appropriate by the Warden.

At no time shall an incarcerated individual, or group of incarcerated individuals, be given control or authority over other incarcerated individuals.


VI. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
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Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other Reference: National Correctional Healthcare Standards
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I. PURPOSE:

This Health Care Services Directive (HCSD) establishes guidelines for providing care for adults with intellectual and/or developmental disabilities.

II. DEFINITIONS:

- A. **DEVELOPMENTAL DISORDER (DD):** A condition involving an impairment in physical, learning, language, or behavioral areas, which may seriously affect learning, socialization skills, vocational adjustment, and/or self-care. Symptoms typically present prior to the end of the developmental period.
- B. **INTELLECTUAL DISABILITY (ID):** A mild, moderate, or severe or profound condition defined in the Diagnosis and Statistical Manual (5th Edition). At a minimum, this includes:
 - 1. Intellectual functioning at or below an IQ score of seventy (70) on a standardized test of intellectual ability.
 - 2. An impaired level of functioning as measured by a score at or below seventy (70) on a standardized test of adaptive functioning.

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III. GUIDELINES:

Most patients who suffer from a developmental disorder or intellectual disability are identified at Intake through History, Pre-Sentence Investigation, or Educational testing. Identified patients shall be fully reviewed by Mental Health staff and have treatment plans established as needed. If needed accommodations are identified by mental health staff, they will be shared with on-site administrative, Unit Team, and Classification staff. If cognitive testing is completed, results shall be entered into the Electronic Medical Record (EMR). Treatment plans shall include interventions to address needs in any of the following areas:

- A. Housing placement;
- B. Educational needs;
- C. Training needs;
- D. Activity and recreational participation and restrictions; and,
- E. Avoidance of victimization.


IV. APPLICABILITY:

This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Title
TRANSITIONAL HEALTH CARE PRE-RELEASE CONTINUUM OF CARE

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other Reference:
IC 11-8-5-2	01-02-101 01-04-101 01-04-105	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) outlines the process for identifying, notifying staff, and coordinating continuum of care for a patient identified as having a special need.

II. DEFINITIONS:

For the purpose of this policy and administrative procedure, the following definitions are presented:

- A. **ACTIVITIES OF DAILY LIVING (ADL):** The basic tasks that must be accomplished every day for an individual to thrive. Examples include bathing, dressing, grooming, and toileting.
- B. **BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS):** Services for individuals with developmental disabilities that enable them to live as independently as possible in their communities.
- C. **CASE MANAGEMENT STAFF:** A member of Unit Team who acts as the initial point of contact in the housing unit for day-to-day issues, coordinates case management matters, facilitates access to programs and services, works with incarcerated individuals to create case plans, and assists in preparing the individual for the release and Re-Entry process.

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- D. CHIEF MEDICAL OFFICER (CMO): An Executive leadership position within the Department designated as head of the Health Services Division, who serves to advise and lead a team of health experts on matters of public health importance.
- E. COMMUNITY TRANSITION PROGRAM COORDINATOR – Community Corrections Division staff located in Central Office, responsible for managing the Statewide program and collaborating with county supervising agencies for program delivery.
- G. CRISIS: An unstable and dangerous mental health state that could negatively affect an individual or the community.
- I. DIRECTOR OF OPERATIONAL SUPPORT SERVICES: Leadership position within the Operations Division that supervises movement, transportation, and facility populations.
- J. DIRECTOR OF TRANSITIONAL HEALTHCARE AND CONTRACT COMPLIANCE: Leadership position within Health Services Division that supervises the Transitional Healthcare Manager, Maternal Child Health Coordinator, and contract compliance
- J. DIVISION OF DATA ANALYTICS: The Division of Data Analytics is responsible for data stewardship and the preservation of Department's data assets. The Division has primary responsibility for Department reporting and analyses of Department data and information collected from the Department's operational systems of record.
- K. EARLIEST POSSIBLE RELEASE DATE (EPRD): The date on which an incarcerated individual would be entitled to discharge or release, taking into consideration: 1) the term of the sentence; 2) the term of any other concurrent or consecutive sentence which the individual must serve; 3) credit time which the individual has earned prior to sentencing; and, 4) the maximum amount of credit time which the individual would earn if the individual remained in the current credit class during the period of confinement.
- L. EPIDEMIOLOGIST: A person who studies or is an expert in the branch of medicine which deals with the incidence, distribution, and possible control of diseases.

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- M. EXECUTIVE DIRECTOR OF TRANSITIONAL HEALTHCARE: An executive leadership member that oversees and supervises Transitional Healthcare within the Health Services Division .
- N. FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA): FSSA is a health care and social service funding agency of the State of Indiana that oversees five (5) care divisions that administer services to Indiana residents.
- O. HEALTH SERVICES ADMINSTRATOR (HSA): A staff person selected by the Health Services vendor that is responsible for planning, directing, and coordinating health care services in a Department facility.
- P. HIV CARE COORDINATION RELEASE OF INFORMATION: A Non-Medical Case Management Release of Information document that authorizes coordination of Case Management services with the Indiana Department of Health relevant to the care of a person living with human immunodeficiency virus who is due to be released from a Department facility.
- Q. H&P: shorthand for history and physical, the initial clinical evaluation and examination of the patient.
- R. IMMEDIATE RELEASE: A court order notification requiring the release of an incarcerated individual immediately upon a completed release review and issuance of a Release Authorization.
- S. INDIANA DEPARTMENT OF HEALTH (IDOH): The public health funded agency of the State of Indiana that promotes quality of life by providing health resources for Indiana residents.
- T. INTELLECTUAL DISABILITY: Disability originating before the age of 18 (eighteen) characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills.
- U. LEVEL OF CARE: the intensity or effort required to diagnose, treat, preserve, or maintain an individual’s emotional or physical health.
- V. LONG TERM CARE: Level of care that provides a variety of services designed to meet a person’s health and personal care needs.

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- W. MEDICAL ISOLATION: Confining a confirmed or suspected case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission.
- X. MANAGED CARE ENTITY (MCE): An entity that provides health care plans and services through health insurance.
- Y. MEDICAL QUARANTINE: Confining individuals who have had close contact with a positive case to determine whether they develop symptoms of the disease.
- Z. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team to record, store, and review data including case plans and progress reports.
- AA. OFFENDER TRANSPORT ORDER (State Form 23605): The document authorizing the transportation of an incarcerated individual from one facility to another facility or agency, authorizing the gate to be released for the transportation and/or serves as a receipt for an incarcerated individual being received or transferred between facilities or agencies.
- BB. PUBLIC HEALTH CRISIS: An urgent situation in which the health status of an area within the territory is adversely affected including localized outbreaks of an infectious disease or a potential outbreak of an infectious disease that has a reasonable possibility of occurring and that poses a significant threat to a community or region in the territory.
- CC. PANDEMIC: A disease outbreak that spreads across countries or continents occurring over a wide geographic area and affecting an exceptionally high proportion of the population.
- DD. PRIOR AUTHORIZATION: A utilization management process used to determine if a health care entity will cover a prescribed procedure, service, or medication.
- EE. REGIONAL DIRECTOR OF TRANSITIONAL HEALTHCARE: A leadership position selected by the Health Services vendor to oversee and direct Transitional Healthcare Liaisons and Transitional Healthcare Facilitators and special needs referrals Statewide.

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- FF. SPECIAL NEEDS DASHBOARD: A database that is managed by Transitional Healthcare that houses information on releasing incarcerated individuals which includes the: EPRD, health classification, location, and potential county of release.
- GG. SPECIAL NEEDS INDIVIDUAL (SNI): An individual who has been determined to require special attention or possess a physical health or behavioral health condition that requires a continuum of care upon release.
- HH. SUPERVISOR OF CLASSIFICATION: The facility employee who renders the final decision on all classification activities at the facility.
- II. TRANSITIONAL HEALTHCARE FACILITATOR: A member of the Health Services vendor that collaborates with Health Services, Addiction Recovery Services, Behavioral Health, family members, supervising agencies, and various community resources in order to address healthcare needs of releasing individuals.
- JJ. TRANSITIONAL HEALTHCARE MANAGER (THM): A member of Transitional Healthcare division that supervises the Transitional Healthcare Specialists and the activation of health coverage for releasing individuals.
- KK. TRANSITIONAL HEALTHCARE LIAISON: An employee of the Health Services vendor who assesses parolee needs and develops, along with advocating for, individual treatment plans, community resources and support services.
- LL. TRANSITIONAL HEALTHCARE): A team within the Health Services Division specializing in coordination and continuum of health care when an incarcerated individual enters and is released from the Department, including the processing of health care applications, and communicating with FSSA in matters related to State of Indiana benefits .
- MM. TRANSITIONAL HEALTHCARE SPECIALIST (THS): A member of Transitional Healthcare team that reviews health care coverage for releasing individuals and assists in continuum of care planning post release.
- NN. TEMPORARY LEAVE: A period of time in which an incarcerated individual is authorized by the Warden to leave the facility, either escorted by staff or unescorted, including temporary passes issued by a Work Release facility.

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OO. UNIT TEAM MANAGER: The administrator and supervisor of a unit who supervises the Casework Manager and Correctional Caseworker.

PP. 24 HOUR SKILLED NURSING: Care that requires around the clock services to complete activities of daily living.

IV. COMMUNICATION AND FACILITY INVOLVMENT:

Communication is necessary and required for the success of the Transitional Healthcare Department. The Transitional Healthcare Facilitator shall host or attend a scheduled meeting monthly to review upcoming special need releases with Case Management, Operations, Classification, and Health Services staff. If a meeting cannot be accommodated, the facilitator shall inform the facility HSA, the Health Services vendor's Regional Director of Transitional Healthcare, Director of Transitional Healthcare and Contract Compliance.

V. ONE HUNDRED AND EIGHTY (180) DAYS FROM EPRD:

A. Identification:

The Division of Data Analytics shall provide the Transitional Healthcare Department and the Transitional Healthcare Facilitators a monthly dashboard of incarcerated individuals releasing within 180 days. This database will include the incarcerated individual's name, DOC number, age, received date, facility, and classification designation.

The Transitional Healthcare Facilitator shall review the data board to triage incarcerated individuals by release date, most severe physical and behavioral health codes. Patients classified with a physical health code of B shall be triaged as potential long-term care or skilled nursing placement.

At the time of CTP eligibility, the CTP Coordinator shall contact Transitional Healthcare regarding any incarcerated individual as a B,C,F, I physical health code, B. C, D disability code, or a C D E or F behavioral health code, to determine capability of participating in CTP. Determination of capability shall be made within five (5) business days of notification.

In the event of an immediate release Case Management staff and on-site Health Services vendor staff shall determine if incarcerated individual requires special needs release planning. This may include, but is not limited to skilled nursing care, durable health equipment, or infectious disease care coordination. If special needs is required, HSA or designee shall

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communicate with Transitional Healthcare Facilitator regarding what referrals are needed for a successful release. If the assigned Case Management staff becomes aware of an immediate release that meets special needs definition, they shall forward an email to SpecialNeedsReleases@idoc.in.gov within one (1) day of notification providing information regarding, placement information, and transition planning concerns.

B . Notification

The Transitional Healthcare Facilitator shall triage their special needs dashboard. They shall contact the HSA to provide clarification and communication of the patient’s diagnosis, physical or behavioral health needs, level of care including ambulation issues, wound care, and any issues related to activities of daily living. Information shall be submitted to the Facilitator within ten (10) business days of initial notification. If a facility does not have an assigned facilitator, the Contracted Medical Vendor Regional Director of Transitional Healthcare (or designee) will work directly with the HSA as needed.

The HSA (or designee) shall ensure that the release planning template is documented in EMR and updated for release planning purposes. The HSA or designee shall ensure all required documentation is current including but not limited to diagnoses match the problem list, detailed H&P if required, detailed description of assistance needed, and any durable medical equipment required for release. HSA shall adhere to HCSD 2.20A, “Communications Regarding Special Needs Patients,” and HCSD 2.03A, “Continuity of Care.”

After physical and behavioral health information has been received from the site HSA, the Facilitator shall import data into the special needs dashboard and document all interactions and referrals in EMR within five (5) business days of notification.

The Transitional Healthcare Facilitator shall review documentation provided by the HSA or designee and generate an appropriate behavioral health and physical health referral for any diagnosis that will require a prior authorization within ten (10) business days of notification

Patients who have been identified with a diagnosis of an intellectual disability shall be triaged as a Bureau of Developmental Disabilities (BDDS) patient. BDDS referral shall be forwarded to the Health Services

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vendor’s Regional Director of Transitional Healthcare for notification for necessary assessments.

The Health Services vendor’s Regional Director of Transitional Healthcare (designee) shall coordinate with the on-site behavioral and physical health staff to determine if additional testing is needed.

The site Psychologist shall ensure any additional testing or assessments are scheduled within seven (7) days of request. Once the application is submitted to the physician for confirmation of diagnosis, the Health Services vendor’s Regional Director of Transitional Healthcare (designee) shall submit the assessment and testing information to the BDDS local office within thirty (30) days of identification.

VI. NINETY (90) DAYS FROM EPRD:

The Transitional Healthcare Facilitator shall contact the HSA to review special needs data board for any change in the patient’s behavioral health or physical health status. The HSA or designee shall review the EMR to ensure that the problem list is accurate and matches all diagnoses that are included on the release template. The HSA shall submit information within five (5) business days of notification. The Transitional Healthcare Facilitator shall update special needs dashboard within five (5) business days of receiving information.

The Health Services vendor’s Regional Director of Transitional Healthcare or designee shall ensure documentation of a continuum of care plan is updated on the special needs dashboard and information is triaged appropriately. This information shall be available to Transitional Healthcare and the Transitional Healthcare Liaisons for monitoring of healthcare coverage status and timeliness of community referrals. Referrals and educational material related to the continuum of care plan shall be provided to the patient via release portfolio.

The Transitional Healthcare Facilitator shall notify the Health Services vendor’s Regional Director of Transitional Healthcare or designee to schedule services for all psychotropic injection participants, patients requiring advanced level of care assessments, and BDDS applicants regardless of supervision type. A continuum of care action plan shall be communicated with Department Transitional Healthcare staff within five (5) business days of notification.

Transitional Healthcare Facilitator shall provide site Addiction Recovery Services (ARS) Director, or designee, with an upcoming release list of patients with “F”

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Behavioral Health codes. The ARS Director shall assess, determine, and communicate level of need and treatment recommendations.

HSA shall contact Health Services vendor’s Regional Director of Transitional Healthcare) or designee with patient information deemed potentially eligible for skilled nursing facility. The Health Services vendor’s Regional Director of Transitional Healthcare or designee shall schedule an assessment with the local Area on Aging to determine eligibility. Once eligibility has been determined, the Health Services vendor’s Regional Director of Transitional Healthcare or designee shall begin identifying appropriate placement options. The Health Services vendor shall notify the Department’s Transitional Healthcare staff to initiate review of healthcare coverage status.

The HSA shall provide oversight to ensure that all diagnoses are correctly documented in the EMR including the current problem list. All EMR documentation shall abide by 2.04 “Physical Health Status Classification Assignments.”

VII. SIXTY (60) DAYS FROM EPRD:

The Transitional Healthcare Facilitator shall contact the OCMS assigned Case Management staff along with Unit Team Manager if placement has not been established or if placement options cannot meet the patient’s level of need.

The Transitional Healthcare Facilitator shall review any pending prior authorization referrals to ensure that all required paperwork is completed. The Transitional Healthcare Facilitator shall contact the assigned Case Management staff as needed to make certain that vital documents have been applied for and received on behalf of the patient.

The Department’s Transitional Healthcare Specialist shall adhere to HCSD 5.02A, “Healthcare Application Process,” when applying for health care coverage for releasing patients. If the patient qualifies for additional State or federal benefits, the Transitional Healthcare Specialist shall make every attempt to apply for qualified benefits.

The HSA and site Transitional Healthcare Facilitator shall adhere to HCSD 3.03A, “Human Immunodeficiency Virus,” and 3.04A, “HCV Management,” in regard to infectious disease release planning.

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If the patient’s Managed Care Entity (MCE) is known, the Transitional Healthcare Facilitator or designee shall contact the assigned Case Management staff in OCMS as needed to obtain a release of information to contact the MCE or community providers for continuum of care planning.

VIII. THIRTY (30) DAYS FROM EPRD:

Patients with a Hepatitis C diagnosis and have successfully completed treatment shall receive educational information about community resources from the Transitional Healthcare Facilitator.

All incarcerated individuals shall receive educational information regarding infectious disease control in their release portfolio

HSA shall ensure that the EMR release planning template notes the date of any physical health or behavioral health injections and shall provide the prescriptions to the Transitional Healthcare Facilitator or designee within three (3) business days of the EPRD. The HSA shall provide documentation that the prescription was sent in the EMR by close of business.

Any patients identified as special needs releasing to Parole supervision shall be referred to the assigned Transitional Healthcare Liaison no later than thirty (30) days from EPRD or within one (1) business day of EPRD change under thirty (30) days. The Transitional Healthcare Facilitator shall provide information, not limited to patient’s physical and behavioral health codes, IDOC number, and any information regarding actions taken by the Transitional Healthcare Facilitator.

A. Transportation

The Supervisor of Classification or designee shall be notified by the HSA or designee if the patient will be released with medication. A transport order shall be completed for all releasing medications.

If a patient is not released with their prescribed medication, the HSA shall overnight medication by close of business the day of the notification, as required in HCSD 2.15A , “Medication Management.” and document the action taken in EMR within one (1) business day of action.

If releasing patient is being transported to a crisis center or hospital emergency department, the Transitional Healthcare Manager or designee shall contact the Director of Operational Support Services to request consideration for a single transport rather than a combined transport. If the

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patient requires a special transport vehicle such as an ambulance, the HSA shall communicate with the Director of Operation Support Services and adhere to Policy and Administrative Procedure 02-03-110, “Adult Offender Transportation,” regarding specialized transportation needs.

If a patient in crisis at time of release, they shall be transported to a crisis center location provided by the Health Services vendor’s Regional Director of Transitional Healthcare and notification forwarded to the Executive Director of Transitional Healthcare or designee. If patient refuses entrance into a crisis center or hospital emergency department, the transporting officer shall contact the Warden immediately for instructions. Unless directed by the Chief Medical Officer, at no time shall the transporting officer leave a patient in crisis unattended.

Any scheduled specialized transportation shall be documented in EMR by close of business day.

In the event that a patient needs released outside of the scheduled release date or time, the Executive Director of Transitional Healthcare shall contact the Executive Director of Classification for approval and assist in completing necessary paperwork.

B. Classification:

The Supervisor of Classification or designee shall contact assigned Case Management staff in OCMS if placement is not confirmed within one week of EPRD.

All code changes (physical health, behavioral health , disability status) shall be forwarded to the on-site Classification staff on the same business day or special need releases, any code changes shall be forwarded to the Transitional Healthcare Facilitator on the same day of the request to Classification.

The Department Transitional Healthcare Specialist shall contact the patient’s assigned MCE, if known, to confirm release date, release address, and healthcare concerns. If the patient is on probation or community supervision, the Department Transitional Healthcare Specialist or designee shall attempt to convey release needs to supervising agency.

IX. CONTIUMUM OF CARE POST RELEASE:

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In the event of a declared public health crisis, release procedures relevant to the Department’s Transitional Healthcare shall be established by the Department’s Epidemiologist and Chief Medical Officer.

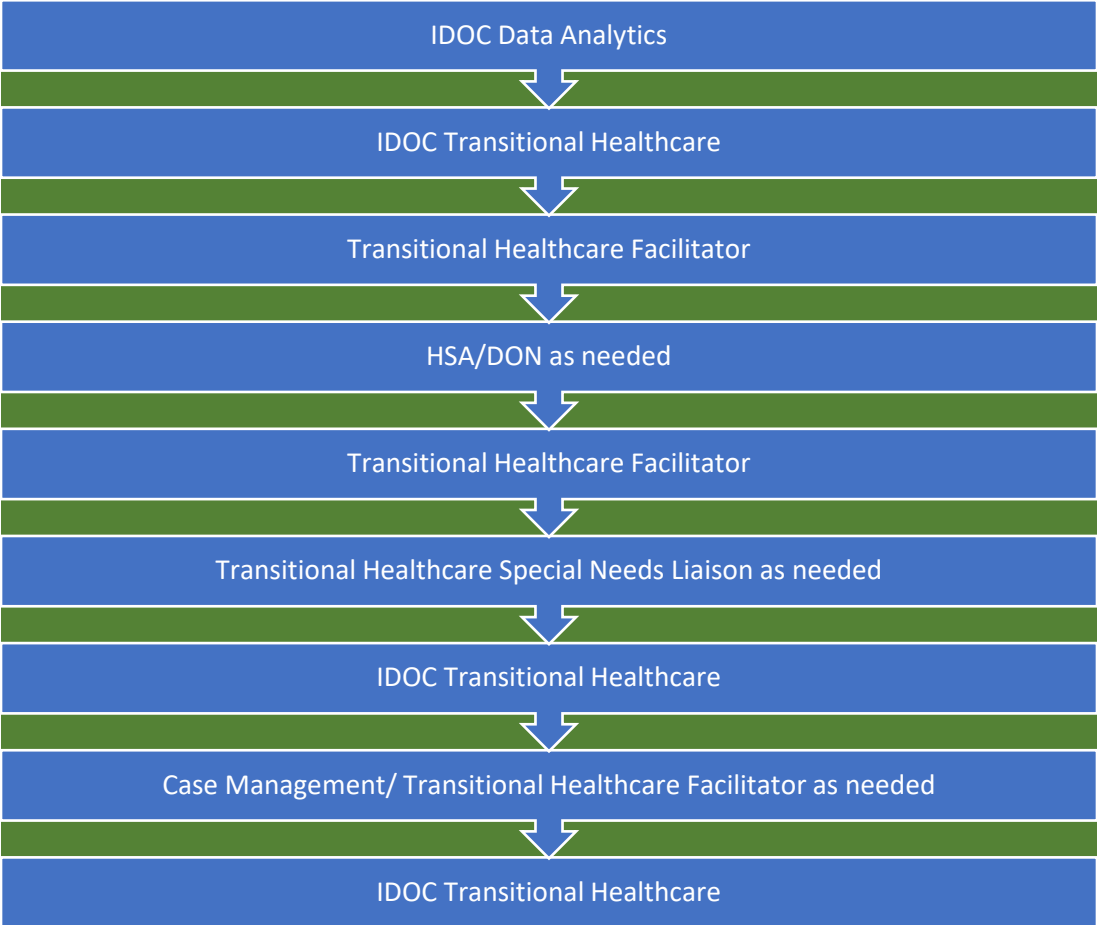
XII. APPLICABILITY:


This HCSD is applicable to all facilities housing incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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Title HEALTHCARE APPLICATION PROCESS
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Legal References (includes but is not limited to) IC 11-8-2-5	Related Policies/Procedures (includes but is not limited to) 01-02-101	Other References (includes but is not limited to) National Correctional Standards
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I. PURPOSE:

The purpose of this Health Care Services Directive (HCSD) is to establish guidelines and responsibilities for the Medicaid/HIP 2.0 application process.

II. DEFINITIONS:

For the purpose of this HCSD, the following definitions are provided:

- A. **AUTHORIZED REPRESENTATIVE (AR):** Designated position to act responsibly on the behalf of the patient in assisting with the healthcare application and renewal of eligibility along with ongoing communications with FSSA.
- B. **CASE MANAGEMENT STAFF:** A member of Unit Team who acts as the initial point of contact for day-to-day issues in the housing unit, coordinates case management matters and facilitates access to programs and services, works with incarcerated individuals to create case plans, and assists in preparing the incarcerated individual for the release and re-entry process.
- C. **COMPREHENSIVE CASE MANAGEMENT SYSTEM (CCMS):** In the Division of Youth Services (DYS), refers to both the process of identifying and assessing the incarcerated individual's risk and needs, developing a Case Plan, linking the incarcerated individual to appropriate services, and monitoring progress. In addition to the electronic database used by treatment staff to record, store, and review incarcerated individual data, including Case Plans and Progress Reports.
- D. **DEPARTMENT OF FAMILY RESOURCES (DFR):** A division of the Family and Social Services Administration. The DFR receives applications and approves

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eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), Cash Assistance (TANF), and childcare; implementing a modernized application process using internet, document imaging, and call-in services. DFR operates in all Indiana counties and administers the childcare licensing and inspection program.

- E. DEPARTMENTAL TRANSITIONAL HEALTHCARE): A team within the Health Services Division of the Department specializing in coordination and continuum of health care when an incarcerated individual enters and is released from the Department, including the processing of health care applications, and communicating with FSSA in matters related to State of Indiana benefits
- F. DIRECTOR OF TRANSITIONAL HEALTHCARE AND CONTRACT COMPLIANCE: Leadership position within Health Services Division supervising the Transitional Healthcare Manager and contract compliance.
- G. DISABILITY: The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than twelve (12) months.
- H. DIVISION OF DATA ANALYTICS: The Division of Data Analytics is responsible for data stewardship and the preservation of Department data assets. The Division has primary responsibility for Department reporting and analyses of Department data and information collected from Department operational systems of record.
- I. EARLIEST POSSIBLE RELEASE DATE (EPRD): The date on which an incarcerated individual would be entitled to discharge or release, taking into consideration: 1) The term of the sentence; 2) the term of any other concurrent or consecutive sentence which the incarcerated individual must serve; 3) credit time which the incarcerated individual has earned prior to sentencing; and, 4) the maximum amount of credit time which the incarcerated individual would earn if they remained in the current credit class during the period of confinement.
- J. EXECUTIVE DIRECTOR OF TRANSITIONAL HEALTHCARE: An executive leadership member within the Health Division supervising the Department's Transitional Healthcare .
- K. FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA): FSSA is a health care and social service funding agency of the State of Indiana that oversees five (5) care divisions that administer services to Indiana residents.

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- L. FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA) DOCUMENTS CENTER: The documents center is an integral part of the eligibility operations and handles the intake of mailed applications, as well as, the scanning and classification of documents using a software solution, enabling the creation and processing of electronic case information, such as used in the online Medicaid application process.
- M. HEALTHCARE SERVICES ADMINSTRATOR (HSA): A staff person selected by the Health Services vendor that is responsible for planning, directing, and coordinating healthcare services.
- N. INDIANA MEDICAID FOR PROVIDER PORTAL: Internet based portal that provides information regarding health coverage eligibility and status of health coverage.
- O. IRIS: The Indiana Department of Correction Records Imaging System.
- P. MEDICAID APPLICATION: Indiana Family and Social Services Administration online application for health care coverage.
- Q. MANAGED CARE ENTITY (MCE): An entity that provides health care plans and services through health insurance.
- R. NEXTGEN: Software that houses electronic health records.
- S. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team to record, store, and review incarcerated individual's data including case plans and progress reports.
- T. OFFENDER INFORMATION SYSTEM (OIS): The electronic database utilized by classification to record, store, and review incarcerated individual information.
- U. OFFICE OF MEDICAID POLICY AND PLANNING (OMPP): Division of FSSA that administers Medicaid programs and policies for the State of Indiana.
- V. PAROLE STAFF: Department staff supervising returned individuals in the community prior to the expiration of the individual's sentence.

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- W. PROJECTED PROGRAM COMPLETION DATE (PPCD): The date established as a target goal and may be positively or negatively affected by the incarcerated individual's behavior and program progress.
- X. PRESUMPTIVE ELIGIBILITY (PE): A process that offers short-term coverage of services. This program exists to ensure that the applicant has immediate access to health care. Incarcerated individuals may be eligible for Medicaid coverage as offered through the Family and Social Services Administration's programs while receiving inpatient services delivered at a Medicaid-approved facility during incarceration.
- Y. RE-ENTRY PORTFOLIO: A folder of information and documents compiled by staff for each incarcerated individual with an EPRD that includes originals or copies of certificates, resume's, birth certificates, Social Security cards, Bureau of Motor Vehicles (BMV)-issued identification cards, and other materials to be used in the community and provided to the incarcerated individual upon release.
- Z. RECIPIENT IDENTIFICATION (RID) NUMBER: A client identification number issued for Medicaid services.
- AA. TRANSITIONAL HEALTHCARE SPECIALIST (THS): A member of the Department's Transitional Healthcare responsible for reviewing health care coverage for releasing individuals and assists in continuum of care planning post-release.
- BB. WARDEN: A leadership position within the Department responsible for oversight of a correctional facility.
- CC. VITAL RECORDS: Documents of life events maintained under governmental authority such as birth certificates, Social Security documents, State identification, etc.

IV. RESPONSIBILITIES OF IDOC :

The Department shall identify incarcerated individuals who are potentially eligible for Indiana Health Care coverage plans and assist such individuals, as appropriate, with completion of the necessary applications for those benefits and for Presumptive Eligibility upon inpatient admission of an incarcerated individual, if needed.

Pursuant to House Enrolled Act 1269, the Department shall be the incarcerated individual's Authorized Representative.

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In addition to the Department assisting incarcerated individuals with the healthcare application process and required documentation; the Department shall notify the Department of Family Resources (DFR) of the incarceration of individuals to request suspension of coverage as necessary as well.

V. FACILITY RESPONSIBILITIES:

The Warden shall be responsible for the following:

A. Admission and Orientation

Ensuring the facility admission and orientation program includes information on the purpose and benefits of Medicaid participation.

B. Communication with Incarcerated Population

The Transitional Healthcare Manager, in conjunction with the Director of Transitional Healthcare and Contract Compliance, shall develop and disseminate communications to the incarcerated population. The Warden shall ensure that these communications are posted in the housing units and made available to the incarcerated population. These communications shall include information on the purpose, application process, and incarcerated individuals' rights related to healthcare coverage. The Transitional Healthcare Manager shall be responsible for ensuring healthcare coverage information is provided for the Re-Entry Portfolio and Tablet system.

VI. DEPARTMENT OF CORRECTION RESPONSIBILITIES:

Division of Data Analytics shall provide a monthly report via Cognos to FSSA of incarcerated individuals coming into the Department needing their health care coverage suspended.

The Division of Transitional Healthcare shall make certain that every releasing individual has been reviewed for access to healthcare coverage prior to release. Prior to completing an electronic healthcare coverage application, a Transitional Healthcare Specialist (THS) shall review all FSSA Cognos reports or the Indiana Medicaid for Provider Portal for active healthcare coverage using the offender information system to obtain identification. If the incarcerated individual has active or suspended coverage, the Department THS shall document such in OCMS, and an application shall not be completed on the incarcerated individual's behalf.

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The Department THS shall review OCMS notes and ensure the incarcerated individual is not approved for out-of-state placement. If out-of-state placement is approved, the THS shall document in notes and shall not complete an application on the incarcerated individual's behalf.

Department Transitional Healthcare shall process the electronic healthcare coverage application no sooner than 180 from EPRD and no later than 30 days post-release using OIS and OCMS for all incarcerated individuals being released from the Department.

Once an online application has been completed, a note shall be entered into OCMS at the time of submission. The note shall document the date of application, application number, and release address type.

If an MCE has requested information on their members releasing from incarceration, a THS shall communicate with the MCE to provide any pertinent information and compile a release plan within ten business (10) days of request to assist in the continuum of care for the incarcerated individual into the community.

If an incarcerated individual is deemed disabled, blind, or is over the age of sixty-five (65), a THS shall submit a disability application on behalf of the incarcerated individual if coverage is not active or in suspension.

Once a disability application has been submitted, a THS shall contact the facility's Transitional Healthcare Facilitator to complete the disability questionnaire. The questionnaire shall be returned to the THS within three (3) business days of request.

A THS shall contact FSSA to schedule an interview on behalf of the incarcerated individual, if required. The THS shall document in OCMS when interview has been completed and coordinate with the assigned Case Management staff to obtain any vital records or IDP's trust account information requested by FSSA.

Communication regarding an incarcerated individual's release date will be funneled through Cognos reporting by the Division of Data Analytics.

After healthcare coverage has been reviewed, Department Transitional Healthcare shall be responsible for coordinating all correspondence between facility staff, Parole staff, FSSA, and the incarcerated individual.

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FSSA shall be notified daily through Cognos data exchange of all incarcerated individuals releasing from the Department with a current mailing address to ensure health care coverage is activated.

THS's shall update their database weekly with application information regarding status of coverage, placement, or the completion of an application.

VIII. PRESUMPTIVE ELIGIBILITY (PE):

If an incarcerated individual is admitted and receives inpatient treatment at a Medicaid-approved facility for twenty-four (24) hours or more, they shall be considered to be presumptively eligible for health coverage under Medicaid/HIP 2.0.

The PE Process is as follows:

- A. The Health Services vendor shall communicate with a designated THS if an incarcerated individual under age 65 has become a hospital admission. The designated THS shall complete the PE questionnaire as requested, prior to midnight of the day of admission
- C. The designated THS shall complete a full Medicaid application within thirty (30) days of admission date if PE questionnaire was completed.
- E. If vital documents are requested by FSSA, the designated THS shall obtain documents from IRIS. If vital documents are not available, the THS shall contact the assigned Case Management staff to obtain the documents within five (5) business days from the request.

IX. PAROLE STAFF RESPONSIBILITY:

During the Initial Interview with a parolee, Parole staff shall discuss health care coverage availability with the parolee. If an application for health care coverage was submitted prior to the parolee's release, parolees shall be instructed to contact the Transitional Healthcare Liaison to inquire about the steps necessary to have their healthcare coverage activated. Parolees shall be encouraged to bring copies of notices of any health care coverage-related paperwork with them to schedule follow up appointments.

If an application for health coverage was not submitted prior to release, Parole staff (or designee) shall contact the *parolereleaseissues@idoc.in.gov* email address to ensure an application has been completed on behalf of the parolee. The Department Transitional

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Healthcare Manager shall communicate with the parolee if any additional information or documentation is needed to process the healthcare application.


X. APPLICABILITY:

This HCSD is applicable to all Indiana Department of Correction facilities housing incarcerated adults, and Parole District offices.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other Reference:
IC 8-2-5 IC 31-33-5-1	01-02-101 01-04-101 01-07-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the transitional healthcare services, of the Transitional Healthcare Liaisons (THL) in order to increase opportunities for a successful transition into the community.

II. GUIDELINES:

Transitional Healthcare Liaisons (THL) will work within the continuum of care directly with the Health Services vendor and Transitional Healthcare Facilitators, the Department's Transitional Healthcare Division, Parole District Supervisors, Parole Agents, and local community providers.

- This HCSD assists with the facilitation of programs, provides guidelines regarding application and services necessary for returning citizens' successful reintegration into society.
- This HCSD assumes the collaborative teamwork effort of all staff within the Health Services Vendor, Transitional Healthcare Facilitators, the Health Services Division, and Parole Services

III. DEFINITIONS:

- A. **ACTIVE CASE LOAD:** Returning citizen non-compliant or needs more intensive follow-up by Transitional Healthcare Liaison and services.

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- B. **COMPLIANT CASE LOAD:** Returning citizen who is compliant with all recommendations of community providers and Parole requirements.
- C. **COMMUNITY REFERRAL:** Written recommendation to a community provider to address, and attend to, a specific area of concern related to the physical, mental, or transitional needs of the returning citizen.
- D. **COMPLIANCE:** The act of complying and following all recommendations of community service providers in correlation with referrals made by Transitional Healthcare Liaisons.
- E. **CRISIS:** An unstable and dangerous mental health state that could negatively affect an individual or the community.
- F. **EARLIEST POSSIBLE RELEASE DATE (EPRD):** The date on which an incarcerated individual would be entitled to discharge or release, taking into consideration: 1) The term of the sentence; 2) the term of any other concurrent or consecutive sentence which the incarcerated individual must serve; 3) credit time which the incarcerated individual has earned prior to sentencing; and, 4) the maximum amount of credit time which the incarcerated individual would earn if the individual remained in the current credit class during the period of confinement.
- G. **EMERGENT REFERRAL:** A referral that must be performed without delay to address a community safety concern or to avoid permanent physical or mental health issues. This referral shall be completed to the THL via telephone.
- H. **HEALTHY INDIANA PLAN (HIP):** HIP is a health insurance program for qualified adults.
- I. **INITIAL CASELOAD:** Returning citizens referred for Transitional Healthcare Liaison services after triage is complete.
- J. **LGBT:** An acronym that stands for lesbian, gay, bisexual, and transgender person.
- K. **TRADITIONAL REFERRAL:** A referral that can be performed within the next business day of services that will not disrupt community safety or the functions of physical or mental health.

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- L. OFFENDER CASE MANAGEMENT SYSTEM (OCMS): The electronic database used by Unit Team to record, store, and review incarcerated individuals' data including case plans and progress reports.
- M. REFERRAL: A documented written or verbal request for further action or review.
- N. RETURNING CITIZEN (RC): An individual serving a sentence inside a correctional facility who has or will be released from a correctional facility. Each returning citizen is considered unique with individualized barriers and needs for assistance before, immediately, and during the reintegration process.
- O. SPECIAL NEEDS INDIVIDUAL : A returning citizen who has been determined to require special attention due to a complex physical or behavioral health condition that requires a continuum of care upon release.
- P. TRANSITIONAL HEALTHCARE FACILITATOR: A member of the Health Services vendor that collaborates with physical health, addiction recovery services, behavioralhealth, family members, supervising agencies, and various community resources inorder address healthcare needs of RCs.
- Q. TRANSITIONAL HEALTHCARE LIAISON: A member of the Health Services vendor's staff that assesses parolee needs and develops, along with advocating for individual treatment plans, community resources and support services.
- R. TRANSITIONAL HEALTHCARE DEPARTMENT (THD): A subdivision within the Health Services Division of the Department specializing in coordination and continuum of health care when incarcerated individual enters and is released from the Department.
- S. TRIAGE: Assessing what appropriate referrals that are needed for an RC.
- T. URINE DRUG SCREEN (UDS): A test that analyzes urine for the presence of certain illegal drugs and prescription medications.

IV. PROCEDURES:

THL shall be assigned by Parole District or specialized care determined by the Health Services vendor's Regional Director of Transitional Healthcare. All performance measurements and production outcomes of the THL are under the direct guidance and supervision of the Health Services vendor's Regional Director of Transitional

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Healthcare and Health Services Division Transitional Healthcare Department. The THL shall be responsible for meeting the following the outlined performance measures:

A. Caseload Management:

The THL shall be responsible for maintaining an updated caseload roster using the designated Department's caseload monitoring system.

The caseload monitoring system shall be housed at a location assigned by the Executive Director of Transitional Healthcare. Each THL is required to use the same caseload monitoring system and they are not authorized to change the formatting of the system.

The caseload roster shall be updated within one business day of referral action. Each RC's needs shall be documented as an individual referral. At no time shall referrals be added together if individual needs are being addressed.

THL shall be responsible for ensuring that RC's information is updated and accurate

The THL shall complete 4 (four) hours of community engagement each month and report the hours to the Health Services vendor's Regional Director of Transitional Healthcare. Community engagement is defined as an entity that can or currently provides services to RCs. This is to ensure that THL make a continued effort in maintaining relationships and positive rapport by engaging with community providers of services.

B. THL Referral Process

Referrals to the THL, regardless of referral source, will be added to the Transitional Healthcare Liaison tracker and referred appropriately to services.

Referrals from Transitional Healthcare Facilitators shall be in accordance with HCSD 5.01A, "Transitional Health Care Pre-Release Continuum of Care."

The following shall be reviewed for referrals received in accordance with HCSD 5.01A:

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1. Ensure RC was released with all prescribed medications in accordance with HCSD 2.15, "Medication Management."
 - a. THL shall contact the Transitional Healthcare by close of business day of notification if medications were not received.
 - b. THL shall contact the Transitional Healthcare Department with questions regarding the status of the RC's health care coverage in accordance with HCSD 5.02A, "Healthcare Application Process."
 - c. THL shall follow up the status of Medicaid application completed while the RC was incarcerated within one week of release.
 - d. THL shall contact the Transitional Healthcare Department regarding any issues with activating health care coverage. A referral to a Community Navigator may be required.
 - e. Any additional food assistance, disability benefits, or childcare assistance applications shall be followed-up as needed within one week of release.
 - f. The THL shall be responsible for triaging referral to a "Traditional" or "Emergent" referral.

2. Traditional Referrals

Any returning citizens with the known following concerns:

- a. Domestic violence situation
- b. Recent death in the family
- c. Loss of employment
- d. Noticeable or verbalized presence of life stressors
- e. Possess protected health concerns
- f. In active crisis mode
- g. Any areas in which the returning citizen is at-risk for reoffending
- h. Testing positive for a prescription medication without a prescription
- i. Known behavioral health code of B or C at time of release
- j. If a returning citizen is pregnant or becomes pregnant
- k. Known self-report of a history of any mental illness
- l. Known report of substance use history
- m. F behavioral health code

3. Emergent Referrals

- a. Known behavioral health code D, E, or F at time of release;
- b. Known physical health code of B or F at time of release;

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- c. Any disability code other than A
- d. Positive UDS for any illegal substances;
- e. Physical Health needs requiring life determinant medication or skilled care;
- f. Behavioral health needs that require immediate intervention;
- g. Classified as special needs SNI per HCSD 5.01A

C. Assessment and Triage for Services:

Once a referral is received, the THL shall assess all below concerns and identify a Triage for Services to ensure appropriate community referrals are completed. Interaction shall be documented in OCMS. The THL shall follow all laws and regulations in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which can be found online.

A triage shall, at a minimum, include the following:

1. Whether the RC is appropriate for inpatient or outpatient treatment.
2. Whether the RC needs detoxification services for substance abuse.
3. Transportation and/or housing barriers
4. Access to a birth certificate, State identification, and Social Security card.
5. Resources available to assist with goals.
6. Specific barriers identified in the RC's life.
7. Any ongoing legal issues
8. Any financial problems
9. Driver's license status.
10. Status of health care coverage.
11. Status and/or applicability of SSI/Disability
12. Family or personal relationship issues
13. Any other applicable barriers identified during the interview
14. Whether an RC self-identifies as a part of the LGBT population.

Once triage for services is completed, returning citizen shall be placed on THL caseload as INITIAL, ACTIVE, or COMPLIANT.

1. INITIAL Case Load Assignment:

If a returning citizen has been referred to a THL for services, they shall be placed on a THL Initial Referral Case Load. The THL shall connect with the returning citizen weekly for a minimum of 30 days from time of release or initiated referral. After thirty days, THL shall review the returning citizen's participation to determine what caseload is appropriate for returning citizen

2. ACTIVE Case Load Assignment:

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Any emergent referral shall be placed on the “ACTIVE Case Load.”

Special Need Individuals shall be placed under ACTIVE case load for 90 days with required weekly contact with RC. After 90 days, the THL shall review the RC’s participation in services to determine placement on ACTIVE or COMPLIANT case load.

If RC is not compliant with services or referral, RC shall remain on ACTIVE caseload for an additional 60 days with a minimum of four contacts. The RC shall remain on the ACTIVE caseload until compliance is met.

3. COMPLIANT Case Load Assignment:

- a. If a special population individual is compliant with services and referral, RC shall be moved to COMPLIANT caseload for an additional 60 days with a minimum of two contacts.
- b. If RC continues to be compliant with community referrals after 60 days, the THL shall discharge returning citizen from COMPLIANT caseload.
- c. If an RC has been compliant with a traditional referral for 30 days and has been successfully clinically discharged from all programming, and verification of that successful discharge is in writing from the service provider, they may be removed from the THL program.
- d. Successful discharges shall be documented in OCMS within 3 business days of occurrence.

B. Community Service Referrals

Once the RC has been triaged and placed on appropriate case load, THL shall complete necessary community service referrals applicable to the RC’s assessment and need.

Community service referrals shall correlate with the RC’s location, physical health, mental health, addiction recovery, and circumstantial need.

All referrals to community agencies shall include the most up-to-date information and include:

1. Current place of residency;
2. Current telephone number of releasing citizen;

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3. Specific information regarding need for referral;
4. If substance abuse related, known substance used and last time of use;
5. If for mental health services, known specific mental health symptoms; and,
6. Required documents as defined in section F.

C. Documents for THL Services

The THL shall obtain the necessary documentation as below to facilitate care coordination with community partners. THL shall coordinate signatures if face to face interaction cannot be arranged. THL shall explain each form's purpose and the importance prior to obtaining the RC's signature.

1. State Form 46729, "Authorization to Release/Request Information;"
2. State Form 55940, "Referral-FSSA Recovery Works."

D. Communication and Documentation

Should the THL receive information that an RC is not in compliance with recommended treatment, the THL shall notify the Supervising Parole Agent via email of the non-compliance within one business day and document any information that was communicated regarding the RC in OCMS, following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191

Documentation in OCMS shall be completed within three business days of occurrence following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

The following events shall be documented in OCMS:

- a. When a referral has been received;
- b. Date of Triage assessment;
- c. Completion of Triage assessment including transitional plan, submission of community service referrals, acknowledgement from RC of assessment results, and date for next follow-up;
- d. Submission of community service referrals;
- e. Monthly status of compliance with community service referrals; and,
- f. Any additional information that will enhance communication regarding the process of the RC.

All assigned goals assigned to the RCs assigned shall be completed on the SMART

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Goal template. Completion of the SMART Goal Template(Attachment) shall be monitored by the assigned THL.

E. Refusal Process

Should an RC be deemed appropriate for a referral to mental health or substance abuse treatment, they are required to adhere to the THL recommendation. Should the RC choose to refuse services, the THL shall utilize motivational interviewing techniques with a minimum of three attempted engagements. An RC can retrack a refusal at any opportunity during Parole supervision. All attempted engagements shall be documented in OCMS.

If an RC is determined as not compliant with mental health or substance abuse treatment recommendations, the THL shall inform the Supervising Parole Agent of the non-compliance for further review. Documentation shall occur in OCMS within 24 hours of occurrence following all laws and regulations in accordance with Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

F. THL Reporting Requirements for Crisis or Public Safety Concern

Should the THL feel that a true emergency exists, such as the RC is having suicidal or homicidal thoughts, and the need for law enforcement and/or medical attention is needed, they shall call 9-1-1 immediately and contact the Parole District Supervisor, Director of Parole Services, and Executive Director of Transitional Healthcare when time permits. Mandatory reporting as defined in Indiana Code 31-33-5-1 shall be followed.

G. Privacy and Security

The THL shall follow all laws and regulations in accordance to Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The THL shall protect an RC's protected health information in verbal communication.

A hard copy file shall be created for each referred RC. The hard copy shall include all referral documents, a copy of the individual's next steps plan, and any follow-up information from providers. Hard copy files shall be kept in a locked cabinet. The hard copy file shall be in compliance with and Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

In the event hard copies are not able to be obtained, THL shall notify the Health Services Vendor's Regional Director of Transitional Healthcare for further instruction.

H. THL Conduct and Expectations for Leave of Absence:

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All THL Staff are to comply with Policy and Administrative Procedure 04-03-103, "Information and Standards of Conduct for Departmental Staff."

The THL should report any leave of absence to the Health Services vendor's Regional Director of Transitional Healthcare by email. All leaves of absence shall be documented on the THL's outlook calendar. The THL outlook calendar shall be shared with the Health Services vendor's Regional Director of Transitional Healthcare.

I. Questions or Conflicts with THL

When questions or conflicts develop, personnel are advised to obtain consultation with the Health Services vendor's Regional Director of Transitional Healthcare and the Executive Director of Transitional Healthcare.

III. APPLICABILITY:

This HCSD is applicable to all Health Services staff, Parole Services staff, Transitional Healthcare Facilitators, and Transitional Healthcare Liaisons.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date



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PAROLE MEDICAL RETURNS

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5	01-02-101 03-03-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) outlines the process that shall occur when a patient on parole is violated due to community safety concerns and must return to a Department facility while experiencing a severe behavior health or a life threatening physical health condition including but not limited to acute substance withdrawal. This type of event shall be considered a medical return regardless of the type of violation or new charge that has occurred.

II. DEFINITIONS:

For the purpose of this HCSD, the following definitions are presented:

- A. EMR: Electronic Medical Record
- B. MEDICAL RETURN: A patient on parole returning to the Department that has severe behavior health or life threatening physical health concerns that affects community safety.
- C. OBGYN: A physician who both delivers babies and treats diseases of the female reproductive organs.

III. PROCEDURE:

- A. In the event Indiana Parole Board has deemed that a patient on parole shall be returned to a Department facility and is a medical return, the Parole Agent shall contact their District Supervisor and Transitional Healthcare Liaison within 1 (one) hour via telephone to provide a description of the incident. The District Supervisor shall contact the Director of Parole Services for instructions for the return. The Director of Parole Services shall collaborate with the Executive Director of Transitional Healthcare to determine if medical clearance is necessary from a community medical facility prior to the return to a Department facility.

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- B. Once it has been determined that a medical return is occurring, the Parole Agent shall compose an email including the patient's name, DOC number, information pertaining to the patient's physical and behavior health history, if known, and a detailed description of the incident that caused the medical return or any information that is available at time of incident. This email shall be delivered to the designed email group within 1 (one) hour of incident or as soon as agent has access to provide information.
- C. The Executive Director of Transitional Healthcare shall communicate with the Executive Director of Behavioral Health and/or the Executive Director of Physical Health to determine if medical clearance is necessary prior to returning to a Department facility.
 1. If medical clearance is not deemed to be clinically indicated, the Executive Director of Transitional Health Care shall work with Executive Director of Classification to determine the appropriate Department facility and make any other appropriate notifications via designated email group, including but not limited to Chief Medical Officer, Health Service vendor's Regional Medical Director, appropriate physical health or behavioral health staff, and Health Service vendor's Transitional Healthcare staff.
 2. If medical clearance is deemed to be clinically indicated, the Executive Director of Behavioral Health and/or the Executive Director of Physical Health shall identify which community medical facility is most appropriate to care for the patient on parole's need.
 3. The Executive Director of Transitional Healthcare shall communicate with Parole staff regarding the identified community medical facility.
 4. The Executive Director of Transitional Healthcare shall communicate with the Executive Director of Classification to ensure the patient on parole is transported to the appropriate Department facility once medically cleared by the community medical facility. If medical clearance is deemed to be indicated, attempts shall be made to ensure medical clearance occurs prior to return to a Department facility. The Executive Director of Classification shall confirm transport and communicate transport plans to the Executive Director of Transitional Healthcare.
 5. The Executive Director of Transitional Healthcare shall advise the Chief Medical Officer, the appropriate Health Services Executive

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Director, Site Medical Director, Health Service vendor's Regional Medical Director, Regional Director of Transitional Healthcare, and appropriate staff of the patient on parole's plan for medical clearance and return to a Department facility as soon as it is established.

6. Prior to the patient on parole leaving the community medical facility the Health Services vendor's staff at receiving Department facility shall conduct a clinician-to-clinician call to obtain ensure all necessary health information has been communicated prior to discharge.

If a clinician is not available at time of discharge, the Health Services vendor's staff shall notify the on-call provider of the discharge to ensure discharge information is communicated. If the clinician-to-clinician call does not occur prior to patient discharge, Health Services vendor's staff shall notify the on-call provider within 1 (one) hour of patient arriving at designated facility.

- F. The Health Services vendor's staff shall make every effort to request and obtain a completed State Form 46729, "Release of Information," for the patient on parole for all involved community provider's medical records. If the patient on parole refuses to sign a State Form 46729, the Health Services staff shall request records in the interest of continuity of care. The HSA or designee shall ensure all health records are available in the EMR within one business day of receipt once the patient on parole has arrived at the designated facility.
- G. If a medical return pertains to a pregnant woman on parole, the Transitional Healthcare Liaison shall request and obtain a completed State Form 46729 for all the patient's OBGYN records and medical treatment received in the community prior to transport to the Indiana Women's Prison. If the pregnant woman on parole refuses to sign State Form 46729, the Health Services staff shall request records in the interest of continuity of care.
- H. If a patient on parole is currently prescribed opioid agonist medication assisted treatment such as methadone or suboxone and deemed a medical return, the Transitional Healthcare Liaison shall contact the designated email group with the patient's name, DOC number, date of birth, information pertaining to the patient's physical and behavioral health history and current concerns, a detailed description of the incident that caused the medical return, clinical information from the Opioid Treatment provided, or the information available at time of the incident. Once email notification has been received, the Executive Director of Transitional

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Healthcare shall initiate any needed exception request through the Department of Mental Health and Addictions and notify the designated HSA and the vendor's Regional Medical Director to locate a suitable Opioid treatment Provider clinic for continuation of care at the facility.

- I. The Health Services vendor's staff shall establish communication between the site Health Services leadership and Opioid Treatment Provider clinic to obtain billing information to the Opioid Treatment Provider for services to be established. Site medical leadership shall coordinate care for the patient in accordance with the exception request.


IV. APPLICABILITY:

This Health Care Services Directive is applicable to Parole Services and Parole Staff, Health Services staff, and facilities receiving Parole Medical Returns.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date

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DENTAL SERVICES

Legal References (includes but is not limited to)	Related Policies/Procedures (includes but is not limited to)	Other References (includes but is not limited to)
IC 11-8-2-5 IC 34-4-12.6	01-02-101	National Correctional Healthcare Standards

I. PURPOSE:

This Health Care Services Directive (HCSD) describes the delivery of Dental Services in Department facilities.

II. DEFINITIONS:

- A. ORAL CARE: Oral care includes instruction in oral hygiene, examination, and treatment of dental problems. Instruction in oral hygiene minimally includes information on plaque control and the proper brushing of teeth.
- B. ORAL SCREENING: Oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.
- C. ORAL EXAMINATION: Oral examination by a dentist includes taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination.
- D. ORAL TREATMENT: Oral treatment includes the full range of service that in the supervising dentist's judgment are necessary for maintaining the patient's health.

III. GUIDELINES:

- A. Dental service provision begins during the Intake process. The Point of Entry, Arrival Screening, and Intake Health Appraisal interventions may identify the presence of serious dental needs. In addition to the dental screening carried out by the trained nursing and practitioner staff within seven (7) days of admission, Dental Services must provide screening and

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assessment by a dentist within seven (7) days of admission. Instruction regarding oral hygiene, preventative self-care, and oral disease education, shall be provided during the reception process.

Along with documentation of dental status, the Intake Dental Services personnel shall provide an initial treatment plan that will guide the provision of services after transfer from the Intake unit. (Dental Services personnel may provide services prior to a patient's departure from an Intake unit, but most services will be provided after transfer to another facility.)

- B. In brief, Dental Services include instruction and assistance in oral hygiene, treatment of dental emergencies, routine restoration services, extraction and other surgical services, and provision of prosthetics. When the primary purpose for a dental intervention is cosmetic, it is not provided.

Dental services are provided in the context of personal responsibility for oral hygiene. Restoration will not save teeth if patient does not support dental health with proper oral hygiene practices.

- C. Oral hygiene supplies must be available (either through free distribution or commissary sources) in all Department facilities.
- D. Consultation and referral to dental specialists, including oral surgery, shall be provided when necessary.

IV. EXPECTED PRACTICES AND STANDARDS:

- A. Oral care for each patient is conducted under the direction and supervision of a licensed dentist.
- B. Care is timely and includes immediate access for urgent conditions.
- C. Oral screening is performed as soon as possible, but no later than 7 calendar days from admission.
- D. Oral screening may be conducted by the dentist or qualified health care professional who has received documented training approved or provided by the dentist.
- E. Instruction in oral hygiene and preventive oral education are given within 30 days of admission.
- F. An oral examination is performed by a dentist within 30 days of admission.

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- G. Oral treatment, not limited to extractions, is provided according to a treatment plan based on a system of established priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected. The Health Services vendor shall develop dental practice standards and procedures in accordance with applicable policies and guidelines and meet community standards.
- H. Radiographs are used in the development of the treatment plan.
- I. Consultation through referral to oral health care specialists is available as needed.
- J. Each patient has access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the patient's needs.
- K. Each patient is offered and provided with a written treatment plan, written orders and plans are carried out by qualified health care professionals, and care is provided without barriers to access.
- L. Extractions are performed in a manner consistent with community standards of care.

All aspects of these standards are addressed by defined procedures.

V. APPLICABILITY:

This HCSD is applicable to all facilities providing Health Services to incarcerated adults.

signature on file

Kristen Dauss, MD
Chief Medical Officer

Date