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		11/1/2024	9	2.01Y
	HEALTH CARE SERVICES DIRECTIVE-YOUTH Manual of Policies and Procedures			

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	Replaces: HCSD 2.01Y / Effective Date 4-1-2022
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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 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. 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. 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.
- F. 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.

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- 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: 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: No unreasonable barriers to stop a youth 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:

Youth 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 youth to initiate requests for health services daily, 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 employee 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 services 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.

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 Services personnel may control access to care

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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 youth 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 clinical setting by qualified health care professionals. Youth must have the opportunity daily to request health care. 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 Custody staff);
- Adequate space and equipment;
- Adequate light;
- Hand washing facilities or a satisfactory substitute; and,
- Easy access to health records.

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

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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, isolation) may be especially desirable to see patients during count periods.

Youth 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 new problems from evaluation when they develop.

Patients do not have the right to specify which type of provider or which Health Services employee they see. If a patient refuses to be seen by the Health Services employee 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 requested to sign State Form 9262, “Refusal and Release from Responsibility for Medical, Surgical, Psychiatric and Other Treatment.” A second staff member shall witness and sign State Form 9262.

IV. CO-PAY

All youth committed to the Department and housed in a Department facility or a facility contracting with the Department shall be subject to a medical co-payment as described in IC 11-10-3-5 and 210 IAC 7-1-1. Health care is not denied based on a youth’s ability to pay. Procedures for co-pay for Health Services are found in Policy and Administrative Procedure 04-01-104, “Offender Trust Fund.”

V. ROUTINE SERVICES

A patient initiated request, through an HCRF (State Form 45913) or routine request initiated by staff or through other means must be triaged within 24 hours. A standardized HCRF 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, an HCRF serial number, 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

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current housing assignments when completing these forms.

- The second section is for use by health care providers. It includes an area in 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. Co-pay is not applicable to Division of Youth Services facilities.

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 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 employees. 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 collect and review all HCRFs daily. An HCRF log shall be maintained to indicate what HCRFs have been received. A nursing assessment must be completed within 24 hours of form collection when the HCRF describes a clinical symptom(s). Health Services staff shall not respond in writing via the HCRF to provide counseling, educational information regarding self-care measures, or referrals to the commissary if there has not been a recent clinical evaluation for the requested care. The HCRF serial number shall be entered into the “Reason for Visit” area of the Electronic Medical Record (EMR) to facilitate tracking.

Nursing triage and nurse sick call visits shall be under the direction of the Director of Nursing (DON), or another assigned Registered nurse (RN). 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 in assessments to a contributory or collaborative role, at the direction of or in conjunction with other members of the health care team. All nurse sick calls are subject to a review process by a supervising RN. The responsible RN must sign off all nurse sick calls completed by an LPN.

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.

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In facilities without 7 days per week nursing staff, an appropriately 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 Health Services employees. The scheduling system shall provide a priority system which allows for urgent needs to be seen first.

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.

VI. URGENT OR EMERGENT SERVICES:

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 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 per day, 7 days per 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.

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When a physician or other practitioner determines that off-site emergency travel is required, orders for that travel must include directions regarding the type of transport vehicle (State vehicle vs. ambulance) 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 youth (either the one who is ill or one who observed them) describes what may be an urgent or emergent situation,
- C. A verbal report from any employee who has received information from other employees 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.

VI. CONVENIENCE CARE:

Convenience care shall not be provided by Health Services staff in the absence of clinical indication.

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.

Health Services staff have the ability to review commissary orders so that a complete perspective regarding clinical decision making and a patient's 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:

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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 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 refer to Dentist. The evaluation by Dental staff must occur within 14 days for routine 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. Behavioral Health review of HCRF: For routine services on all business days; and,
7. Behavioral Health 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.

C. Point of Entry

Upon entry to a facility, all youth must be informed (verbally and in writing) regarding access to health services, both routinely and emergently, as well as procedures for submitting grievances, and co-pay procedures in a language that is easily understood by the patient. Signs shall be posted in Intake areas, providing brief instruction regarding this, and facility handbooks shall provide detailed instruction.

Youth that require assistance with accessing health care shall have individualized plans (i.e., Non-English speaking, inability to read and write, and those with disabilities).

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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 (See Facility Directive):

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, Behavioral Health, Optometry, etc.). Some facilities may find it useful to expand upon other areas in this HCSD.

IX. APPLICABILITY:

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

Adrienne Bedford, MD
Chief Medical Officer

Date