Arizona Department of Corrections Rehabilitation and Reentry

Technical Manual

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CHAPTER: 1100

Inmate Health Services

DEPARTMENT ORDER:

1101 – Inmate Access to Health Care

OFFICE OF PRIMARY RESPONSIBILITY:

Medical Services Contract Monitoring Bureau (MSCMB)

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TECHNICAL MANUAL:

Medical Services Technical Manual (MSTM)

EFFECTIVE DATE:

10/01/2022

SUPERSEDES:

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Grant Phillips MD, Medical Director — Date: 9/13/2022

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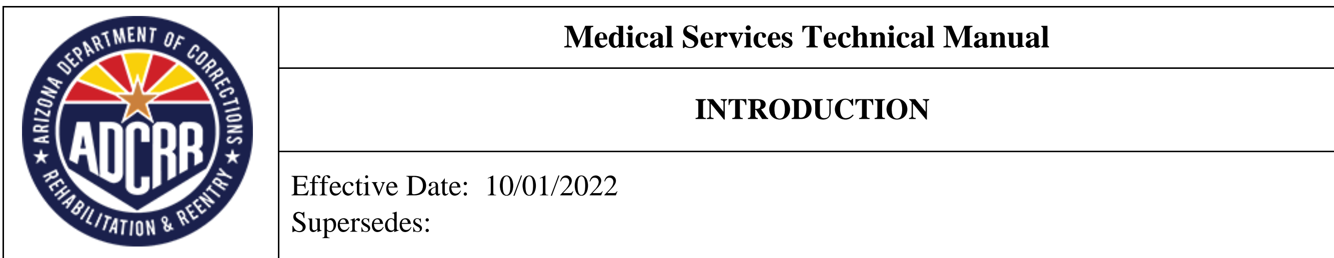

	Medical Services Technical Manual
	INTRODUCTION
	Effective Date: 10/01/2022 Supersedes:

INTRODUCTION

PURPOSE: This Medical Services Contract Monitoring Bureau (MSCMB) Medical Services Technical Manual (MSTM) was created to provide technical and professional guidance in the delivery of high-quality and well-organized healthcare to the incarcerated individuals within the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) facilities or their supporting non-ADCRR organizations.

RESPONSIBILITY: It is the responsibility of the ADCRR Contract Healthcare Provider (CHP), with oversight monitoring by MSCMB, to ensure that adequate dental, medical, mental health, nursing, pharmaceutical, health records, laboratory, and x-ray services are available to the inmate population incarcerated within the ADCRR.

It is the shared mission of the MSCMB and our contracted healthcare partners to provide constitutionally mandated healthcare to the inmate population of Arizona while protecting the health of its employees. ADCRR provides resources to the inmate population so they may live a healthy lifestyle and through its CHP provide appropriate access to medical, mental health and dental services at reasonable fees. ADCRR MSCMB provides oversight to ensure that all inmates are provided access to scheduled and emergency (as needed) healthcare that is consistent with community standards, and are not refused healthcare treatment due to inability to pay.

ADCRR and its contract partners recognize that a well-trained, professional workforce serves and protects our communities by effectively employing the field's best security practices and proven pre-release programming support to prepare for the release and reintegration of ex-offenders as civil, productive citizens in society.

ADCRR does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in the provision of healthcare.

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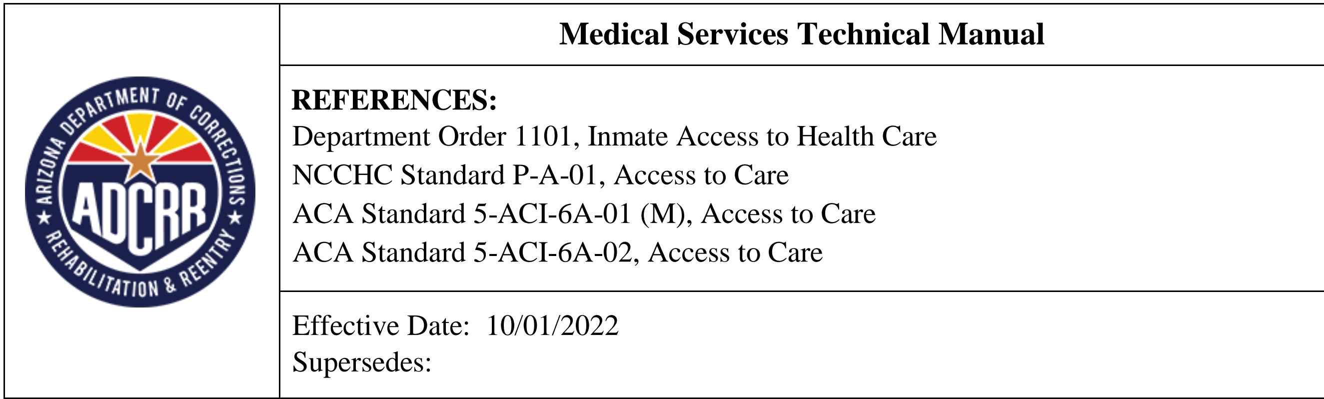


	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-A-01, Access to Care ACA Standard 5-ACI-6A-01 (M), Access to Care ACA Standard 5-ACI-6A-02, Access to Care
	Effective Date: 10/01/2022 Supersedes:

P-A-01.01 Access to Healthcare

PURPOSE: To ensure all inmates have reasonable and appropriate access to care and receive medical, dental, and mental health services from admission to discharge per clinical treatment plan recommendations, orders, and evidence-based practices to meet their medical, dental, and mental health needs.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) shall ensure that adequate healthcare services are available to the inmate population.

PROCEDURE:

1.0. Scheduled healthcare appointments and emergency healthcare shall be accomplished through cooperation and coordination between security, programs, transportation, and the CHP staff.

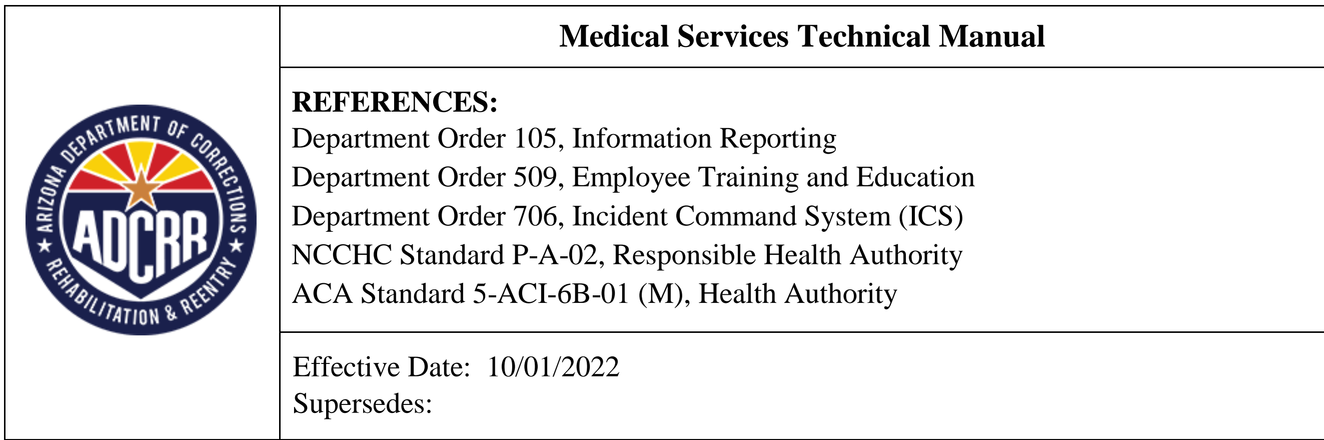
    1.1. CHP and the Arizona Department of Corrections Rehabilitation and Reentry shall identify and eliminate any unreasonable barriers intentional and/or unintentional to patients receiving healthcare.

2.0. The CHP Regional Leadership or designee shall ensure consistency and continuity of care in the delivery of healthcare to the inmate population.

    2.1. The CHP Regional Leadership or designee shall ensure that all patients are provided access to scheduled and emergency healthcare and are not refused healthcare treatment due to financial reasons.

3.0. Reasonable fees shall be charged in accordance with Department Order #1101, Inmate Access to Healthcare.

    3.1. Patients shall not be denied care based on their ability to pay.



	Medical Services Technical Manual
	REFERENCES: Department Order 105, Information Reporting Department Order 509, Employee Training and Education Department Order 706, Incident Command System (ICS) NCCHC Standard P-A-02, Responsible Health Authority ACA Standard 5-ACI-6B-01 (M), Health Authority
	Effective Date: 10/01/2022 Supersedes:

P-A-02.01 Authority and Accountability

PURPOSE: To establish general authority for the provision of clinical services by the Contract Healthcare Provider (CHP) at each complex.

RESPONSIBILITY: Beginning July 1, 2012, all aspects of the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) health services were privatized. The ADCRR Assistant Director for Medical Services provides guidance to the Medical Services Contract Monitoring Bureau (MSCMB) staff in order to meet the mission of ADCRR and MSCMB, as well as ensure, through a joint effort with the CHP, the provision of constitutionally-mandated health care to inmates in the custody of ADCRR. The process of monitoring health services provided by the CHP will be accomplished through the use of quality improvement tools.

ROLES:

1.0. MSCMB

- 1.1. The CHP is responsible to ensure that all patients are provided access to scheduled and emergency (as needed) healthcare, and are not refused healthcare treatment due to financial reasons. The CHP shall ensure that healthcare is delivered through a joint effort of the CHP and security operations. The MSCMB staff shall monitor compliance with the contract. The ADCRR Assistant Director for Medical Services accomplishes this through the MSCMB Team.
- 1.2. The MSCMB will review annually and update as necessary the Medical Services Technical Manual (MSTM).
  - 1.2.1. The following departments will be notified of annual updates: MSCMB staff, ADCRR Central Office Custody Leadership, CHP Regional Leadership or designee, Private Prison Regional Leadership, Inspector General's Office, and others as applicable.
    - 1.2.1.1. The CHP's supervisory staff members shall sign and date each annual review.

2.0. Complex Responsibilities

- 2.1. <u>General Administration</u>
  - 2.1.1. The CHP Facility Health Administrator (FHA) or designee is responsible for ensuring all CHP staff adheres to ADCRR Department Orders, all Medical Services Contract Monitoring Bureau Technical Manuals, and Complex specific Post Orders. It is the responsibility of the CHP FHA or designee to ensure that adequate services are available to the inmate population in the following areas: Dental, Medical, Mental Health, Nursing, Pharmacy, Health Records, Laboratory, and X-ray.

2.1.2. The CHP FHA is responsible for guiding and monitoring the daily operations of the healthcare delivery system to ensure actions are compliant with all administrative directives and pertinent state regulatory agency technical provisions.

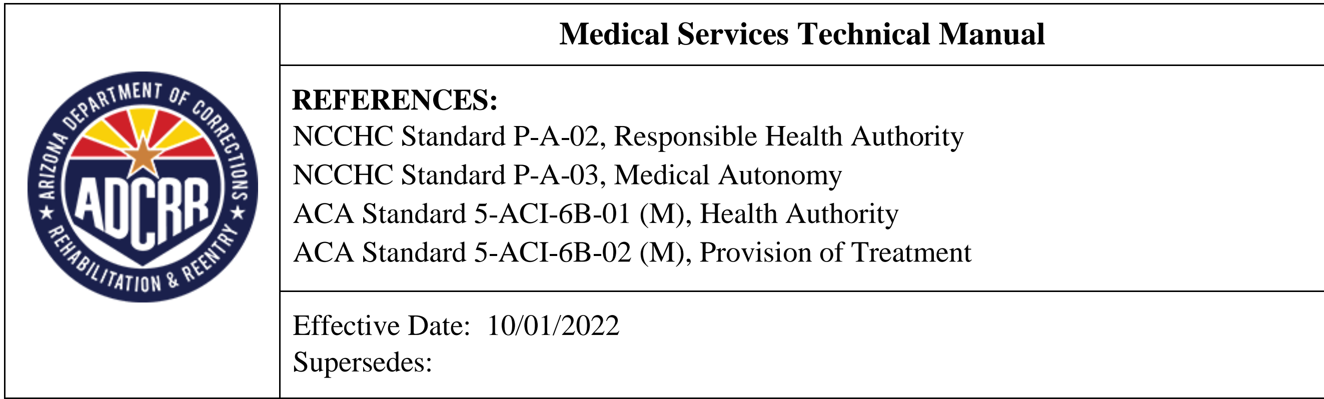
2.1.3. The CHP FHA in conjunction with the on-site ADCRR Contract Monitor, is charged with ensuring the adherence by all staff to the governing professional and technical regulations, ADCRR Department Orders, Medical Services Technical Manual, and Post Orders.

2.2. Personnel

2.2.1. Position Authority: The CHP FHA at each complex is designated as the Responsible Health Authority. Their responsibilities are delineated by the CHP's job description, Position Description Questionnaire, MSTM, and the Contract.

2.2.2. The Responsible Health Authority is responsible complex-wide, for all levels of healthcare, providing quality accessible health services to all inmates. The CHP FHA shall ensure that all facility health staff are knowledgeable of the FHA's liaison responsibilities.

2.2.3. The CHP's site Medical Director is designated as the Responsible Physician for each complex. The responsibility for senior clinical judgment and final authority for clinical issues at the complex resides in this position.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-A-02, Responsible Health Authority
NCCHC Standard P-A-03, Medical Autonomy
ACA Standard 5-ACI-6B-01 (M), Health Authority
ACA Standard 5-ACI-6B-02 (M), Provision of Treatment

Effective Date: 10/01/2022
Supersedes:

P-A-03.01 Medical Autonomy

PURPOSE: Healthcare decisions are made by qualified healthcare professionals for clinical purposes. To provide direction regarding communication between the Medical Services Contract Monitoring Bureau (MSCMB) staff and the Contract Healthcare Provider (CHP) staff and promote an atmosphere of shared information/communication.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) and the CHP to communicate openly and effectively with one another to promote an atmosphere of shared information to improve healthcare delivery.

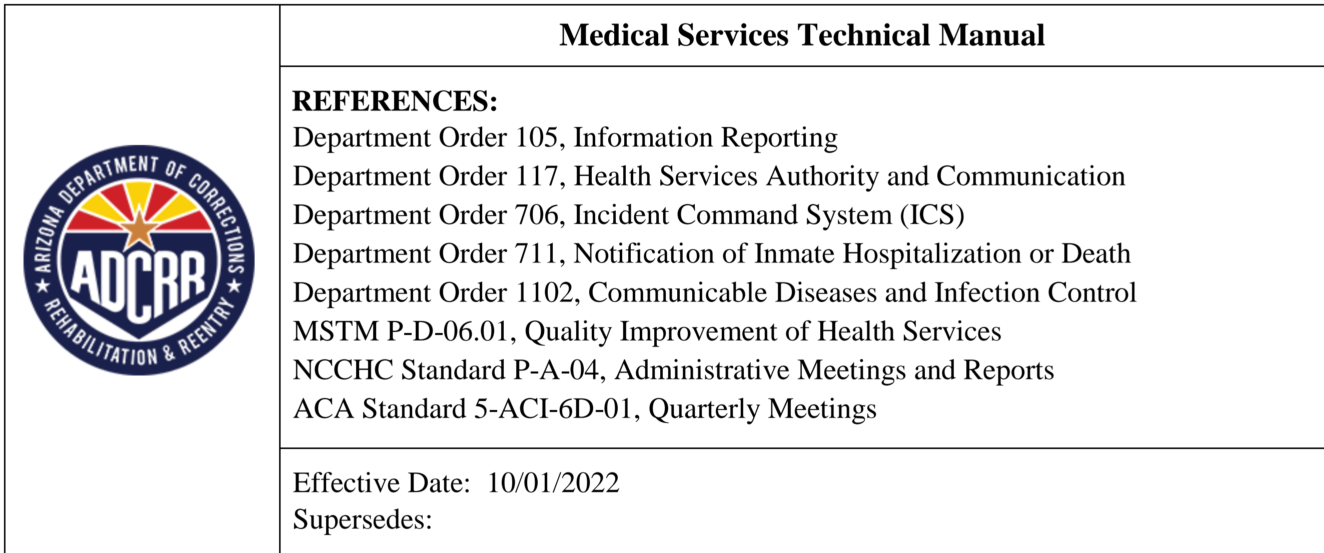
PROCEDURES:

1.0. Responsibilities
- 1.1. Healthcare shall be delivered through a joint effort of the CHP and security operations. The CHP staff are subject to the same security regulations as other ADCRR employees.
- 1.2. The ADCRR Assistant Director for Medical Services is responsible for providing strategic direction to the MSCMB staff. The MSCMB staff share responsibility with the CHP to ensure that all inmates are provided access to scheduled and emergency healthcare, and are not refused healthcare treatment.
- 1.3. The CHP is responsible for ensuring that all contracted health services or other visits to the facility are cleared by security prior to the visit in accordance with Department Order #202, Public Access – Tours and Board Hearings.
- 1.4. Wardens, Deputy Wardens, and Administrators are responsible for ensuring security/transportation staff transport patients for scheduled and emergency healthcare, and for ensuring appropriate security escort is provided when patients are transported by ambulance.

2.0. The Facility Health Administrator (FHA) onsite is the responsible health authority at each complex who is responsible complex-wide, for all levels of healthcare, providing quality accessible health services to all inmates.
- 2.1. The CHP FHA or designee will discuss with the Warden or designee the implementation of any new or revised health services programs which have an impact on institution operations. The FHA shall ensure that all facility health staff are knowledgeable of their technical, professional, and operational responsibilities.

3.0. Physicians

3.1. Matters of medical, mental health, and nursing care judgment and orders are the sole responsibility of the CHP clinical staff with appropriate monitoring by MSCMB. Clinical decisions and actions regarding healthcare services provided are the sole responsibility of qualified healthcare professionals. Medical, mental health, nursing care, and dental judgments are the sole responsibility of qualified healthcare personnel and are not to be compromised for security reasons. Final clinical judgments will rest with the site CHP Medical Director, Dental Director, or Director of Nursing who is designated as the responsible clinician for each complex.



	Medical Services Technical Manual
	REFERENCES: Department Order 105, Information Reporting Department Order 117, Health Services Authority and Communication Department Order 706, Incident Command System (ICS) Department Order 711, Notification of Inmate Hospitalization or Death Department Order 1102, Communicable Diseases and Infection Control MSTM P-D-06.01, Quality Improvement of Health Services NCCHC Standard P-A-04, Administrative Meetings and Reports ACA Standard 5-ACI-6D-01, Quarterly Meetings
	Effective Date: 10/01/2022 Supersedes:

P-A-04.01 Communications, Meetings, and Reports

PURPOSE: To provide an outline of mechanisms for communication with different Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) individuals and groups both within and outside of the Medical Services Contract Monitoring Bureau (MSCMB) and other state agencies.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) personnel and MSCMB to ensure that the communications regarding activities affecting the delivery of healthcare services are accurate, complete, and timely; each is to be responsive to the other.

PROCEDURES:

1.0. Communication: All communication between MSCMB and the CHP, written or verbal shall be transmitted in the most direct, concise, timely, and clear manner in order to facilitate issue resolution.

- 1.1. Written communication includes, but is not limited to ADCRR Department Orders, ADCRR Director's Instruction, ADCRR Technical Manuals, technical/clinical notices, Standard Operating Procedures, meeting minutes, addendums, letters, and memorandums.
- 1.2. Verbal communication includes, but is not limited to conference calls, information requests, and status inquiries.
- 1.3. All communication via telephone or face-to-face will be conducted professionally and courteously. Significant verbal decisions and/or directions given or received by the initiator shall be followed up by a written memorandum to the other party.
- 1.4. Emergency Notifications to Regional Leadership
  - 1.4.1. The CHP Facility Health Administrator (FHA) or designee shall notify the CHP Regional Leadership or designee and the ADCRR Assistant Director for Medical Services or designee immediately when any of the following significant events occur:
    - 1.4.1.1. Any unusual incidents that may be newsworthy or politically important.
    - 1.4.1.2. Major disturbances (e.g., riots).
    - 1.4.1.3. Death of CHP's employee.
    - 1.4.1.4. Inquiries from the Governor's Office, Congressional delegation, members of the State Legislature, other elected officials and the news media.
    - 1.4.1.5. Any significant communicable disease in accordance with Department Order #1102, Communicable Disease and Infection Control.

1.4.1.6. All violations or breaches of conduct, Code of Ethics, licensure or certification, and/or Community Standards of Care.

1.4.2. The CHP FHA or designee shall forward a written Information Report, Form 105-2, to the CHP Regional Leadership or designee and ADCRR Assistant Director for Medical Services detailing the circumstances by the close of business on the next business day following the occurrence.

1.5. Emergency Notifications to Warden: The CHP FHA or designee shall notify the Warden, or designee, of all serious illness, injury, communicable disease outbreak, or potential disease outbreak. The Warden shall be notified of a patient health status when, as determined by health staff:

1.5.1. Any unusual incidents that may be newsworthy or politically important.

1.5.2. Major disturbances (e.g., riots).

1.5.3. Any clinical condition requiring notification of next of kin.

1.5.4. Any incident involving reported potential safety hazards.

1.5.5. Any suicidality or self-harm event

1.5.6. The Warden shall be notified of the death of a patient. Notification to next of kin will be carried out by Security Operations and/or the chaplain service according to established policy at the local prison complex and Department Order #711, Notification of Inmate Hospitalization or Death.

1.5.6.1. When referred to the CHP FHA, every effort shall be made to answer any related questions or inquiries by the family within the confines of confidentiality policies.

2.0. Meetings

2.1. The CHP FHA shall attend a weekly meeting of their facility management team consisting of the FHA, ADCRR Complex Compliance Monitor, Complex Warden and other invited guests as deemed necessary.

2.2. The CHP FHA shall convene a monthly Complex Continuous Quality Improvement (CQI) Committee meeting in accordance with Medical Services Technical Manual P-A-06.01, Quality Improvement of Health Services.

2.3. The CHP FHA shall conduct monthly Medical Advisory Committee (MAC) meeting in accordance with Department Order #117, Health Services Authority and Communication.

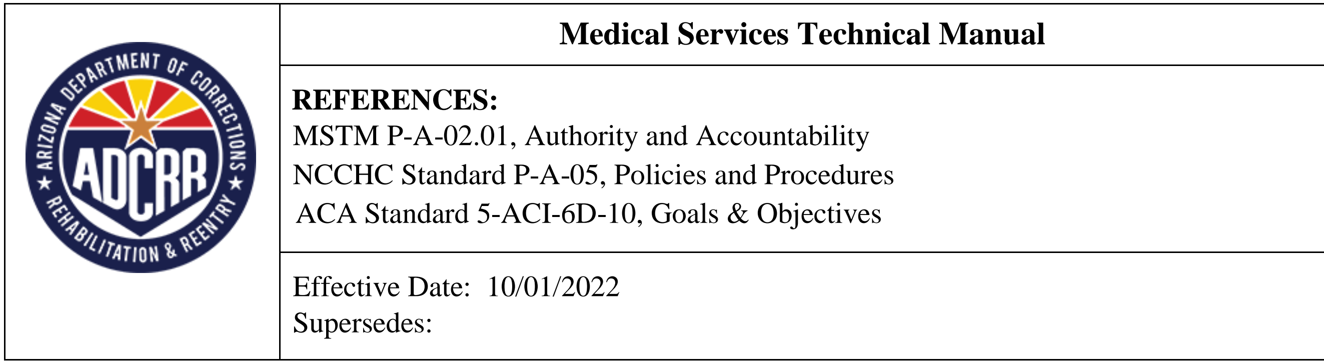
2.4. The CHP and MSCMB staff members as applicable shall conduct quarterly Pharmacy and Therapeutics Committee meetings.

2.5. Minutes of the meetings shall be made available to all members of the committee and the CHP's clinical staff, as appropriate.

3.0. Reports

3.1. Information Reports: Incident report formatting and submission of such reports are to be in compliance with Department Order #105, Information Reporting and Department Order #706, Incident Command System (ICS). CHP staff shall complete an Information Report, Form 105-2, or a Significant Indent Report, Form 105-3, in accordance with Department Order #105, Information Reporting.

3.2. Statistics and Reporting Requirements: The CHP shall ensure that all the required reports and statistics are completed and submitted before the established due date as required by the Contract and in accordance with ADCRR Department Orders.



Medical Services Technical Manual

REFERENCES:
MSTM P-A-02.01, Authority and Accountability
NCCHC Standard P-A-05, Policies and Procedures
ACA Standard 5-ACI-6D-10, Goals & Objectives

Effective Date: 10/01/2022
Supersedes:

P-A-05.01 Policy Administration (Policy and Procedures)

PURPOSE: This manual is provided to assist the Contract Healthcare Provider (CHP) personnel in the delivery of healthcare to the inmate population. It is designed to intertwine with state and federal regulations and professional standards.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Medical Services Contract Monitoring Bureau (MSCMB) to provide current Policy guidance to the CHP. It is the responsibility of all CHP staff to ensure standardized policies that are published, are adhered to, in accordance with sound medical and security practices.

PROCEDURES:

1.0. The ADCRR MSCMB maintains a Medical Services Technical Manual (MSTM) that serves as an adjunct to the ADCRR Department Orders.
- 1.1. The MSTM shall contain only those policies that are approved by the ADCRR Assistant Director for Medical Services.
- 1.2. The policy statements define the official position on particular issues, and procedures describe how the policies are carried out.
- 1.3. The MSCMB will review and update the MSTM annually and the CHP's supervisory staff members shall sign and date each annual review in accordance with MSTM P-A-02.01, Authority and Accountability.

2.0. Each institution CHP FHA or designee is responsible for regularly reviewing policies and procedures to identify and document desired or approved deviations. The review should involve subordinate staff and deviations are to be discussed with affected staff to determine ways to improve the process, or, the policy and procedure.

3.0. Each MSTM policy and each Post Order will be cross-referenced with the appropriate ADCRR Director's Instructions, ADCRR Department Orders, National Commission on Correctional Healthcare (NCCHC) Standard(s), American Correctional Association (ACA) Standard(s) if applicable, and any other appropriate official document(s).
- 3.1. The CHP FHA or designee is responsible to copy and distribute the entire MSTM and any new policy updates to all health units under their supervision. Upon completion of the entries into the unit MSTM, the transmittal should be dated and initialed by the FHA or his administrative designee and filed with the FHA's Master MSTM (maintained under the control of the FHA and located in the FHA's office).

3.2. The cover sheet of the FHA's master MSTM must indicate (by dated signature) an annual review of the MSTM by the facility's CHP Medical Director, Directors of Nursing, and the FHA.

3.3. Any modifications or additions to the existing MSTM that need to be implemented prior to the scheduled annual review shall be made in the form of an appendix, with notifications taking place by way of existing policies and procedures.

3.3.1. During the annual MSTM review, updated information will be incorporated into the appropriate chapter.

4.0. All policies are provided as guidance in administration by MSCMB. The CHP is responsible for ensuring compliance with the policy.

4.1. Should a CHP staff member perceive a need for a change to policy or a waiver of policy, as it affects the specific complex health facility, the CHP shall produce a letter to the ADCRR Assistant Director for Medical Services or designee that:

4.1.1. Identifies the particular policy element that presents a problem.

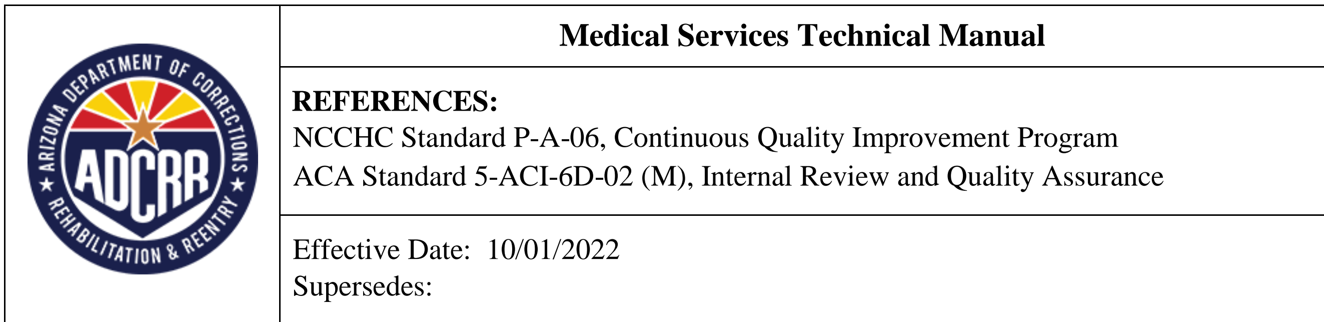
4.1.2. Identifies what is requested to be waived.

4.1.3. Describes any recommended changes to the policy.

4.1.4. Describes the expected outcome should the waiver not be granted.

4.2. The letter must receive a comment and endorsement by the appropriate CHP Regional Leadership or designee, prior to a decision by the ADCRR Assistant Director for Medical Services or designee.

4.3. The original policy shall be complied with until and unless the waiver is authorized and approved by the ADCRR Assistant Director for Medical Services or designee.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-A-06, Continuous Quality Improvement Program
ACA Standard 5-ACI-6D-02 (M), Internal Review and Quality Assurance

Effective Date: 10/01/2022
Supersedes:

P-A-06.01 Quality Improvement of Health Services

PURPOSE: To provide guidance for a Continuous Quality Improvement (CQI) Program for the Contract Healthcare Provider (CHP) to monitor and improve healthcare delivery in the facility through continuous improvement activities.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Assistant Director for Medical Services or designee, the CHP Regional Leadership or designee, the CHP Medical Directors or designee, the CHP Facility Health Administrators (FHA) or designee, and CHP Supervisory staff to ensure program compliance. It is the responsibility of all CHP staff to implement and utilize quality tools and concepts. The CHP Quality Improvement Director or designee is responsible for ensuring that the daily operations of the Quality Improvement Program are in compliance with the ADCRR Department Orders, National Commission on Correctional Healthcare (NCCHC) guidance, American Correctional Association (ACA), and Medical Services Contract Monitoring Bureau (MSCMB) Technical Manuals.

PROCEDURES:

1.0. Complex CQI Committee Responsibilities: The CHP is responsible to ensure the establishment of the complex CQI Committee. The CQI Committee should consist of representatives from all disciplines practicing at the complex. The site CHP Medical Director (responsible physician) must be involved in the CQI process. This group will meet monthly, and minutes of the committee meetings will be prepared utilizing an approved agenda format. CQI minutes should provide sufficient detail to guide future discussions. The committee:
   - 1.1. Identifies healthcare aspects to be monitored and establishes thresholds for the following:
      - 1.1.1. Access, timeliness, completeness, and quality of care delivered.
   - 1.2. Designs quality improvement monitoring activities.
   - 1.3. Analyzes the results of monitoring activities, for factors that may have contributed to not reaching the desired threshold.
   - 1.4. Develops and implements improvement strategies to improve/correct the identified healthcare problem.
   - 1.5. Re-monitors/re-audits the areas where improvement strategies were implemented to determine if change/improvement has occurred.

2.0. The CQI committee will assure that the following areas to be reviewed at least annually include (but are not limited to): access to care, admission screening and evaluations, nursing and provider lines, chronic disease services, health assessments, continuity of care, hospitalizations, infirmary care, pharmacy services, diagnostic services, dental services, high-risk populations, adverse patient occurrences, and all deaths. Further review will include man down drills, disaster drills, environmental inspection reports, grievances, and infection control practices.
   - 2.1. The committee completes an annual review of the effectiveness of the CQI Program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials.

2.2. Items that do not meet agreed benchmarks for compliance will require a more frequent review.

3.0. Quality assurance/continuous quality improvement chart reviews: The site CHP Medical Director (or a Physician designated to perform chart reviews in that complex) completes monthly quality assurance/continuous quality improvement chart reviews.

3.1. The focus of these reviews is the clinical aspects of the outpatient healthcare delivery system. Criteria for a quality assurance chart review include patients with high-risk conditions and those at risk for poor outcomes.

3.2. Chart reviews and the findings will be reviewed during the complex monthly CQI committee meeting.

3.2.1. Facilities with a population of less than 500 inmates review a minimum of 10 charts monthly.

3.2.2. Facilities with a population of 500-2000 inmates review a minimum of 15 charts monthly.

3.2.3. Facilities with a population of 2000 or more inmates review a minimum of 20 charts monthly.

3.3. When the committee identifies a healthcare problem from its monitoring, a process and/or outcome quality improvement study is initiated and documented. One process study and one outcome study is required annually.

4.0. CQI Studies:

4.1. Process quality improvement studies examine the effectiveness of the healthcare delivery process by:

4.1.1. Outcome studies examine whether expected outcomes of patient care were achieved.

4.1.2. CQI Study Reporting:

4.1.2.1. How the topic was selected

4.1.2.2. Methodology used to study the topic

4.1.2.3. Establish thresholds

4.1.2.4. Review findings of the group

4.1.2.5. Implement the plan for improvement based on evidence

4.1.2.6. Implementation plan

4.1.2.7. Outcome following monitoring of three, six, or nine months to assess the effectiveness of the corrective action plan.

4.1.2.8. CQI Study reports will be an attachment to the monthly CQI meeting minutes.

5.0. The CQI committee should monitor the completion of peer reviews for licensed staff as required by NCCHC and per contract terms and the status be reported in the monthly minutes.

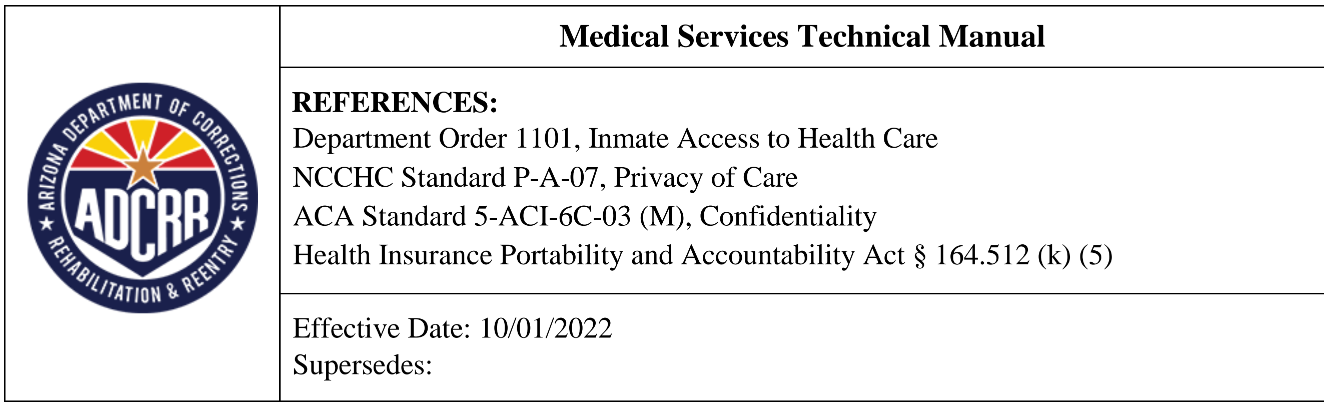
6.0. The CHP will forward a copy of each complex CQI monthly meeting minutes to the MSCMB as required by the contract. The CQI meeting minutes must include an update on any ongoing CQI process and/or outcome studies in process, as well as a review of grievances, infection control, review of emergency transports, medication errors, overview of chart reviews, environmental inspections, and any healthcare delivery concerns or improvements addressed by the committee. Action plans and any necessary remediation will be included in this report.

7.0. The CHP shall institute a system to review adverse events, near miss clinical events, and sentinel events.

7.1. The CHP designated staff member should analyze each adverse clinical or near miss event. These events shall be discussed as part of the CQI Program.

8.0. CHP designee in charge of the CQI Program shall conduct at least annual training with site FHA and other pertinent clinical leadership to enhance their skills and the program's effectiveness.

9.0. Some processes require a multidisciplinary approach including custody staff in such cases the FHA or designee may request participation from site custody leadership.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
NCCHC Standard P-A-07, Privacy of Care
ACA Standard 5-ACI-6C-03 (M), Confidentiality
Health Insurance Portability and Accountability Act § 164.512 (k) (5)

Effective Date: 10/01/2022
Supersedes:

P-A-07.01 Confidentiality

PURPOSE: To educate the Contract Healthcare Provider (CHP) staff regarding the impact of the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements, and the proper authorities surrounding the use of information, the release of information, and the importance of confidentiality. To provide an environment where there is an assurance on behalf of the patient that healthcare encounters remain private and that the patient's dignity is protected.

RESPONSIBILITY: It is the responsibility of the CHP Facility Health Administrator (FHA) or designee to ensure that all clinical encounters are conducted in private and carried out in a manner designed to respect the patient's privacy and encourage the patient's subsequent use of health services.

PROCEDURES:

1.0 Unless otherwise directed by Arizona law, all health records, and the information contained in the health records, are privileged and confidential. A CHP Practitioner may only disclose part or all of a patient's health records as authorized by Arizona State or federal law. The CHP Practitioner may disclose information upon receipt of a written authorization signed by the patient.

2.0 The HIPAA addresses correctional institutions and other law enforcement custodial situations. It allows permitted disclosures.

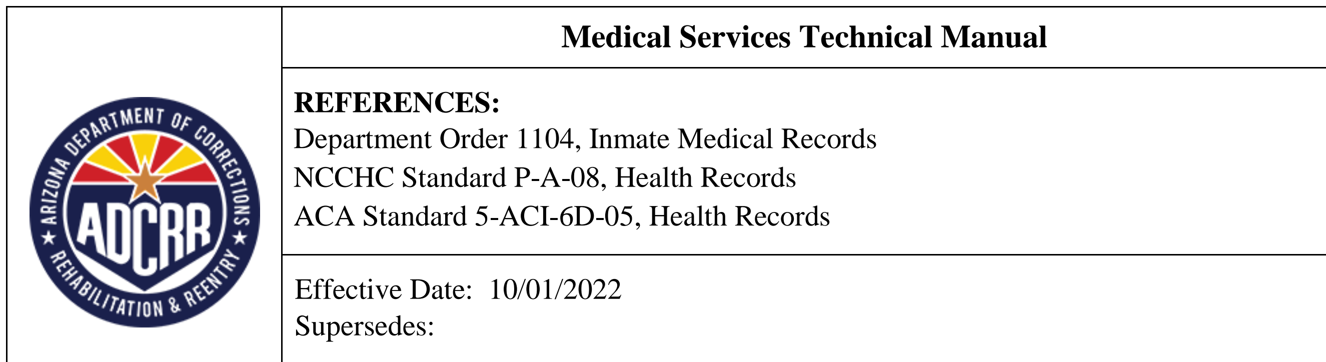
- 2.1. The first comprehensive set of Federal Regulations of Health Information, the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996, came into effect in April 2003.
- 2.2. Under the HIPAA Privacy Rule, protected health information (PHI) is defined very broadly. PHI includes individually identifiable health information related to the past, present or future physical or mental health or condition, and the provision of healthcare to an individual.
- 2.3. HIPAA section 164.512 (k) (5) Uses and discloses for which consent, an authorization, or opportunity to agree or object is not required. Correctional institutions and other law enforcement custodial situations. (1) Permitted disclosures. A covered entity may disclose to a correctional institution having lawful custody of an inmate, protected health information (PHI) about such inmate, if the correctional institution represents that such health information is necessary for the provision of care.

3.0 Privacy: Visual supervision of patients by escorting officers will be maintained as much as possible while respecting the privacy issues of patients during "sensitive physical examinations".

3.1. Clinical encounters are conducted in private, without being observed or overheard by security personnel. When triage is required to be conducted at the patient's cell, health services staff will take extra precautions to promote private communication between health staff and the patient.

3.1.1. Exception: Security personnel is to be present (in the same room) only if the patient poses a risk to the safety of the healthcare Practitioner/Provider or others.

3.1.1.1. When safety is a concern and full visual privacy cannot be afforded, alternative strategies for partial privacy, such as a privacy screen, will be utilized.



Medical Services Technical Manual

REFERENCES:
Department Order 1104, Inmate Medical Records
NCCHC Standard P-A-08, Health Records
ACA Standard 5-ACI-6D-05, Health Records

Effective Date: 10/01/2022
Supersedes:

P-A-08.01 Establishment and Organization of the Health Record

PURPOSE: To provide a uniform document in which a record of an patient's health status, diagnosis(es), examination(s), evaluation(s), treatment(s) and response(s) to treatment(s) can be recorded and maintained.

RESPONSIBILITY: The uniformity and maintenance of the health record (paper version or electronic version), is the responsibility of the Contract Healthcare Provider (CHP) staff. The CHP must have policies and procedures with a process for health information management, which meets or exceeds all rules and regulations for the handling, storage, disposal, and maintenance of health records, protected health information, and release of records. The CHP must also have a downtime policy and process.

PROCEDURES:

1.0. Establishment of Health Records: Upon arrival at Reception Centers CHP health record staff shall establish the patient's health record.

2.0. Inmate Identification Information: The paper health record jacket shall contain the following information in the upper right-hand corner of the file jacket:
- 2.1. Patient's full name (last name, first name) and Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) number (which becomes the health record file number). List any aliases to the left of the name label.
- 2.2. Information regarding any allergies the patient may have will be annotated in red on the front of the file jacket.
- 2.3. The ADCRR inmate number will be adhered to the bottom edge of the back cover of the jacket.

3.0. All documents contained in the health record must contain the following identifying information, and be entered in chronological order, with the most current on top:
- 3.1. Patient's full name, and
- 3.2. Patient's ADCRR inmate number, and
- 3.3. Patient's date of birth, and
- 3.4. Patient's current location (prison, unit).

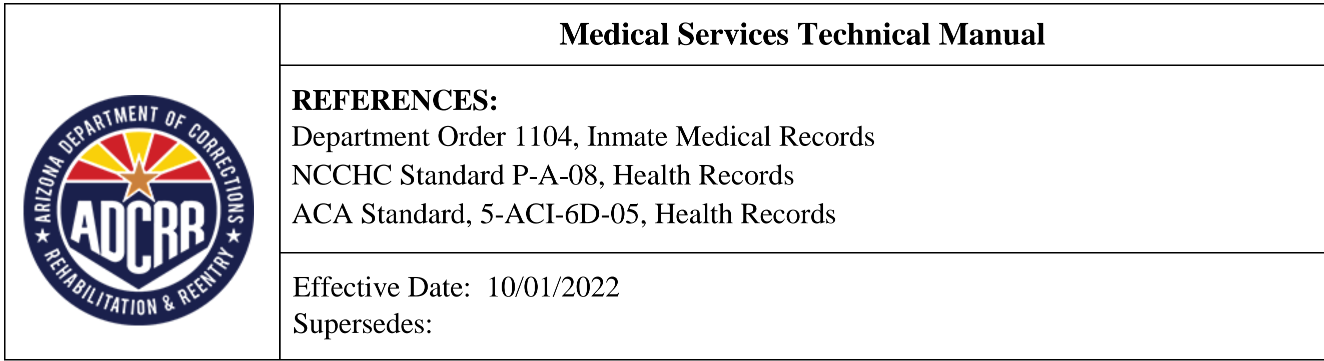
4.0. Organization of all ADCRR patient's health records shall be in accordance with the approved ADCRR MSCMB format. Organization of all ADCRR paper health records shall be done in accordance with Medical Services Technical Manual (MSTM) Attachment P-A-08.01A, Organization of a Paper Heath Record:
- 4.1. Filed in 4-part classification-type binders, in standard letter size (8 1/2" X 11").
- 4.2. Only forms that have been approved by ADCRR Medical Services Contract Monitoring Bureau (MSCMB) may be used in the health record.

4.3. Contents of the health record must be organized in ADCRR MSCMB approved format and be in chronological order.

5.0. A stamp or handwritten "MEDICAL RECORDS" is designated on the front of the health record jacket in the left-hand lower portion of the chart.

6.0. Paper health records (current volume and previous volumes) are kept on file in a designated area of the health unit(s) in numerical order as defined by the ADCRR inmate number.

6.1. For instructions on thinning a paper health record current volume, see MSTM Attachment P-A-08.01B, Thinning a Paper Health Record.



Medical Services Technical Manual

REFERENCES:
Department Order 1104, Inmate Medical Records
NCCHC Standard P-A-08, Health Records
ACA Standard, 5-ACI-6D-05, Health Records

Effective Date: 10/01/2022
Supersedes:

P-A-08.02 Documenting in the Health Record

PURPOSE: To ensure documentation made in the progress note section of the health record is consistent and that it meets all necessary health records requirements.

RESPONSIBILITY: The accuracy of the information entered into the health record is the responsibility of all professionals authorized to document in the health record. Each individual making an entry must reference and follow Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) policies.

PROCEDURES:

1.0. Documentation of all encounters with patients is completed in accordance with Department Order #1104, Inmate Medical Records.

2.0. Required format for the progress note:
- 2.1. All progress note entries will be made in accordance with the following format:
  - 2.1.1. Subjective (S): Patient's complaint and answers to direct questioning about the current illness, other systemic complaints, past medical history, family medical history, and social history.
  - 2.1.2. Objective (O): Pertinent findings in the mental status exam and physical exam, including vital signs, radiological imaging studies, and laboratory data.
  - 2.1.3. Assessment (A): Provider's diagnosis or a nursing assessment.
  - 2.1.4. Plan (P): Treatment provided or diagnostic/treatment plan developed based upon the assessment. Specific directions were provided to the patient.
  - 2.1.5. Education (E): The education given to the patient.

3.0. Progress notes will meet the following general criteria:
- 3.1. Entries
  - 3.1.1. The documentation will be made the same day as the encounter and completed at or as close to the actual time of the encounter as possible. All entries are to be completed within 24 hours of seeing the patient.
  - 3.1.2. Complete vital signs are documented at each clinical encounter when applicable.
  - 3.1.3. All entries must include complete patient identifying information and be chronological and continuous.
  - 3.1.4. Late Entry:
    - 3.1.4.1. The author will document the date and time of the late entry and on the first line state: "Late Entry": On (actual date/time of the occurrence or encounter) the following occurred (and then proceed with the Progress Note), complete the entry with the signature of the writer.
    - 3.1.4.2. Late entries are to be made as soon as possible after the encounter.
  - 3.1.5. Entries include the date (month/day/year) and time (24-hour, military style).

3.1.6. Handwritten entries must be legible and clear and can be either in cursive or print style and written in black ink. Blue ink is acceptable if the writing is dark enough to be copied.

3.1.7. "Whiteout®" or liquid paper is never to be used on paper records, nor is obscuring an original entry ever to be performed on an official document within the paper health record.

3.1.8. Any abbreviations documented in the health record shall be done in accordance with Medical Services Technical Manual Attachment P-A-08.02A, Approved Abbreviations for Documenting in the Health Record.

3.2. Format

3.2.1. If paper records are being utilized, all entries will be made within the margins of the Progress Note or no closer than ½ inch from the edge of the page when the progress note is being entered on other approved forms for progress note documentation.

3.2.2. If paper records are being utilized and if an entry is of sufficient length to extend from one page to another, the last line on the first page will be annotated "Continued" and signed and stamped by the author. The second page entry will begin with the date and time (military time) and "Continued", and proceed with the note.

3.2.3. If an entry does not continue to the end of the current page, but the author elects to make an entry on a new page, the author will draw several diagonal lines from the last line of the entry to the bottom of the page, thus preventing subsequent entries being made out of sequence to the actual time frames.

3.3. Identification (if paper records are being utilized)

3.3.1. The complete signature (as found in legal documents) and initials of the author's professional title are required at the end of their entry.

3.3.2. The author's name stamp is required. If the author does not have a name stamp, then, the author will print his name and title under the signature.

3.4. Corrections when utilizing paper records

3.4.1. To make a correction to an entry that is not lengthy, the author must:

3.4.1.1. Draw a single line through the incorrect entry (the original entry must be visible and legible).

3.4.1.2. Write "Error" above or beside the incorrect entry.

3.4.1.3. Make the correct entry; initial the correction and entry.

3.4.2. To make a correction to an entry that is lengthy:

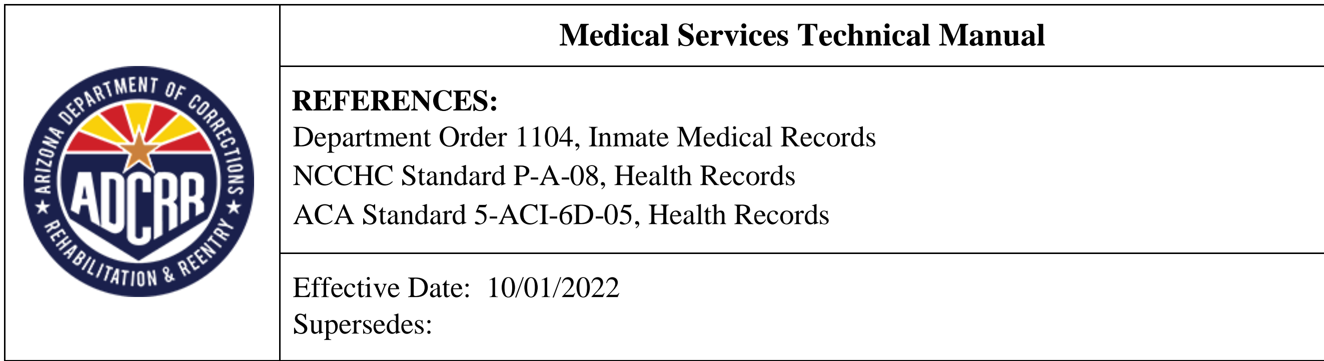
3.4.2.1. The author must either draw a single line through the entire original entry or draw a large "X" over the original entry (the original entry must be visible and legible).

3.4.2.2. Write the word "Error" diagonally across the entry.

3.4.2.3. Make the correct entry.

3.4.2.4. Initial the corrected entry.

3.4.3. At no time is it acceptable to remove any entry which has been placed in a health record, either individual entries or whole pages which then are re-written to exclude the original entry.



	Medical Services Technical Manual
	REFERENCES: Department Order 1104, Inmate Medical Records NCCHC Standard P-A-08, Health Records ACA Standard 5-ACI-6D-05, Health Records
	Effective Date: 10/01/2022 Supersedes:

P-A-08.03 Access to Health Record Information

PURPOSE: To provide guidance and instructions on how to respond to requests to review patient health records, receive copies of patient health records, and/or allow a verbal exchange of health information while maintaining confidentiality.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) health records staff must adhere to the strict rules of release of information. The CHP Health Record Supervisor will instruct and guide the CHP health records staff when processing requests for medical information. The CHP Facility Health Administrator (FHA) or designee shall respond to requests from family members/designees/attorneys for access to inmate health information.

PROCEDURES:

1.0. Patients Access to Health Record Information

1.1. Record Review: Patients are authorized to review their health records once per quarter by submitting an Inmate Letter, Form 916-1, to the CHP health record staff. The CHP Health Records staff will identify the sections of the records that need to be printed for review and schedule an appointment for the patient to review their records for a time period not to exceed forty-five minutes. If they require additional health records review appointments (more than once per quarter), the patient shall submit an Inmate Letter, to the CHP Facility Health Administrator (FHA) to justify the request.

1.1.1. Any patient request to review mental health records shall be forwarded by CHP health records staff to the CHP Mental Health Lead, who will review the mental health records and remove any documentation that could potentially worsen the patient's mental health condition if reviewed by the patient.

1.2. Remove all legal/administrative documents, under Section 4: Legal/Admin tab, prior to review by the patient.

1.3. Complete Form 1104-11, Guidelines for Inmate Medical Records Reviews and file in Section IV, under Legal/Administrative tab.

1.4. Patients may have a translator assigned in accordance with Department Order #704, <u>Inmate Regulations</u> and local procedure.

1.5. The health records are state property. Anyone caught tampering or destroying information contained in the health record will be referred for disciplinary action.

1.5.1. If a patient is found guilty of tampering or destroying information, any future reviews of the health record must be approved by the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Assistant Director for Medical Services.

1.6. In accordance with state and federal law, patients are not allowed to possess nor view the records of other patients.

1.7. Patients may request copies of their health records. Upon receipt of an Inmate Letter identifying specific portions of the health record to be copied, the CHP Health Records staff shall:

1.7.1. Forward the letter to the ADCRR Health Records Monitor who will forward it to Legal Services.

1.7.1.1. Staff shall not relinquish health record copies to any patient unless authorized by the ADCRR Medical Records Monitor.

1.7.1.2. Upon notification from the Office of the Attorney General that all requirements have been met, ensure that the copies of the appropriate portions of the Health Record are prepared by CHP Health Records staff, who shall give the copies directly to the patient after the following have been completed:

1.7.1.2.1. The patient shall sign the Form 1104-8, Inmate Medical Record Waiver of Liability. The CHP staff shall sign the form as a witness and file/scan the form in the patient's health record.

1.7.1.2.2. For the Private Prison Facilities, ADCRR Medical Records Monitor processes the health record request in the database, faxes the authorization and the health record request to the Health Records staff with an identification of which records to copy.

1.7.1.2.3. The patient shall be charged $.50 per page for records, or no charge if the patient is indigent.

1.7.1.3. If the patient is not authorized to receive records, the ADCRR Medical Records Monitor shall inform the patient in writing.

2.0. Outside Parties Access to Health Record Information

2.1. Health record information may be released upon receipt of a valid authorization from a patient, from a released offender, a subpoena, or upon receipt of a court order.

2.1.1. Health record information may be released upon the written authorization of the patient that meets the following requirements:

2.1.1.1. Authorization for Release of Protected Health Information, Form 1104-2, must be signed by the patient. If the patient is active it must be witnessed by ADCRR staff or CHP staff.

2.1.1.2. If the patient is released a copy of their government issued photo identification must accompany the signed request.

2.1.1.3. Specifies information to be provided with dates of service.

2.1.1.4. Gives the full name, address, contact number and email address of the person to whom the records are to be released.

2.1.1.5. Authorization must be dated within 60 days of the release request.

2.1.1.6. If the patient is housed at a Private Prison and is required to sign Form 1104-2, the CHP Health Records Supervisor or designee will complete the authorization form (Form 1104-2) and have the patient sign it.

2.1.2. A prior authorization is not required from a patient or released inmate to release health record information for the following:

2.1.2.1. Court Order

2.1.2.2. For Law Enforcement agencies (i.e., Federal Bureau of Investigation, Federal Marshall, police department, sheriff's office, jails, prisons)

2.1.2.2.1. Mental health records may only be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing evaluation and treatment or to report a crime on the premises or to avert a serious and imminent threat to an individual or the public.

2.1.2.3. Medical Examiner
2.1.2.4. Public Health Department
2.1.2.5. For emergency treatment at a hospital
2.1.2.6. State licensure board (i.e., Board of Medical Examiners or State Board of Nursing)

2.2. Deceased Patient's Records release. Records may be released to patients' family (next of kin) with the approval of the Division Administrator.

2.2.1. Authorization to Disclose Copies of health records must be completed by next of kin and witnessed by a Notary.

2.2.1.1. Family shall provide verification of relationship:
2.2.1.2. Death Certificate
2.2.1.3. A copy of Driver's License required prior to the release of health records.
2.2.1.4. Payment is required before copies are released.
2.2.1.5. Invoice will be mailed/faxed to the requestor.

2.2.2. The ADCRR Medical Record Monitor is responsible for processing the copies of a deceased patient's health records.

3.0. Release of Health Record Information, Legal Services

3.1. Patient authorization is required for subpoenas, requests from Attorney General's Office and ADCRR Discovery unit

3.1.1. Health records may be released in response to a Subpoena or Court Order, which has been validly served upon the Custodian of health records. In the Private Prison Facilities that is the ADCRR Medical Records Monitor, in ADCRR facilities that is the CHP health record staff.

3.2. Subpoenas or Court Order may be served in person in civil cases, or in person or via US mail in criminal cases. Out of State subpoenas will not be accepted.

3.3. The receiver of the Subpoena or Court Order shall document the following information on the face of the Subpoena and then send a copy to the Discovery Unit:

3.3.1. Date and time of the of receipt of the Subpoena,
3.3.2. Manner of Services (in person or via mail),
3.3.3. Signature and title of Custodian of health records

3.4. Processing legal request for copies:

3.4.1. Compile requested records in accordance with subpoena or court order.

3.4.1.1. Compute charges as appropriate and invoice requester.
3.4.1.2. Accept payment and complete a Receipt
3.4.1.3. Send a copy of the Authorization and health record copies to the requester

3.4.2. Include a Declaration Statement with following information: Patients name, patients ADCRR inmate number, date range, number of pages, signature and title of health records staff, and date completed.

3.5. File all documents in Section IV of the health record under the Legal/Administrative tab. Attach a copy of the Declaration Statement to the documentation.

4.0. Release of Health Record Information, Outside Provider

4.1. A request by ADCRR or CHP Provider to send or receive past health records to or from outside Providers does not require an authorization from the patient.

4.2. The Request for Medical Records, Form 1104-1, is completed and sent to obtain previous records and then filed or scanned in the previous record section.

4.3. Upon receipt of requested records the CHP Health Records staff shall forward them to the CHP Practitioner to review, sign, and date. The "outside" records are filed or scanned in Previous Records after the provider reviews them.

4.4. Offsite Medical Practitioners responsible for the patient’s care may receive health information from ADCRR and the CHP without the patient’s authorization as it pertains to the continuity of care of the inmate.

4.5. The Industrial Commission, employers of inmates (patients) filing industrial injury claims or the legal representatives of those employers, to the extent they relate to the claim.

5.0. Charging for Health record Copies

5.1. Charges for copies of health records: ADCRR may charge a reasonable fee for the production of the health record copies.

5.1.1. Reasonable fees are set as:

5.1.1.1. $.10 per page for digital copies and $.50 per page for paper copies.

5.1.1.2. X-Ray film by authorization: $15.00 for each sheet.

5.2 Authority to assess charges and collect fees: Only the ADCRR Medical Record Monitor or the CHP Health Records Supervisor or designee may assess charges for health record copies and collect the fees.

5.3 A cashier’s check or money order shall be accepted; no personal checks will be accepted. Law firm checks shall be accepted. Cash/debit payments will be accepted using the adcpay website.

5.4 All checks received shall be sent to the Budget/Business office, along with a copy of the receipt.

5.5 There is no charge for copies of the health record released for the following purposes: Continuity of Care, Social Security, Legal Advocate or to Discovery-ADCRR Legal Services/Attorney General’s Office.

6.0. Processing

6.1. For the Private Prison Facilities: ADCRR Medical Records Monitor notifies the Private Prison Health Records Supervisor or designee via email which records need to be compiled. Once the records are compiled the Private Prison staff will send the records to the ADCRR Medical Records Monitor via a secure link provided to them.

6.2. The CHP Health Records Supervisor or designee will be responsible for compiling the records, invoicing the requestor, and sending the records once payment is received. (Records for continuity of care do not need to be invoiced and can be sent immediately upon receipt of the request.)

6.2.1. Once the records are sent, the CHP health records staff will scan the request into the electronic health record (EHR), documenting on the bottom of the request the number of pages sent, mode of transportation, date sent, and the name and the signature of the CHP Health Records staff who sent the records.

7.0. Release of Health record Information, Individual Staff Member Named in Lawsuit

7.1. When an ADCRR Medical Services Contract Monitoring Bureau staff member or previous ADCRR Health Services employee or Medical Services Contract Vendor employee is named in a lawsuit and served with a subpoena to answer interrogatory questions, the ADCRR Medical Record Monitor shall be notified.

7.1.1. Staff are not permitted to review or copy any health records without the approval of the ADCRR Medical Record Monitor and the FHA.

7.2. CHP Health Records staff may be called upon to testify in a court of law regarding status or maintenance of health records.

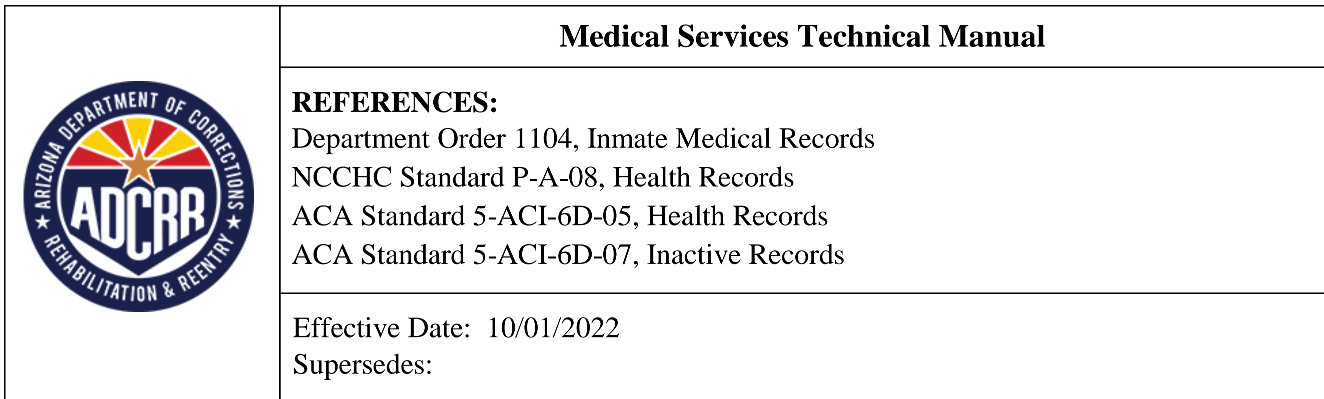
7.2.1. The best support for this activity is to ensure, on a daily basis, that:

7.2.1.1. Record management is performed in accordance with policy

7.2.1.2. Accuracy in copying of records in response to subpoenas

7.2.1.3. Ensuring that each copy is legible and straight on the page

7.2.1.4. Accuracy in accounting for, counting, and numbering pages
7.2.1.5. Preparation of declarations of specified date ranges on the MRR



Medical Services Technical Manual

REFERENCES:
Department Order 1104, Inmate Medical Records
NCCHC Standard P-A-08, Health Records
ACA Standard 5-ACI-6D-05, Health Records
ACA Standard 5-ACI-6D-07, Inactive Records

Effective Date: 10/01/2022
Supersedes:

P-A-08.04 Health Record Security, Accountability and Transfer

PURPOSE: To establish a procedure for the control and retention of health records for active, released, and deceased patients and to assure that the confidentiality of the health information is maintained. To provide guidelines allowing access to custody information necessary to treat the patient.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Health Records staff are responsible to ensure that health record information is maintained and properly protected from unauthorized release.

PROCEDURES:

1.0. The CHP staff has access to custody information as outlined in Department Order #901, Inmate Records Information and Court Action.
- 1.1. Name and Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) number of any patient committed to ADCRR.
- 1.2. Conviction data contained in the Judgment of Sentence or minute entry.
- 1.3. Verified conviction data from Arizona Correctional Information System.
- 1.4. The date of admission.
- 1.5. The institution where the patient is housed, unless the file indicates that location is not to be released.
- 1.6. The date of scheduled release and/or discharge.
- 1.7. Decisions of the Arizona Board of Executive Clemency (Board).
- 1.8. The name and office telephone number of the supervising Parole Officer.

2.0. Health records stored in the facility are maintained under secure conditions separate from correctional records.

3.0. Removal of Paper Health Records from the File
- 3.1. Health records may not be removed from the health unit and/or health administration area without the express authorization/direction of the CHP Facility Health Administrator (FHA), CHP Health Records Supervisor, CHP Regional Leadership or designee, or ADCRR Medical Records Monitor or designee.
- 3.2. Staff may not make copies or utilize medical documents for personal use (i.e., response to lawsuit, development of anecdotal files, etc.)

4.0. Retention of Health Records for Active Patients
- 4.1. Order of filing health records on shelving units.
  - 4.1.1. Health records shall be filed on the shelving units by the ADCRR number.
  - 4.1.2. Active and previous volumes shall be filed separately in ADCRR number order.

4.1.3. The health records volumes shall be numbered with the volume numbers: Volume 1 of 3, Volume 2 of 3, Volume 3 of 3. Each previous volume should have written on the front of the chart "DO NOT USE see new volume".

5.0. Health Records of Released Patients

5.1. Health records of released patients are to be removed from the active shelves and kept separate from other health records in the Health Records area.

5.2. Following a patient's release from ADCRR, health records are sent directly to the Contracted Storage Facility (CSF) for retention. Health records shall be kept on the releasing unit for at least 3 months but no longer than 6 months prior to being sent to the CSF. In accordance with the Retention Schedule on file with CSF and CHP, health records of released offenders shall be stored for the remainder of the time period unless otherwise noted and destroyed upon written notification from Medical Services Contract Monitoring Bureau (MSCMB).

5.2.1. See Medical Services Technical Manual Attachment P-A-08.04A, Health Record Inventory Entry into IHAS (Inmate Health Appointment System) for released record processing instructions.

5.3. CSF provides listings of records destroyed and the destruction date, which is kept on file in the State Records Management Center.

5.4. The health records of minors are processed in the same manner as the adults. The health records will be destroyed after the minor has reached 24 years of age (unless the record has been folded into a re-incarceration health record).

5.5. The health records of patients who are transferred to another state for Interstate Compact are to be sent to ADCRR Medical Records Monitor for storage until ADCRR is informed that the patient is released from that state or the patient is received back as an active inmate in Arizona.

6.0. Use of CSF

6.1. Information to be completed on the Boxed Records Data Entry Form for CSF is as follows:

6.1.1. Record Series Code: (i.e., number 35012 (Adult) and 35013 (Minor))

6.1.2. Two copies of the Single Box Report are printed from IHAS. One copy is placed in the box and one copy is maintained on-site at the facility for three years.

6.2. Storage boxes are prepared for transmittal:

6.2.1. One Data Entry Bar Code Label is prepared and affixed to each storage box.

6.2.2. One label is attached to the "Boxed Records Data Entry Form" at the unit by Health Records staff.

6.2.3. Information to be included in the box is as follows

6.2.3.1. Single Box Report sheet of health records contained in the box.

6.2.3.2. The number of volumes in the box must be counted and match the inventory sheet.

6.2.3.3. Signature of the CHP health records staff and the date must be written on the inventory sheet.

6.2.4. All records processed for CSF are entered into a database, with hard copies included in the box. Delivery of the boxed health records shall be arranged jointly between the CHP and the CSF.

7.0. Reactivation of Health Records for Patients Returned to ADCRR Custody:

7.1. If an offender returns to the ADCRR system within the 6-year retention time period set with the CSF, the receiving facility shall contact the CSF to obtain the old volumes of the offender's health record.

7.2. If the patient was released and the health record is still at the unit they were released from, the CHP Health Records staff is responsible for contacting the previous health unit to obtain health records.

7.3. The CSF shall securely package the health record(s) prior to sending them to the appropriate facility.

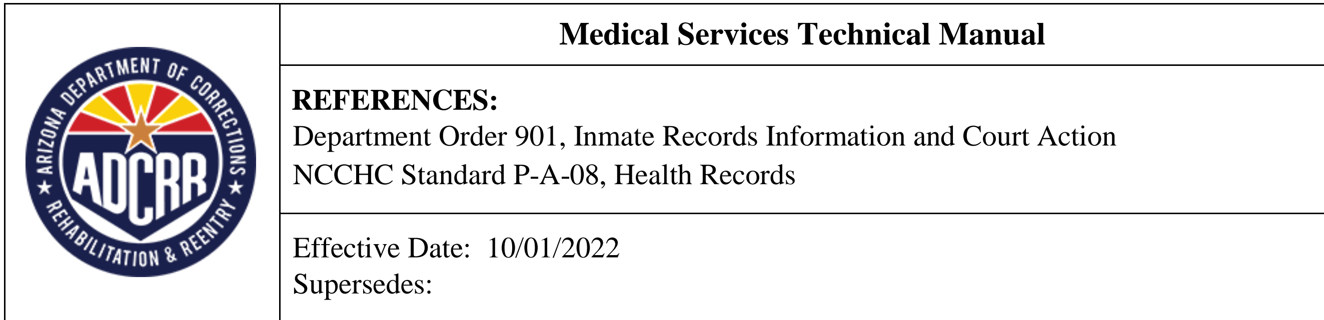
8.0. Health Record of Deceased Patients

8.1. When a patient has expired the CHP Health Records staff at the facility shall secure all volumes of the health records, any “loose sheet” filling, Medication Administration Records, and any diagnostic reports that have not been signed by the provider.

8.1.1. The date of death and complex shall be marked on the front of each volume.

8.1.2. The health record(s) should be secured at the patient’s most recent designated housing facility and a Mortality Review Committee meeting shall be scheduled in accordance with Department Order #1105, Inmate Mortality Review.

8.1.3. The health record(s) shall be sent to storage at the CSF according to the retention schedule unless requested to be sent to the ADCRR Medical Record Monitor



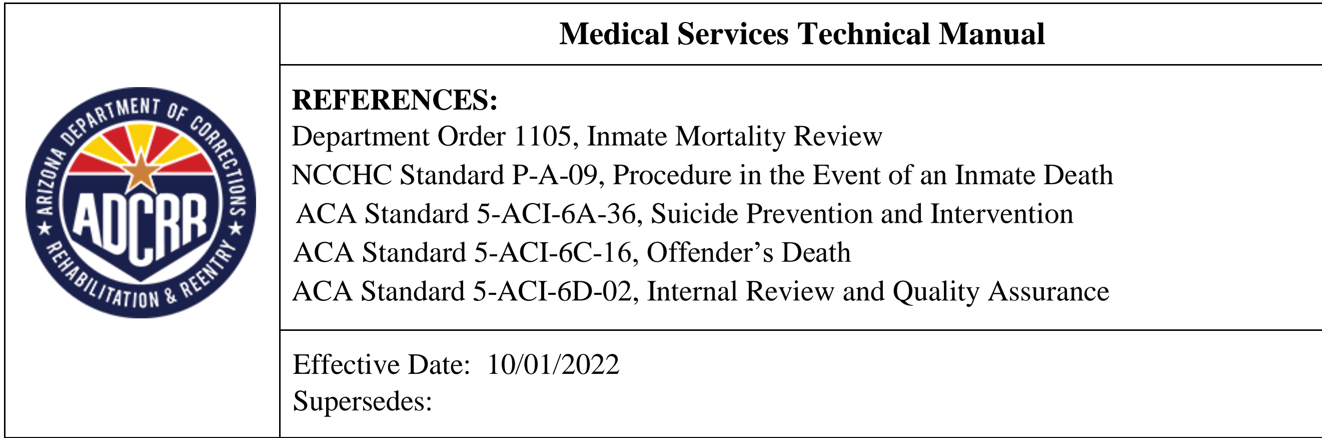
P-A-08.05 Medical Arizona Correctional Information System (ACIS) Entries

PURPOSE: To provide a system whereby authorized Contract Healthcare Provider (CHP) staff can enter pertinent medical, dental, or mental health information into the Arizona Corrections Information System (ACIS) described in Department Order #901, Inmate Records Information and Court Action. Entry is to assist Prison Operations staff in decisions for appropriate placement of patients.

RESPONSIBILITY: It is the responsibility of the CHP Facility Health Administrator (FHA) or designee to ensure that proper entries are made by CHP staff. CHP health records staff is responsible to monitor and maintain ACIS data, either by direct entry, or verification that information is transferred through the electronic health record.

PROCEDURES:

1.0. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff may enter information regarding patient's medical, mental health, or dental needs.
  - 1.1. Medical Restrictions
    - 1.1.1. A patient with special medical or mental health needs which are usually permanent in nature may require housing at specific ADCRR facilities.
  - 1.2. Medical Holds
    - 1.2.1. A medical hold for 90 days or less shall be placed on any patient with a pending appointment for outside consultation, postoperative recovery, etc.
  - 1.3. Special Diets
    - 1.3.1. A patient may require a special medical diet due to medical diagnosis and/or condition.
  - 1.4. Special Needs Related to Medical/Mental Health Issues
    - 1.4.1. Special needs shall be entered to include special duty status, special housing considerations, lower bunk, extra mattress/pillows/wedges, shaving waivers, Americans with Disabilities Act (ADA) status. Special needs may be permanent or temporary in nature.
  - 1.5. Medical and Mental Health Scores *(Private Prisons Only)*
    - 1.5.1. Enter information regarding Medical and Mental Health scores, as determined by medical and mental health providers.



	Medical Services Technical Manual
	REFERENCES: Department Order 1105, Inmate Mortality Review NCCHC Standard P-A-09, Procedure in the Event of an Inmate Death ACA Standard 5-ACI-6A-36, Suicide Prevention and Intervention ACA Standard 5-ACI-6C-16, Offender's Death ACA Standard 5-ACI-6D-02, Internal Review and Quality Assurance
	Effective Date: 10/01/2022 Supersedes:

P-A-09.01 Inmate Mortality

PURPOSE: To establish guidance for acknowledging, documenting, and reviewing mortalities of inmates who die while in the custody of the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR).

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Regional Medical Director retains responsibility to administer death events. It is the responsibility of all CHP clinical staff to understand and comply with this policy in supporting the reviews of deaths to validate the quality of care and to apply lessons learned in future mortalities. This process shall be incorporated into the Continuous Quality Improvement (CQI) program.

PROCEDURES:

1.0. Pronouncement:

1.1. A Registered Nurse, mid-level Practitioner/Provider, or a Physician may pronounce death. Only a certified coroner can certify death. A Registered Nurse should only pronounce death when all resuscitation efforts have failed.

1.2. As soon as possible after an inmate is determined to be dead, the Coroner or Medical Examiner will be called by the ADCRR security staff.

1.3. The facts surrounding the pronouncement will be reported to the CHP Regional Medical Director or designee by the CHP Facility Health Administrator or designee within 24 hours of the death.

1.4. All records, reports, databases and meetings, are protected by patient confidentiality and are held in strict confidence and shall not be subject to disclosure in accordance with Department Order #1105, Inmate Mortality Review.

2.0. Mortality Review: All incidents of inmate death, regardless of circumstances or cause, shall be referred for investigation.

2.1. Upon the death of an inmate, fetal death or fetal sentinel event beyond the first trimester, the procedures listed in Department Order #1105, Inmate Mortality Review, shall be followed.

2.2. For the first review, within SEVEN business days of an inmate's death, fetal death or fetal sentinel event beyond the first trimester, the CHP Facility Health Administrator (FHA) of the institution, shall:

2.2.1. Complete the Contract Health Administrator Questionnaire, Form 1105-10, and forward to the CHP Regional Medical Director or designee and the ADCRR Medical Records Monitor or designee.

2.2.2. Convene the Complex Mortality Review Committee (CMRC). The CMRC shall:

2.2.2.1. Complete the Mortality Review Case Abstract and Cover Sheet, Form 1105-1.

2.2.2.2. Forward the completed Mortality review Case Abstract and Cover Sheet form with copies of all pertinent health records, Emergency Medical Services (EMS) notes (if utilized) and Incident Command System (ICS) Information Reports to the ADCRR Medical Director or designee, the CHP Regional Medical Director and the ADCRR Medical Records Monitor or designee.

2.2.2.3. If the incident resulted in an ICS being initiated, the CMRC shall include the Deputy Warden and unit Chief of Secretary in the initial meeting.

2.3. Psychological Autopsy

2.3.1. The CHP Regional Mental Health Director shall ensure that a Psychological Autopsy is completed on all inmates who commit suicide. The Psychological Autopsy is completed utilizing the Psychological Autopsy, Form 1105-9.

2.3.2. Within 14 calendar days of the notification of an inmate's suicide:

2.3.2.1. The CHP Regional Mental Health Director shall convene a Psychological Autopsy Committee (PAC). The PAC shall:

2.3.2.1.1. Review the inmate's Medical/Mental Health record, including autopsy and toxicology reports.

2.3.2.1.2. Review any source of data (e.g., Information Reports, investigation reports, and Department documents, etc.) relevant to the incident.

2.3.2.1.3. Make recommendations concerning corrective actions, policy or procedural changes, as necessary.

2.3.2.1.4. The CHP Regional Mental Health Director assigns a CHP Psychologist to complete a Psychological Autopsy.

2.3.3. Within 30 calendar days of an inmate's suicide:

2.3.3.1. The assigned CHP Psychologist shall compose an integrated report and send it to the CHP Regional Mental Health Director and the ADCRR Mental Health Director or designee.

2.3.3.1.1. The CHP Regional Mental Health Director and the ADCRR Mental Health Director or designee shall meet with the Criminal Investigations Unit investigator assigned to the case to discuss any relevant information that either party has received.

2.3.3.1.2. The CHP Regional Mental Health Director shall consolidate the necessary information and publish a final Psychological Autopsy Report.

2.4. Health records from ADCRR complexes and the Private Prisons are to be forwarded to the ADCRR Medical Records Monitor at the Medical Services Contract Monitoring Bureau (MSCMB) after the second mortality review has been completed. All Electronic Health Records shall be printed and filed into the current volume. Death Records must be sent via approved commercial courier to the ADCRR Medical Records Monitor at MSCMB. Complete the Inmate Chronological Movement Record. Mark each volume with the date of death and the complex on the front cover under the inmate label.

2.5. Joint Mortality Review Committee (JMRC)

2.5.1. Within 30 calendar days of the mortality, the ADCRR Medical Director or designee shall convene a monthly JMRC meeting consisting of CHP medical personnel and the Department's medical personnel for review of mortality cases in accordance with Department Order #1105, Inmate Mortality Review.

2.5.1.1. Following this meeting the Mortality Review Committee Report, Form 1105-3 will be submitted, with the check box indicating "Joint Mortality Review Committee," and signed by the ADCRR Assistant Director for Medical Services, ADCRR Medical Director or designee, and CHP Regional Medical Director.

2.5.2. The CHP Regional Medical Director and the ADCRR Medical Director or designee shall review the report with the ADCRR Assistant Director for Medical Services, and recommend any corrective action plans, as required. The report shall be forwarded to the respective ADCRR Deputy Director through the chain of command.

2.6. Within three business days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office, the CHP Facility Health Administrator shall reconvene the CMRC. The CMRC only needs to reconvene if the Autopsy and Toxicology Report were not available during the mortality review that took place within 30 calendar days of the inmate's death. The CMRC shall:

2.6.1. Review the Autopsy and Toxicology reports and complete a secondary review utilizing the Mortality Review – Case Abstract and Cover Sheet form, updating the facts and conclusions as appropriate.

2.6.2. Forward the completed form to the ADCRR Medical Director or designee, the CHP Regional Medical Director and the ADCRR Medical Records Monitor or designee.

2.7. Within 10 business days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office:

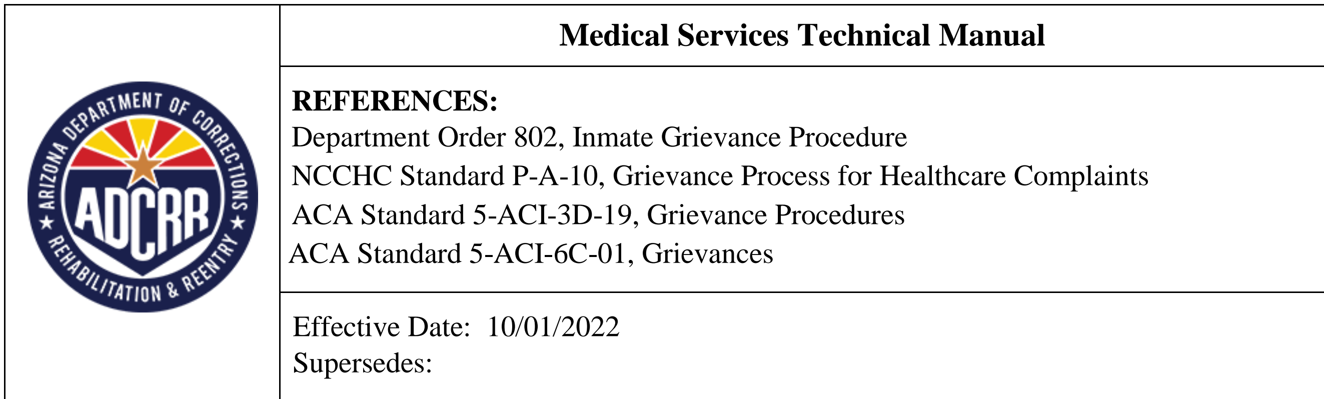
2.7.1. A final independent clinical mortality review will be completed by the ADCRR Medical Director or designee. This review only needs to be completed if the Autopsy and Toxicology Report was not available during the mortality review that took place within 30 calendar days of the inmate's death.

2.7.2. The ADCRR Medical Director or designee shall communicate with the CHP Regional Medical Director and convene another JMRC, if needed.

2.7.3. The Mortality Review Committee Report (Form 1105-3) is marked "final" and is completed by the ADCRR Medical Director or designee based on the review of the Autopsy and Toxicology report.

2.8. Internal Review and Quality Assurance: Mortality reviews shall identify and refer deficiencies to appropriate Managers and Supervisors, including Continuous Quality Improvement (CQI) Committee, for corrective action implementation.

2.8.1. The ADCRR Medical Director or designee shall convene a monthly meeting with the CHP Regional Medical Director or designee for a JMRC Monthly Report meeting. Additional attendees will be assigned by the ADCRR Medical Director and CHP Regional Medical Director. The purpose of this meeting is to track corrective action plans for compliance and to identify trends that may need to be addressed by the CHP's CQI process.



Medical Services Technical Manual

REFERENCES:
Department Order 802, Inmate Grievance Procedure
NCCHC Standard P-A-10, Grievance Process for Healthcare Complaints
ACA Standard 5-ACI-3D-19, Grievance Procedures
ACA Standard 5-ACI-6C-01, Grievances

Effective Date: 10/01/2022
Supersedes:

P-A-10.01 Grievance Process for Healthcare Complaints

PURPOSE: The grievance process provides patients with a mechanism to resolve issues of concern.

RESPONSIBILITY: It is the responsibility of all ADCRR employees and Contract Healthcare Provider (CHP) to promote meaningful and timely written communication with inmates to resolve complaints and disputes at the lowest possible level within the organization and at the earliest opportunity.

PROCEDURE:

1.0. Inmates are authorized and encouraged to utilize the Inmate Communication System described in Department Order #802, Inmate Grievance Procedure.

2.0. Healthcare Grievances (referred to as Medical Grievances in Department Order #802, Inmate Grievance Procedure):

- 2.1. Filing the Grievance: The inmate shall attempt to resolve the complaint informally, prior to filing a formal grievance, in accordance with the procedure outlined in Department Order #802, Inmate Grievance Procedure. In attempting to resolve the complaint, the inmate's assigned CO III has authority to correspond or speak with the appropriate medical staff to develop a response.
- 2.2. In the event an inmate is unable to resolve their complaint through informal means, he/she may submit an informal Complaint on an Inmate Informal complaint Resolution form (Form 802-11) to the Correctional Officer (CO) IV in their respective unit who will upload the complaint into the Arizona Correctional Information System (ACIS) which will assign a case number. The informal complaint must be submitted within ten workdays from the date of the action that caused the complaint. The inmate shall attach copies of all documentation to support his/her complaint.
  - 2.2.1. Within 15 workdays of the CO IV upload the CHP Assistant Director of Nursing or designee shall investigate the complaint and respond to the inmate’s informal complaint using ACIS, as outlined in Department Order #802, Inmate Grievance Procedure.
  - 2.2.2. Inmates may file a Formal Grievance if they are dissatisfied with the inmate’s informal complaint response or if the time frames for the response have been exceeded.
- 2.3. Formal Grievance Process (Medical)

2.3.1. An inmate may file a Formal Grievance should he/she be unable to resolve their complaint informally. The inmate has five workdays from receipt of the response from the CHP Director of Nursing (DON) or designee to submit a Formal Grievance to the unit CO IV Grievance Coordinator, using the Inmate Formal Grievance Response, Form 802-2.

2.3.1.1. Upon receipt of any Medical Grievance, the unit CO IV Grievance Coordinator shall immediately upload the Formal Grievance form into ACIS.

2.3.2. Within 15 workdays of uploading the grievance, the CHP DON or designee shall:

2.3.2.1. Investigate the complaint.

2.3.2.2. Respond to the inmate's formal grievance. The typed response to the inmate shall include:

2.3.2.2.1. A summarization of the inmate's complaint.

2.3.2.2.2. A description of what action was taken to investigate the complaint to include the date and content if a personal meeting with the inmate was conducted.

2.3.2.2.3. A summary of findings.

2.3.2.2.4. The decision and supporting rationale in reaching the decision.

2.3.2.2.5. The decision from the facility level shall either be "Resolved" or "Not Resolved."

2.3.3. The unit CO IV Grievance Coordinator shall utilize ACIS and the date of the typed response to close out his/her tracking log, print a completed formal grievance response and forward the response to the inmate.

2.4. Emergency Medical Grievances: For emergency complaints, inmates shall seek emergency medical attention as outlined in Department Order #1101, Inmate Access to Healthcare.

3.0. Appeals to the Contract Facility Health Administrator (Medical)

3.1. Inmates may elect to appeal the decision of the CHP DON or designee to the CHP Facility Health Administrator (FHA) or designee within five workdays of receipt of the CHP DON's or designee's decision by submitting an Inmate Grievance Appeal, Form 802-3, to the unit CO IV Grievance Coordinator. Inmates may not file an appeal to the CHP FHA until the Inmate Grievance Procedure within their assigned unit has been exhausted.

3.2. The unit CO IV Grievance Coordinator shall immediately enter the appeal into ACIS and notify the CHP FHA or designee and ADCRR Medical Grievance Investigator or designee via email. Each appeal will be logged using the date the email notification was sent to the CHP FHA or designee on the Unit Coordinator Grievance Log, form 802-9.

3.3. Within 30 calendar days of receiving the Inmate Grievance Appeal, the CHP FHA shall:

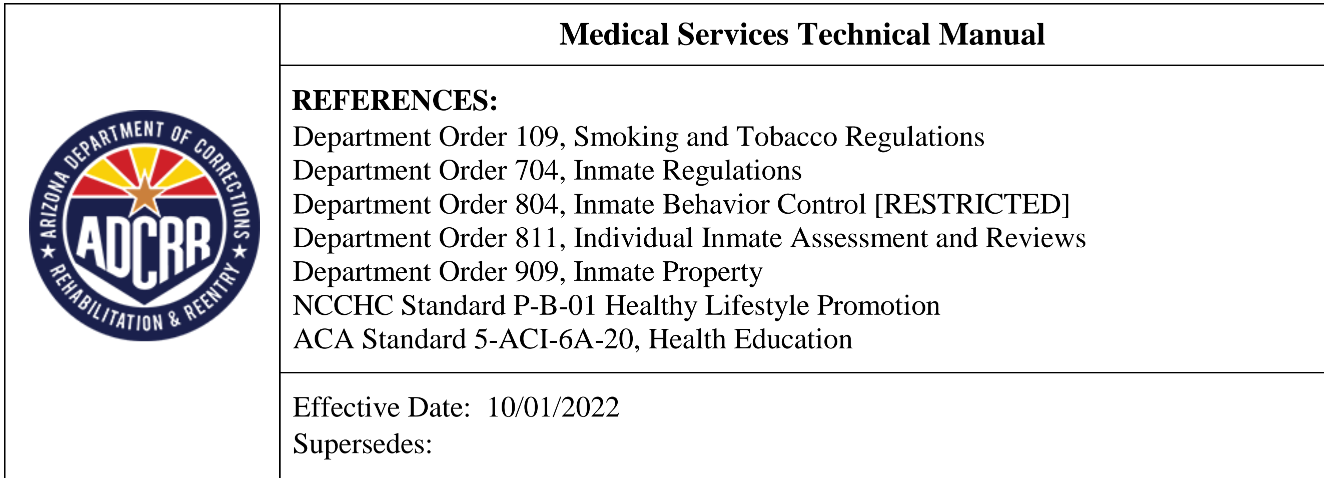
3.3.1. Respond using Inmate Grievance Response Form (802-2) and upload into ACIS.

3.3.2. Notify the CO IV Grievance Coordinator and ADCRR Medical Grievance Investigator or designee via email that a written response was submitted.

3.4. The decision of the CHP FHA or designee is final and constitutes exhaustion of all remedies within the Department.

3.5. The unit CO IV Grievance Coordinator shall utilize ACIS and the date the response email notification is sent to close out their tracking log, print the completed appeal response and forward to the inmate.

4.0. Reporting and record requirements: The unit CO IV Grievance Coordinator shall forward the previous month grievance log form (form 802-9) to ADCRR Medical Grievance Investigator or designee via email no later than the 25th of each month.



	Medical Services Technical Manual
	REFERENCES: Department Order 109, Smoking and Tobacco Regulations Department Order 704, Inmate Regulations Department Order 804, Inmate Behavior Control [RESTRICTED] Department Order 811, Individual Inmate Assessment and Reviews Department Order 909, Inmate Property NCCHC Standard P-B-01 Healthy Lifestyle Promotion ACA Standard 5-ACI-6A-20, Health Education
	Effective Date: 10/01/2022 Supersedes:

P-B-01.01 Health Education and Promotion

PURPOSE: The Contract Healthcare Provider (CHP) will provide information and services that promote healthy lifestyle, prevent disease, provide early detection and treatment of disease, and teach self-care.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to educate patients whenever possible in self-care strategies and to promote healthy lifestyle choices.

PROCEDURE:

1.0. Patients with chronic diseases will be provided with information either on an individual or group basis that is designed to increase their ability to monitor and manage their health status.

2.0. Tobacco Use as outlined in Department Oder #109, Smoking and Tobacco Regulations
- 2.1. General Complex guidance: Smoking and vaping shall be limited to outside areas only. Outside smoking areas shall not subject normal traffic to second-hand smoke (e.g., smoking and vaping shall be prohibited near entrances to buildings).
- 2.2. All used smokeless tobacco (e.g., chewing tobacco, plug tobacco and/or snuff) shall be disposed of in a covered receptacle (i.e., an empty soda can or cup).

3.0. Inmate Tobacco Use
- 3.1. Smoking cessation information shall be made available to inmates. The CHP staff will make information available to inmates who request assistance with cessation of use of tobacco products.
- 3.2. Smoking and the possession of tobacco and all smoking-related materials are totally prohibited by inmates placed in: reception centers, minors units, all detention units, special management units, all medical units, and inpatient patient care (IPC) areas.

4.0. Exercise
- 4.1. Exercise focusing on large muscle activities such as walking, jogging in place, basketball and isometrics is encouraged.
- 4.2. CHP Practitioners/Providers should consider, if appropriate, exercise as an adjunct to any treatment plan.

5.0. Personal Hygiene

5.1. Inmates are allowed to shower in accordance with Department Order #704, Inmate Regulations, Department Order #804, Inmate Behavior Control, and Department Order #811, Individual Inmate Assessments and Reviews.

5.1.1. CHP staff shall write a Duty/Special Needs Order, Form 1101-60, for inmates who need additional temporary shower accommodations due to medical needs.

5.2. Personal hygiene items are issued to inmates in accordance with Department Order #909, Inmate Property. These items include soap, tooth care items, toilet paper, and women's sanitary care items. Additionally, a wide array of personal hygiene items is available to inmates for purchase from the Inmate Store.

5.2.1. CHP staff shall write a Duty/Special Needs Order, Form 1101-60, for inmates who need additional or alternative personal hygiene products due to medical issues.

5.3. Shaving/Grooming: The inmate barber shall be available on a specified schedule for inmate haircuts. Individual shaving instruments shall be available to general population inmates. Electric razors may be shared on certain units provided the razor is sanitized between inmates.

5.4. Nail clippers or Dremel shall be available for use in the health unit though the submission of a Health Needs Request (HNR), Form 1101-10, or by submitting an electronic HNR 1101-10(e), via the inmate tablet program.

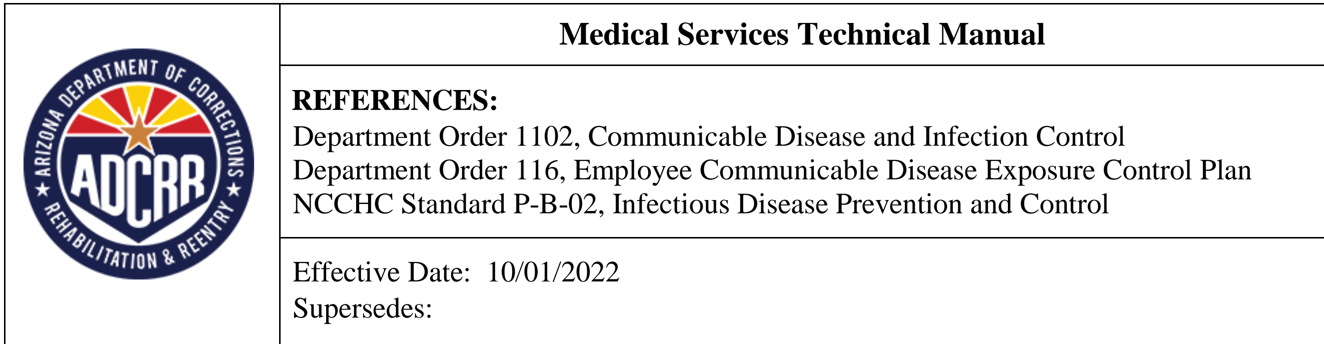
6.0. Sun Exposure Protection

6.1. Diagnosis of illnesses which can be exacerbated by exposure to sun must be well documented for a patient to qualify for issuance of a long sleeved protection.

6.2. Patients on medications which have photosensitivity reaction to sun as a common adverse reaction may also qualify for an issuance of a long sleeved protection.

6.3. If the inmate is on an outside work crew and meets criteria for sun exposure protection, security staff bears the responsibility to provide the necessary clothing items.

6.4. Inmates who are not assigned to an outside work crew and who otherwise satisfy the requirements for sun exposure protection shall have the necessary items provided to them by the CHP.



	Medical Services Technical Manual
	REFERENCES: Department Order 1102, Communicable Disease and Infection Control Department Order 116, Employee Communicable Disease Exposure Control Plan NCCHC Standard P-B-02, Infectious Disease Prevention and Control
	Effective Date: 10/01/2022 Supersedes:

P-B-02.01 Infectious Disease Prevention and Control

PURPOSE: To coordinate identification of and responses to infectious or potentially infectious diseases.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for surveillance, prevention, diagnosis, and treatment of suspected or confirmed communicable diseases and making proper notifications when necessary.

PROCEDURE:

1.0. For the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) facility exposure control plan see Department Order #116, Employee Communicable Disease Exposure Control Plan.

2.0. The CHP Facility Health Administrator (FHA) ensures that:
- 2.1. Medical, dental, and laboratory equipment and instruments are appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations.
- 2.2. Sharps and biohazardous wastes are disposed of properly.
- 2.3. Surveillance to detect patients with infectious and communicable disease is effective.
- 2.4. Patients with contagious diseases are identified and, if indicated, medically isolated in a timely fashion.
- 2.5. Infected patients receive medically indicated care.
- 2.6. Patients requiring respiratory isolation are housed in a functional negative pressure room.

3.0. Standard precautions are always used by all staff to minimize the risk of exposure to blood and body fluids.

4.0. Inmate workers are trained in appropriate methods for handling and disposing biohazardous materials and spills.

5.0. Patients who are released with communicable or infectious diseases have documented community referrals, as medically indicated.

6.0. Upon initial nursing screening the CHP nurse will screen the individual for ectoparasites.
- 6.1. If the individual is found with ectoparasites, they are isolated from the rest of the population and immediately issued intervention. The CHP nurse is responsible for instructing the individual in the treatment of ectoparasites according to nursing procedures and documenting the encounter in the health record.
  - 6.1.1. The CHP nurse shall make the necessary notifications to include the complex CHP Director of Nursing, CHP FHA, ADCRR Complex Compliance Monitor, and Warden or designee.

6.2. All roommates will be screened for ectoparasites by the CHP nursing staff and treated accordingly.

6.3. Hygienic maintenance of clothing, bedding, and personal hair items. This needs to be performed **simultaneously**.

6.3.1. The CHP unit nurse will instruct security to have linens and clothes washed and dried at the prison laundry services. Place linens and clothes in a black bag with a label tag. Remind laundry staff to use gloves and follow all required precautions. Have the black bag sit in the sun for 3 days prior to washing.

6.3.2. Have the patient wash his/her mattress. The prison laundry service will wash bedding and all of his/her clothes after cream/shampoo is applied. Cloth mattresses or mattresses with holes must be bagged in a black bag for 4-5 days prior to washing.

6.3.3. All hair combs/brushes are discarded and re-issued by security.

6.4. Isolation of the patient:

6.4.1. For head lice/pediculosis: Once the shampoo treatment occurs, the bedding, clothing, and the mattress are to be washed and the isolation cell cleaned and sanitized with disinfectant cleaner, then the patient is released from isolation.

6.4.2. For scabies/body lice: Once the cream has been left on for 8 to 14 hours, the clothing, linen, and mattress must be washed and the isolation cell is sanitized with disinfectant cleanser, then the patient can be released from isolation.

6.4.2.1. The patient will remain isolated from the rest of the population until the treatment is finished. Once treatment is completed, the CHP nurse must evaluate the individual to ensure that the signs and symptoms of lice/scabies are no longer present.

6.4.2.1.1. The patient is released from isolation per CHP Provider order.

6.4.2.1.2. If treatment is initiated with oral medication, the patient maybe released from isolation only with a CHP Provider order.

6.4.3. For Ringworm or Tinea Capitas (ringworm of the scalp)

6.4.3.1. The patient does not have to be isolated from the other population. The nurse will monitor the patient weekly on nurses' line until resolved.

6.5. Patient follow-up for head lice/pediculosis, scabies or body lice.

6.5.1. In seven days the CHP nurse will evaluate the patient on the nurse's line for recurrence of signs and symptoms of lice/scabies.

6.5.2. Appointments need to be scheduled at the time of the initial incident, in case of a transfer.

6.5.3. Lice and scabies are not retreated unless ectoparasites are present again.

6.6. Patients who are transferred to another facility after receiving treatment.

6.6.1. When a patient is transferred the transferring CHP nurse will schedule follow-up electronically.

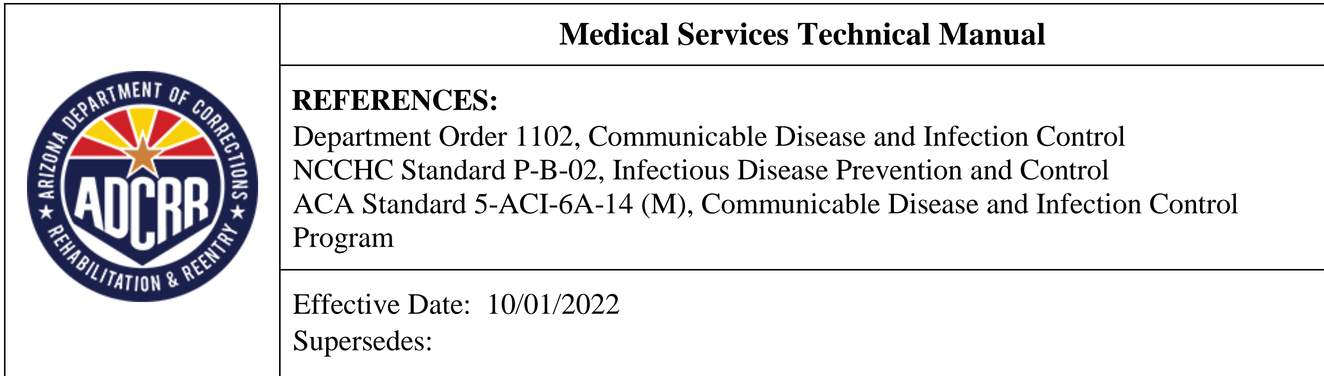
6.6.2. The receiving CHP nurse who performs the chart review for intake confirms scheduled follow-up on nurse's line. This visit will be for the purpose of screening the patient a second time for ectoparasites. If the date falls on a weekend, the CHP nurse shall screen the patient for ectoparasites, and treat accordingly.

6.7. All processes are documented in the health record.

7.0. An environmental inspection of the health services areas is conducted monthly to verify cleanliness and safety of all patient housing; laundry, kitchens and housekeeping practices; pest control measures; risk exposure containment measures; equipment inspection and maintenance; and occupational and environmental safety measures.

7.1. The CHP FHA are responsible to ensure that all manufacturer and state regulatory agency required inspections are completed on health services division equipment.

7.2. Inspection reports including documented corrective actions must be reviewed by the CHP FHA or designee. The filed original may be retained by the appropriate supporting staff (e.g., Office of Safety and Environmental Services Liaison, Occupational Health Unit, etc.).



Medical Services Technical Manual

REFERENCES:
Department Order 1102, Communicable Disease and Infection Control
NCCHC Standard P-B-02, Infectious Disease Prevention and Control
ACA Standard 5-ACI-6A-14 (M), Communicable Disease and Infection Control Program

Effective Date: 10/01/2022
Supersedes:

P-B-02.02 Tuberculosis Screening & Management

PURPOSE: The purpose of this policy is to provide standard guidelines for the:

- initial screening,
- annual screening,
- reading and documenting a Purified Protein Derivative (PPD) skin test,
- management of latent tuberculosis infection (LTBI),
- management of active tuberculosis (TB disease),
- contact investigation,
- reporting requirements,
- and refusal process

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for ensuring that all CHP medical providers and CHP nursing staff respectively comply with these guidelines. The topic shall be included as part of the CHP New Employee Orientation Program and reviewed annually.

The CHP Facility Health Administrator (FHA) is responsible for monitoring Health Staff compliance at the complex level.

PROCEDURES:

1.0. Initial Screening and Return to Custody

1.1. Symptom Screening: Nursing staff shall provide all patients symptom screening for pulmonary Tuberculosis (TB) within 24-hours of admission.

1.1.1. Pulmonary symptoms include: prolonged cough (longer than three weeks duration), chest pain and hemoptysis (bloody sputum); or at least three of the following systemic symptoms: fever, chills, night sweats, easy fatigability, loss of appetite, and unexplained weight loss.

1.1.1.1. Patients who screen positive for being at risk for TB will be masked immediately, isolated in a private room and placed on airborne precautions.

1.1.1.2. Patients with symptoms will be referred to the CHP Medical Provider for further evaluation.

1.2. TB Skin Testing: CHP nursing staff shall perform a PPD skin test on all patients without PPD results recorded on the transfer summary from the sending County and without documented history of a positive skin test. Patients vaccinated with Bacilli Calmette-Guerin (BCG) are not excluded from receiving a PPD test or an Interferon-Gamma Release Assay (IGRA).

1.3. All patients that received their PPD (or Gamma interferon release assay (IGRA) blood test) at the Reception Center shall remain at the reception center for a minimum of 48-hours so the test results may be obtained and documented in the health record, prior to movement to their permanent facility.

1.3.1. All PPD skin tests shall be read and documented in accordance with section 3.0 below.

1.3.2. If the skin test reaction is 5-9 millimeters (mm) of induration, with no history of exposure to TB, a repeat PPD shall be performed within 7-12 days following the first PPD.

1.3.3. If the administered PPD test is inconclusive upon reading, order a repeat PPD in 7 to 12 days. If indicated, the patient may be transferred prior to the completion of the repeat PPD and the Transfer Summary should note that a repeat PPD is required.

1.4. A PPD is not administered to patients who have a confirmed past positive PPD or a confirmed history of TB.

1.5. Inmates returning to custody shall receive the PPD at the receiving institution. A repeat PPD test is NOT required if less than **90 days** have passed from the prior release**.**

1.5.1. All return-to-custody inmates with a history of a positive PPD or positive IGRA test will have a chest x-ray (CXR) completed. A repeat CXR is not required if 90 days or less have passed since release or if a documented negative CXR report is included or annotated on the Transfer Summary.

2.0. Annual Screening

2.1. Patients shall be screened **annually** for tuberculosis by PPD skin test and TB symptoms screening.

2.2. If the skin test reaction is 5-9 mm of induration, with no history of exposure to TB, a repeat PPD shall be performed within 7-12 days following the first PPD.

2.3. A PPD is not administered to patients who have a confirmed past positive PPD or a confirmed history of TB.

3.0. Reading and Documenting PPD Skin Test

3.1. Trained healthcare staff interpret the reaction to the PPD skin test 48 to 72 hours after the injection by measuring the area of induration (the palpable swelling) at the injection site. The diameter of the indurated area is measured across the width of the forearm. Erythema (the redness of the skin) is not measured.

3.1.1. All reactions, even those classified as negative, are recorded in millimeters of induration (00mm, 1mm, etc.).

3.1.2. 10 or more (10 ≥) mm induration is considered a positive result in the majority of cases. These results are documented in the patients' health record and referred to the CHP Practitioner for further evaluation and chest x-ray (CXR).

3.1.3. 5 or more (5 ≥) mm induration is considered a positive result if patient has any of the following conditions: HIV, recent close contact of someone with TB disease, CXR consistent with previous TB disease, organ transplant recipient, immunosuppression, or a history of injection drug use with unknown HIV status.

3.1.3.1. Negative skin test: CHP nursing staff shall evaluate patient's HIV status according to health record.

3.1.3.2. On all HIV positive patients with a skin test ≥ 5mm

3.1.3.2.1. Nursing staff shall refer to CHP medical Practitioner (Provider) for chest x-ray (within 72 hours of a positive PPD) & evaluation for TB disease.

3.2. Documentation of completed TB screening shall include:

3.2.1. Documentation of a completed TB symptomology and/or PPD shall be noted in the appropriate area of the patient's health record.

3.2.2. An updated Medical Work-Up, Form 1101-68, for facilities that utilize a paper record.

3.2.3. Documented history of a positive skin test: CHP nursing staff shall check for completion of treatment or a history of a BCG vaccine.

3.2.3.1. History of completed treatment: CHP nursing staff shall perform symptom screening annually.

3.2.3.2. History of incomplete treatment: CHP nursing staff shall refer patients to CHP medical Practitioner/Provider for CXR & possible initiation of therapy. CHP nursing staff shall also perform symptom screening annually.

4.0. Management of LTBI

4.1. A CXR shall be performed on a patient with a positive PPD skin test or a patient with a negative PPD test who has symptoms such as cough, anorexia, weight loss, fever and/or hemoptysis.

4.1.1. Patients with a history of a positive PPD who are asymptomatic shall NOT have a CXR, unless there is a suspicion of TB or exposure.

4.2. CHP will provide evaluation and management of TB and LTBI to meet clinical guidelines and best practices.

4.2.1. HIV infected with skin test result ≥ 5 mm induration.

4.2.2. Recent close contact of an infectious TB and skin test result ≥ 5mm induration.

4.2.3. Chest radiograph suggestive of previous TB disease and skin test result ≥ 5mm induration.

4.2.4. Immunocompromised who require ≥ 15mg Prednisone a day for at least one month with skin test result ≥ 5 mm induration.

4.2.5. TB skin test result ≥ 10mm induration.

4.3. If a patient on LTBI treatment is released before completion of TB therapy, the patient shall be provided one month's supply of their current treatment regimen. The patient shall also be provided the name(s) and address (es) of the appropriate local health department where treatment can be obtained.

4.4. If a patient on LTBI treatment is transferred to an outside facility before completion of TB treatment, the CHP unit nurse or complex CHP Director of Nursing (DON) of the sending facility shall notify the receiving correctional facility of the patient's current TB medication and requirements for completion of therapy.

5.0. Management of Active TB

5.1. A positive culture for M. tuberculosis confirms a diagnosis of TB disease. In the absence of a positive culture, TB may also be suspected on the basis of clinical signs & symptoms, smear for Acid Fast Bacillus (AFB) or Nucleic Acid Amplification (NAA).

5.2. CHP nursing staff shall immediately put a surgical mask on all TB cases or suspects.

5.3. CHP Medical Practitioner/Provider or CHP Nurse shall counsel the patient on the findings and treatment.

5.4. A TB case or suspect shall be excluded from work and any other group activities and placed immediately in an airborne infection isolation and/or referred to the appropriate healthcare facility with airborne infection isolation capabilities, until all the following conditions are met:

5.4.1. At least three successive sputum smears collected eight hours apart, at least one of which is taken first thing in the morning, are negative for acid-fast bacilli (AFB).

5.4.2. Anti-tuberculosis treatment is initiated.

5.4.3. Clinical signs and symptoms of tuberculosis are improved and patient is asymptomatic.

5.5. CHP Medical Practitioner/Provider shall ensure all TB cases or suspects are administered appropriate medical treatment. Drug regimen shall be monitored by the CHP health staff within consultation as needed from the Arizona Department of Health Services (ADHS) until completion of therapy.

5.6. All active TB medications shall be administered by DOT to ensure adherence to treatment.

5.7. A patient on TB treatment shall receive thorough medical evaluation by a CHP Medical Provider and be monitored by a CHP Nurse or medical Provider for signs and symptoms of adverse reaction.

5.8. If a patient on TB treatment is released or transferred to an outside facility before completion of TB treatment, the public health department or receiving correctional facility shall be notified by the CHP Facility Health Administrator or designee no later than 24 hours of release or transfer to ensure appropriate placement and completion of treatment. For deportation cases, contact the Arizona Department of Health Services TB Program.

5.9. In the event the patient is noncompliant with TB treatment, counseling with the CHP Nurse and/or medical Provider shall occur and be documented in the health record. If the patient continues to refuse, the CHP Regional Medical Director or designee shall be immediately notified for case review.

5.10. Employee Precautions: Employees shall wear a particulate mask (N95) when:

5.10.1. Entering rooms housing individuals with suspected or confirmed infectious TB.

5.10.2. Performing a high hazard procedure (i.e. cough-inducing procedure) on a patient with suspected or confirmed TB disease.

5.10.3. Transporting a patient with confirmed or suspected TB disease.

6.0. Contact Investigation of offenders diagnosed with active or suspected TB.

6.1. The CHP Facility Health Administrator shall immediately notify the CHP Regional Medical Director or designee.

6.2. The CHP Regional Medical Director shall immediately notify the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Medical Director and ADCRR Assistant Director for Medical Services.

6.3. The CHP Regional Medical Director or designee shall provide direction to the facility regarding contact investigation.

6.4. The CHP health staff in consultation with the local or state health department will provide direction to the facility in defining who is a close contact.

6.5. CHP nursing staff shall identify all individuals who had prolonged contact in an enclosed environment with a TB case.

6.6. Evaluation of a contact's TB infection status shall be completed within three working days after being identified as a contact to a TB case.

6.7. The CHP Facility Health Administrator or designee after consultation with the CHP Regional Medical Director shall release the gathered information regarding contacts, upon request by the local or state health department.

6.8. A Contact Investigation teleconference shall be convened and shall include the following members as needed:

6.8.1. Arizona Department of Health Services TB Control Office

6.8.2. County Health Department TB Control Office

6.8.3. CHP Regional Medical Director or designee

6.8.4. CHP complex health staff

6.8.5. CHP Facility Health Administrator

6.8.6. CHP complex Director of Nursing

6.8.7. Complex Warden or Deputy Warden

6.8.8. ADCRR Complex Compliance Monitor

6.8.9. ADCRR Medical Director or designee

6.8.10. ADCRR Program Evaluation Administrator or designee

6.8.11. ADCRR Occupational Health Administrator

6.8.12. ADCRR complex Occupational Health Nurse

6.8.13. Representative from Offender Classification

6.9. The CHP Regional Medical Director or designee will facilitate the teleconference and provide a written summary of the teleconference for distribution electronically to the participants to include recommendations and follow-up meetings as necessary.

6.10. Close contacts, shall have a PPD skin test unless they have had a known positive PPD.

6.11. Close contacts with a known positive PPD shall undergo chest x-ray. Follow-up chest x-ray will be completed at 6 month, 12 month and 2 year intervals from exposure. If the chest x-ray remains negative after the 2 year period, the investigation is completed.

6.12. Close contacts receiving a PPD skin test with a negative reading shall be retested at 12 weeks.

7.0. Reporting Requirements

7.1. The CHP FHA shall immediately notify the CHP Regional Medical Director or designee of any newly diagnosed patient to determine if respiratory isolation and/or transfer to a hospital for evaluation and treatment is indicated.

7.2. The CHP Regional Medical Director or designee shall notify ADCRR Medical Director and ADCRR Assistant Director for Medical Services.

7.3. The CHP Facility Health Administrator or designee shall immediately notify the Department's Occupational Health Administrator of any TB case or suspected case.

7.4. The Facility Health Administrator or designee, after consultation with the CHP Regional Medical Director, shall report the TB case to the Arizona Department of Health Services TB Control Program within one working day of receipt of diagnosis. Send the appropriate report to the ADHS. Refer to the Arizona Department of Health Services TB Control Manual for appropriate reporting forms.

7.4.1. State Required Reports: CHP nursing staff shall complete all state required reports except for the Report of Verified Case of Tuberculosis (RVCT) which shall be completed by the diagnosing agency (State Lab or Hospital). A copy of the RVCT shall be requested by CHP Nursing staff from the diagnosing agency and filed in the patient's health record.

7.4.1.1. The original ADHS Prevention Registry Form shall be filed or scanned into the patient's health record. A copy shall be submitted to ADHS for each of the following situations: positive PPD, positive symptom screen, positive chest X-ray, and completion of Isoniazid (INH) therapy, release or death of a patient prior to completion of INH therapy.

7.4.1.2. Each time a copy of the Prevention Registry Form is sent to ADHS, this shall be documented at the bottom of the original form.

7.4.1.3. An Infection Control/Reportable Diseases Report shall be submitted to the Medical Services Contract Monitoring Bureau (MSCMB).

8.0. Refusal Process

8.1. If a patient refuses to submit to a PPD test, chest x-ray or, in suspicious cases, a medical workup, the nurse shall attempt to gain the patient's voluntary compliance by providing counseling regarding the intent of the test and the necessity to safeguard the patient's health, and that of others.

8.2. If a patient does not cooperate after receiving counseling, the CHP Director of Nursing shall notify the CHP FHA, who shall notify the Warden or designee.

8.3. After being notified by the CHP FHA, the Warden or designee shall:

8.3.1. Facilitate the testing requirement by asking the patient to sign the Involuntary Tuberculosis Test, Form 1102-4.

8.3.2. If the patient refuses to sign the Involuntary Tuberculosis Test form, note on the form the patient refused to sign.

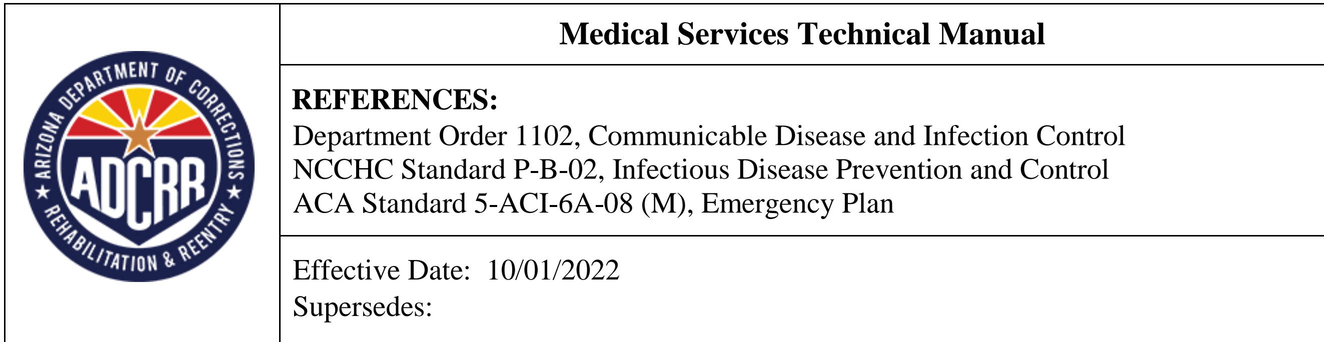
8.3.3. Inform the patient he or she will be secured to a maximum restraint chair or bed, if necessary, and tested.

8.3.4. Ensure only necessary force is used if the patient still refuses to cooperate. After necessary force has been applied, a nurse shall administer the procedure.

8.3.5. Ensure the entire procedure is video recorded by whatever means is available to operations staff, including the instructions to the patient and the application of necessary force.

8.3.6. Ensure the test is administered away from other patients and not in a housing area.

8.3.7. Ensure the patient is escorted to the health unit at a prescribed time so healthcare staff can assess the skin test.



	Medical Services Technical Manual
	REFERENCES: Department Order 1102, Communicable Disease and Infection Control NCCHC Standard P-B-02, Infectious Disease Prevention and Control ACA Standard 5-ACI-6A-08 (M), Emergency Plan
	Effective Date: 10/01/2022 Supersedes:

P-B-02.03 Influenza like illnesses and COVID-19

PURPOSE: To coordinate identification of and responses to infectious or potentially infectious diseases.

RESPONSIBILITY: The Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Medical Director or designee is responsible for directing the ADCRR Medical program to provide surveillance, prevention, diagnosis and treatment of suspected or confirmed communicable diseases. Contract Healthcare Provider (CHP) who operate facilities for the Department are responsible for promulgating an inmate screening program for communicable disease.

PROCEDURES:

1.0. Immediately upon arrival to any ADCRR facility, all inmates shall be screened for recent exposure to and/or current symptoms of COVID-19.

1.1. Symptoms of COVID-19 may include:

1.1.1. Fever (≥38°C, 100.4°F), or

1.1.2. Symptoms of lower respiratory illness (cough or shortness of breath), or

1.1.3. Close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset.

1.1.4. Chills with or without shaking

1.1.5. Muscle pain

1.1.6. Headache

1.1.7. Sore Throat

1.1.8. New loss of taste or smell

1.1.9. Congestion or runny nose

1.1.10. Nausea or vomiting

1.1.11. Diarrhea

1.2. Patients who screen positive for being at risk for COVID-19 will be masked immediately, isolated in a private room and placed on droplet precautions, contact precautions, and standard precautions.

1.2.1. All persons entering the suspected COVID-19 room shall wear at a minimum:

1.2.1.1. Surgical (medical) mask

1.2.1.2. Gown

1.2.1.3. Gloves

1.2.1.4. Face shield and/or eye protection

1.3. Only essential healthcare personnel should enter the patient's room to evaluate or care for the patient.

2.0. The CHP shall have a policy in place that addresses the following topics in the management of COVID-19:

2.1. Maintaining a healthy workforce, including policies regarding employees who are sick or have been exposed to possible cases of COVID-19

2.2. Sanitation and environmental cleaning, including hand washing and cleaning of high-touch surfaces

2.3. Intake and transfer screening of inmates, including identification of individuals who have had close contact to COVID-19 cases, as well as patients with symptoms of possible COVID-19

2.4. Isolation of confirmed cases or persons under investigation for COVID-19, including discontinuation protocols

2.5. Quarantine or cohorting of patients who have been exposed to COVID-19, including discontinuation protocols

2.6. Testing protocols, including quarantined individuals, patients who will be undergoing medical procedures, surveillance testing, and mass testing

2.6.1. Options for polymerase chain reaction (PCR), as well as point of care antigen testing (e.g. BinaxNOW) may be available.

2.7. Modifications of service delivery, like routine visits and offsite referrals

2.7.1. Modifications of some routine and non-essential in healthcare services must be outlined.

2.7.2. Priority is to be given to evaluation and management of patients with respiratory symptoms or other urgent health issues. Essential and emergency services continue at all times.

2.8. Treatment of COVID-19 infected patients and determination of transfer to a higher level of care

2.8.1. Monitoring frequency and protocols

2.8.2. Staff adherence to infection control procedures

2.8.3. Thresholds for transfer to a higher level of care based on symptom presentation, objective findings (i.e. oxygen saturations), and a patient's risk factors

2.9. Hospital discharge planning, including continuation of isolation based on Centers for Disease Control and Prevention (CDC) guidelines, continuation of recommended treatment, and follow up with prison healthcare providers and offsite specialists.

2.10. Education of staff and inmates about infection prevention protocols and when to seek care for symptoms, including facial coverings, soap and water, and social distancing when possible

2.11. Facility considerations, including coordination with custody leadership regarding inmate movement, consistent use of face coverings by staff and inmates, and staffing limitations due to absences

2.12. Discharge planning to the community, including notification of community resources regarding patients who are infected, in isolation, or under quarantine

2.12.1. Coordination of transportation and housing

2.13. Reporting to local health authorities, including:

2.13.1. Arizona Department of Health Services (ADHS), County Health Department, the CDC, Health and Human Services or other health authority, as well as specific forms required by ADCRR related to a pandemic

2.13.2. Reporting may include:

2.13.2.1. Provision of updates on the number of infected individuals

2.13.2.2. Any deaths believed to be related to COVID-19

2.13.2.3. Any other information requested by ADCRR related to the event

2.13.2.4. Required reporting to ADHS for tracking the number of staff who callout or identified COVID-19 exposure

2.13.2.5. Maintaining minimum necessary staff and resources to provide priority and urgent medical and mental health services, as well as pandemic related healthcare, in all areas of the facility including those designated as quarantined and non-quarantined.

3.0. Testing:

3.1. COVID-19 Strategic Surveillance Testing

3.1.1. Testing all or a designated portion of the inmate patient population shall be initiated or discontinued under the direction of the ADCRR Medical Director or designee and ADHS.

3.2. COVID-19 Testing After Vaccination

3.2.1. Inmates

3.2.1.1. Testing of fully vaccinated inmates will take place under the guidance of the ADCRR Medical Director or designee and ADHS.

3.2.1.1.1. Any fully vaccinated inmate who becomes symptomatic or who is exposed to a known case of COVID-19 will be tested for COVID-19 and isolated if necessary.

3.2.1.2. Any inmate who has not been fully vaccinated shall continue to follow current protocols for COVID-19 screening testing.

4.0. Vaccinations:

4.1. Vaccination Protocols

4.1.1. The CHP shall provide COVID-19 vaccinations for inmates, under the guidance of ADCRR and ADHS.

4.1.1.1. ADCRR will follow recommendations from ADHS regarding inmate populations to vaccinate, the timing of vaccinations, and allocations of vaccine doses to each facility.

4.1.1.2. COVID-19 Vaccine Consent, Form 1101-110 (available in English and Spanish) shall be used.

4.1.1.3. The Medical Services Contractor shall ensure documentation of vaccine administration into the Arizona State Immunization Information System (ASIIS) takes place.

4.1.1.3.1. A process shall be in place to ensure that patients are provided with their vaccination cards, indicating the patient's name, date of birth, type of vaccine administered, lot number, and date of administration.

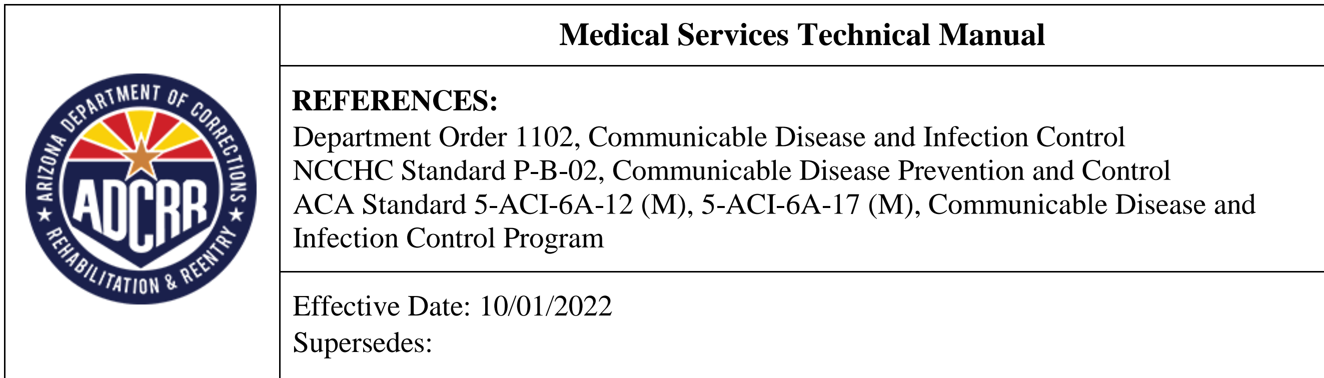
4.1.1.3.2. A copy of the vaccination card will be scanned into the electronic health record.

4.1.1.3.3. The vaccination card will be provided to patients who are leaving custody, regardless of the stage of their vaccination process (i.e. after the first dose or after the second dose).

4.1.2. Adverse Events

4.1.2.1. Healthcare staff should follow existing emergency protocols to assess and treat individuals with an adverse reaction following a vaccine.

4.1.2.2. Utilization of the Vaccine Adverse Event Reporting System (VAERS) shall be done to report adverse effects from a vaccine.



Medical Services Technical Manual

REFERENCES:
Department Order 1102, Communicable Disease and Infection Control
NCCHC Standard P-B-02, Communicable Disease Prevention and Control
ACA Standard 5-ACI-6A-12 (M), 5-ACI-6A-17 (M), Communicable Disease and Infection Control Program

Effective Date: 10/01/2022
Supersedes:

P-B-02.04 Communicable Disease Reporting

PURPOSE: Communicable disease notification and reporting shall occur to ensure that all inmates and staff are protected from communicable disease, in accordance with state and local requirements as part of the infectious disease program/protocols.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for ensuring that all CHP medical providers and CHP nursing staff respectively comply with proper communication and notifications are made regarding communicable diseases in accordance with these guidelines.

PROCEDURE:

1.0. In accordance with Department Order #1102, Communicable Disease and Infection Control, the CHP FHA or designee shall submit a communicable disease report to the County Health Department (or Indian Health Service Unit) within the required time frame of a case or a suspect case of the diseases and conditions as listed on the link provided in section 1.1.

1.1. LIST OF REPORTABLE DISEASES: Arizona Administrative Code Requires Providers to report the following Reportable Diseases as listed on https://azdhs.gov/documents/preparedness/epidemiology-disease-control/communicable-disease-reporting/reportable-diseases-list.pdf

1.1.1. Report within 24 hours of diagnosis if inmate is a food handler.

1.1.2. Report outbreaks only.

1.1.3. Report directly to State Health Department at (602) 230-5830

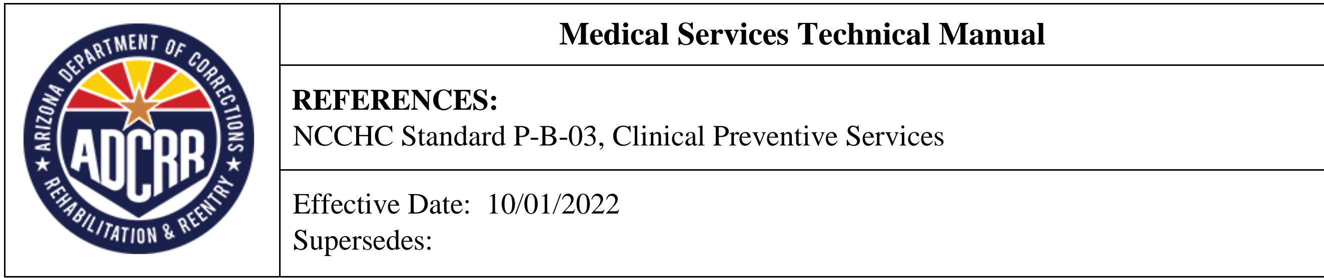
1.2. When reporting the communicable diseases the CHP staff will use the ADHS form available on the following link: https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-investigation-resources/communicable-disease-report-form.pdf

2.0. The CHP FHA or designee shall submit a written report of positive laboratory findings, based on timelines outlined by ADHS, for the communicable disease pathogens listed on the ADHS Arizona Laboratory Reporting Requirements on the following link: https://azdhs.gov/documents/preparedness/epidemiology-disease-control/communicable-disease-reporting/lab-reporting-requirements.pdf

3.0. All suspected or confirmed communicable diseases are reported to the site CHP Medical Director or designee for guidance on management in accordance with timelines outlined by ADHS.

3.1. The CHP Regional Medical Director, ADCRR Medical Director, and Assistant Director shall be notified.

3.2. No area, unit, or complex shall be placed in isolation status without the CHP Regional Medical Director or designee and ADCRR Medical Director's guidance.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-B-03, Clinical Preventive Services

Effective Date: 10/01/2022
Supersedes:

P-B-03.01 Clinical Preventive Services

PURPOSE: To provide guidance in the provision of clinical preventive services to patients as medically indicated.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for providing clinical preventive services as clinically indicated to the inmate population.

PROCEDURE:

1.0. Periodic health assessments shall be completed annually for every patient age 45 and older.
- 1.1. A chronic care visit alone does not qualify as a periodic health assessment.
- 1.2. Patients under 45 years of age with or without a chronic condition shall be scheduled for a physical examination following submission of a health needs request (HNR).

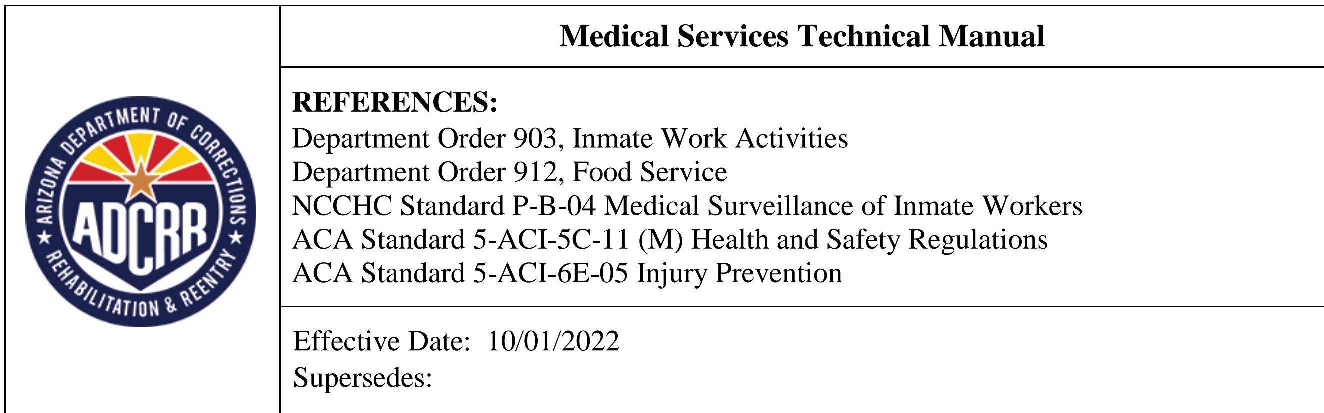
2.0. The responsible physician determines the medical necessity and/or timing of screenings and other preventive services (e.g., mammograms, colorectal screening, prostate screening, cervical cancer screening).
- 2.1. All patients ages 45 to 75 shall be offered colorectal cancer screening based on a frequency set forth by national guidelines.
- 2.2. The CHP shall provide women's health education programs and preventive healthcare services such as mammography, cervical cancer screening, and health education.
  - 2.2.1. Cervical cancer screening testing will be performed during the intake physical exam, when applicable.
  - 2.2.2. All females ages 21 to 65 shall be offered a cervical cancer screening (when indicated) in accordance with current screening guidelines.
  - 2.2.3. All females age 50 and older shall receive a baseline mammogram screening at age 50 and every 24-month thereafter unless more frequent screening is medically indicated.
- 2.3. Prostate cancer screening is a shared decision making process between the provider and patient, which should occur as part of age-based health education. Documentation of this conversation shall be entered in the patient's health record.

3.0. Vision Services:
- 3.1. Patients under 50 years of age may request vision services every two years.
- 3.2. Patients 50 years of age or older may request vision services every year.
- 3.3. Eyeglasses shall be provided as prescribed.
  - 3.3.1. In the event a patient's lens prescription changes or another medical necessity arises in less than 24-months, a new prescription lenses and frames shall be provided.
- 3.4. Patients with a confirmed medical indication shall be offered an exam by an Optometrist or Ophthalmologist on an annual basis.

4.0. The dentist determines the frequency and content of periodic dental evaluations in accordance with the Dental Technical Manual, Periodic Oral Examinations (Procedure 440.2).

5.0. The responsible physician determines the medical necessity and/or timing of screening for communicable diseases (e.g., HIV, syphilis, gonorrhea, chlamydia), to include laboratory confirmation, treatment, and follow-up if indicated beyond tests already conducted during intake process.

6.0. Immunizations that are part of healthcare maintenance are offered to patients as clinically indicated.



	Medical Services Technical Manual
	REFERENCES: Department Order 903, Inmate Work Activities Department Order 912, Food Service NCCHC Standard P-B-04 Medical Surveillance of Inmate Workers ACA Standard 5-ACI-5C-11 (M) Health and Safety Regulations ACA Standard 5-ACI-6E-05 Injury Prevention
	Effective Date: 10/01/2022 Supersedes:

P-B-04.01 Medical Surveillance of Inmate Workers

PURPOSE: To provide guidance and ensure the health and safety of the inmate worker population is protected.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to develop a program including medical screening and surveillance to prevent illness and injuries among the inmate worker population and to identify and reduce work related health risks.

PROCEDURE:

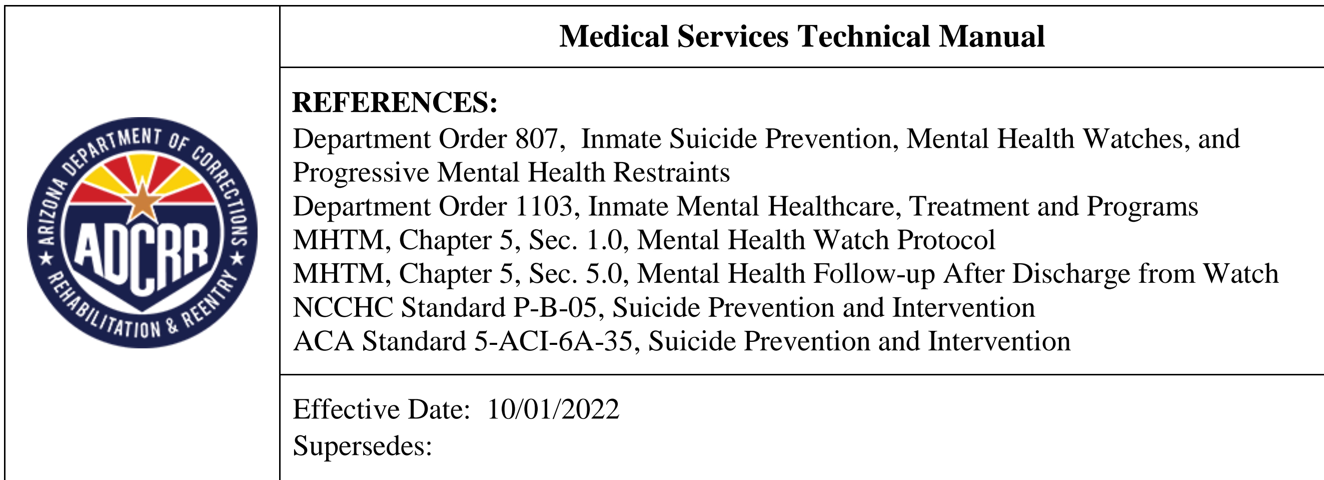
1.0. There is an institutional committee or equivalent body that identifies and oversees inmate occupational-associated risks through a medical surveillance program as referenced in Department Order #903, Inmate Work Activities.

2.0. An initial medical screening of an inmate for contraindications to a work program, based on job risk factors and patient condition, is conducted prior to enrollment in the program.
   - 2.1. Inmates who have been identified to be assigned as Food Service/Kitchen Workers must be medically cleared prior to assignment to the position in accordance with specifications of the Food Service Technical Manual and Department Order #912, Food Service.
   - 2.2. All questions regarding eligibility of Inmate workers shall be referred to the CHP who shall make the final clearance determination.

3.0. Ongoing medical screening of inmates in work programs is conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs.
   - 3.1. When there is a change in the patient's condition (e.g., a change in medication or functional status) the medical provider will reassess the patient for appropriateness of their work assignment.

4.0. The responsible physician reviews and approves the health aspects of the medical surveillance program.

5.0. Inmate illnesses or injuries potentially related to occupational exposure or with occupational implications are identified and the information provided to the quality improvement committee for review.



	Medical Services Technical Manual
	REFERENCES: Department Order 807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints Department Order 1103, Inmate Mental Healthcare, Treatment and Programs MHTM, Chapter 5, Sec. 1.0, Mental Health Watch Protocol MHTM, Chapter 5, Sec. 5.0, Mental Health Follow-up After Discharge from Watch NCCHC Standard P-B-05, Suicide Prevention and Intervention ACA Standard 5-ACI-6A-35, Suicide Prevention and Intervention
	Effective Date: 10/01/2022 Supersedes:

P-B-05.01 Suicide Prevention and Intervention

PURPOSE: Suicides are prevented when possible by implementing prevention efforts and interventions.

RESPONSIBILITY: It is the responsibility of any staff member who becomes aware of an inmate who is at risk of a suicidal gesture/acute mental health issue to notify the shift commander or the Contract Healthcare Provider (CHP) medical/mental health staff so appropriate measures to protect the inmate can be initiated.

PROCEDURES:

1.0. Inmates are placed on mental health watch in accordance with the Mental Health Technical Manual (MHTM) Chapter 5, Sec. 1.0, Mental Health Watch Protocol and Department Order #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints.

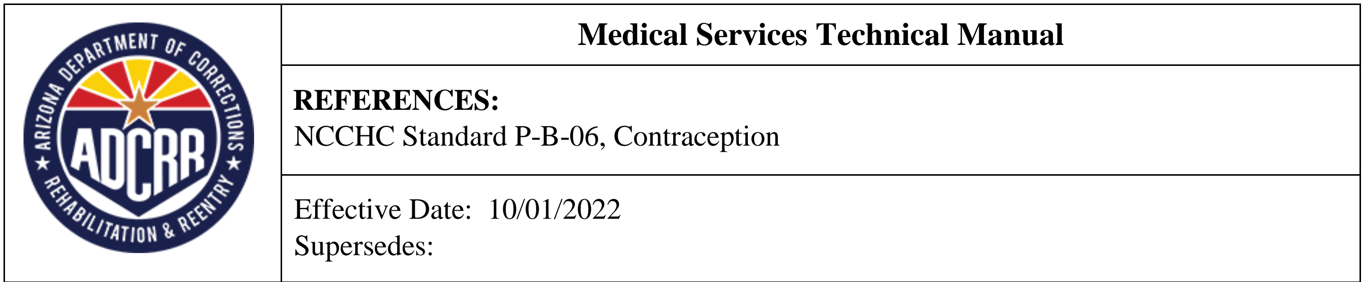
2.0. The responsible health authority and facility health administrator approve the facilities suicide prevention program.

3.0. A suicide prevention program includes the following:
- 3.1. Facility staff identify suicidal inmate and immediately initiate precautions.
- 3.2. Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow up as needed.
- 3.3. Acutely suicidal inmates are monitored by facility staff via constant observation.
- 3.4. Non-acutely suicidal inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.

4.0. The use of other inmates in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.

5.0. Treatment plans addressing suicidal ideation and its reoccurrence are developed.

6.0. Patient follow-up occurs in accordance with MHTM Chapter 5, Section 5, Mental Health Follow-up After Discharged from Watch.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-B-06, Contraception
	Effective Date: 10/01/2022 Supersedes:

P-B-06.01 Contraception

PURPOSE: Contraception is made available as clinically indicated.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide access to contraception to women who want to initiate a method for medical or contraceptive reasons.

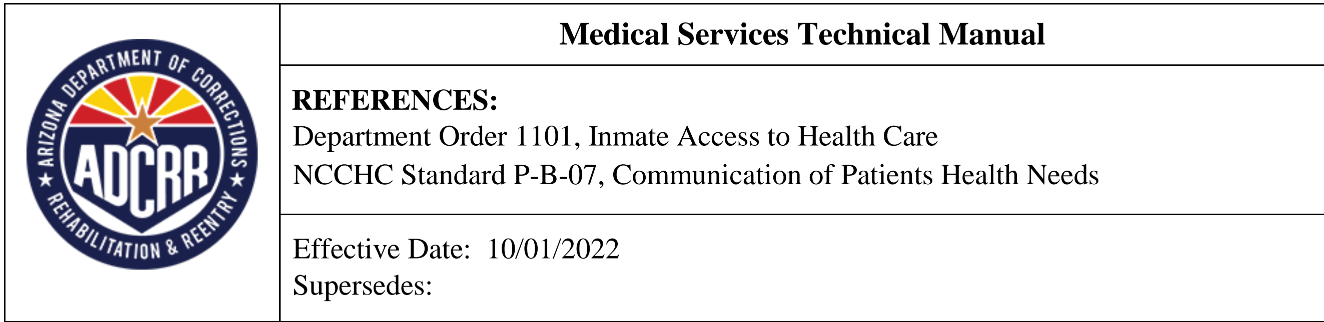
PROCEDURES:

1.0. Emergency contraception is available to women at intake.

2.0. Women using hormonal contraception for medical reasons other than, or in addition to, contraception must also be allowed to continue these or equivalent methods while in custody.

3.0. Upon request contraception may be prescribed and dispensed to females one month prior to release with an additional month's supply given at time of release.

3.1. Information about contraceptive methods and community resources is available.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-B-07, Communication of Patients Health Needs
	Effective Date: 10/01/2022 Supersedes:

P-B-07.01 Facility Capabilities Supporting Special Needs and Services

PURPOSE: To share information between the facilities security, administration, and treating clinicians regarding the patients significant health needs that must be considered to preserve the health and safety of the inmates or staff.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) to work with the Warden to jointly ensure that a cooperative relationship exists between correctional staff and CHP staff in the dissemination of vital information relative to the special needs of the inmate population.

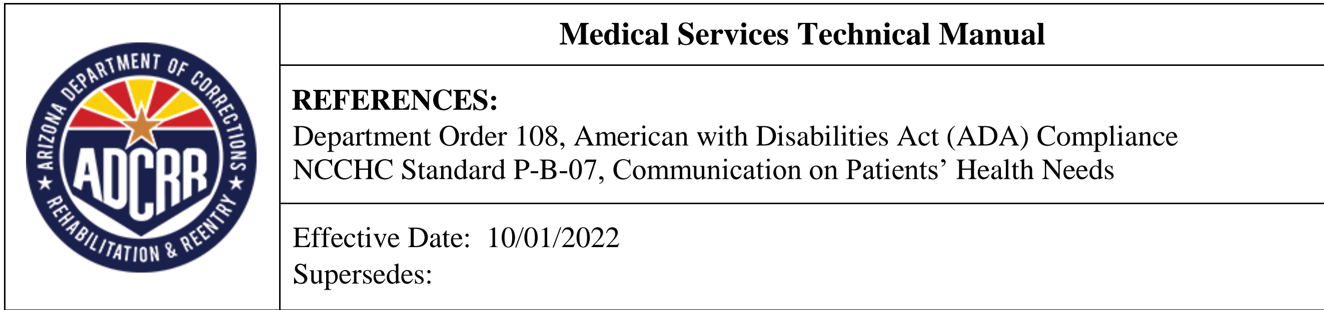
PROCEDURES:

1.0. Healthcare needs are to be considered in decisions regarding the patient's housing assignment, work assignment, and programming. All patients shall be housed in a facility that can accommodate their healthcare needs. Any patient who has restrictions shall not be assigned work or programming that presents a risk of further injury or physical/mental debilitation.

   1.1. Correctional and Classification staff must be advised of patient's special needs (e.g., clinical, mobility, functional) that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication must be documented and performed in such a manner that does not compromise confidentiality of health information.

2.0. Information regarding a patient's health status is found in the Arizona Correctional Information System (ACIS) comments. A health status determination is to be completed during the initial Health Assessment and/or when a new health condition is identified.

   2.1. Food allergies shall be entered into the ACIS to allow other Corrections Divisions (i.e., food service) to access this information. All other allergies (drug/substance) shall be entered into the patient's health record on the Health Problem Summary Listing.



	Medical Services Technical Manual
	REFERENCES: Department Order 108, American with Disabilities Act (ADA) Compliance NCCHC Standard P-B-07, Communication on Patients' Health Needs
	Effective Date: 10/01/2022 Supersedes:

P-B-07.02 Americans with Disability Act (ADA) Eligible Inmate Management

PURPOSE: To ensure removal of barriers to programs, services and processes for inmates with qualifying disabilities pursuant to Title II of the ADA and consistent with reasonable accommodation and security requirements. This policy is focused only on the ADA as it relates to inmate services.

RESPONSIBILITY: Each complex/institution Warden has designated a Deputy Warden or Associate Deputy Warden to serve as the ADA Institutional Liaison. That individual is responsible for coordinating the implementation of all ADA-related issues at the complex/institution.

PROCEDURES:

1.0. An Assistant Deputy Warden designated at each complex/institution to be the ADA Institutional Liaison is responsible for coordinating the implementation of all ADA-related issues at the complex/institution.

- 1.1. The Contract Healthcare Provider (CHP) Regional Medical Director or designee is authorized to override an inmate's request to waive transfer to an ADA-accessible facility, and to revoke a previously approved waiver.

2.0. Procedures at the Reception Center and during any future assessments resulting in the subsequent transfer of a patient with disabilities to an ADA-accessible facility are provided in Department Order #108, Americans with Disability Act (ADA) Compliance.

- 2.1. During an assessment if a CHP medical Provider identifies a patient who meets the designated criteria for transfer/placement of a disabled patient, they shall perform an examination on the Functional Assessment, Form 108-1, and offer the patient an opportunity to sign a Waiver of Liability by an Inmate with a Disability, Form 108-2.
- 2.2. If a patient is identified outside of a regularly scheduled assessment the complex CHP Director of Nursing (DON) or designee shall ensure a functional assessment examination (and form/documentation) is completed within seven work days after the patient is identified or a request received for evaluation.
- 2.3. The CHP Medical Practitioner/Provider shall assign a medical and healthcare needs (M) score and ensure the score and related disability needs information is relayed to the Offender Services Division and entered into the patient's health record on the problem list. The M score and related disability needs information shall also be entered into the ACIS system to communicate the special needs of the patient.
- 2.4. The CHP Facility Health Administrator or designee will immediately forward all related documentation to the CHP Regional Director of Nursing (RDON), for review by the CHP Regional Medical Director to verify that the criteria is met.
  - 2.4.1. If criteria are met, the CHP RDON or designee will complete a request for Inmate Transfer for Medical Reasons. Upon approval, the CHP RDON will forward the request to Central Classification for transfer orders.

3.0. The CHP DON or designee will complete a periodic reassessment and reevaluation of patients with temporary disabilities who are assigned to an ADA-accessible facility.

3.1. On a case-by-case basis and in order to follow-up on a chronic condition, perform at least a quarterly re-assessment of the medical and disability needs of each patient with disabilities.

3.2. Ensure the revised disability needs information is entered on the patient's problem list in the health record.

3.3. Immediately after receiving a revised M score and related [changed] disability needs information from the CHP Medical Provider, notify the CHP RDON

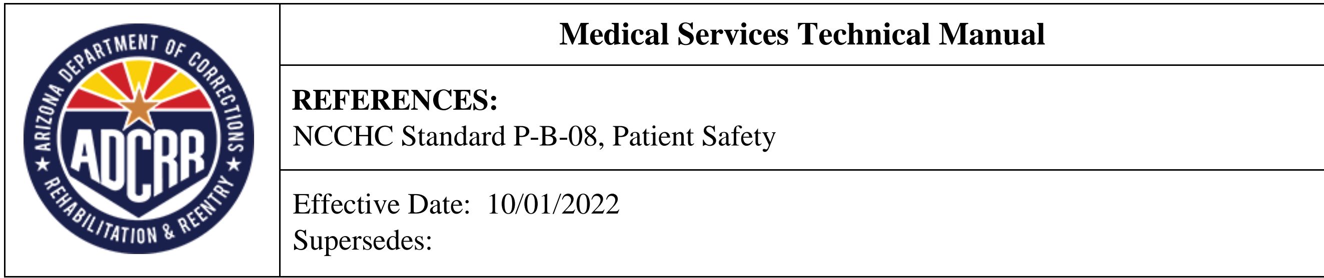
3.4. If needs change based on reassessment, the CHP RDON or designee shall complete the Transfer for Medical Reasons, and forward the form to Central Classification.

4.0. Auxiliary Aids and Services

4.1. As described in Department Order #108, American with Disability Act (ADA) Compliance, as consistent with security requirements, ADCRR CHP shall provide or allow auxiliary aids and services to individuals with disabilities to enable them to communicate effectively and to participate in or to receive services, programs, and activities, provided that doing so will not result in undue hardship or cause a fundamental alteration to a service, program or activity.

4.2. If a request cannot be accommodated, the Complex ADA Coordinator shall be contacted for advice and technical assistance in making appropriate auxiliary aids available for patients at designated ADA facilities, special services beds and complexes.

4.3. CHP Practitioner/Providers, in considering work restrictions are informed that ADA-qualified patients shall be eligible to apply for work, provided that their participation does not pose a direct threat to the health or safety of themselves or others.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-B-08, Patient Safety
	Effective Date: 10/01/2022 Supersedes:

P-B-08.01 Patient Safety

PURPOSE: Design patient safety systems to prevent adverse or near-miss clinical events.

RESPONSIBILITY: The Contracted Healthcare Provider (CHP) is responsible for implementing systems to reduce risk and prevent harm to patients.

PROCEDURES:

1.0. Facility staff implement patient safety systems to prevent adverse and near-miss clinical events.

2.0. The Facility Health Administrator (FHA) implements a reporting system for health staff to voluntarily report adverse and near-miss events affect patient safety.

3.0. Adverse Drug Reaction

3.1. Adverse drugs reactions, as noted by any serious, rare, and/or unusual reaction to a drug, will be noted in the patient's health record.

3.1.1. When an adverse drug reaction is suspected, the CHP Nurse, or CHP Pharmacist will notify the attending CHP Practitioner/Provider for their review.

3.1.2. The reaction will be recorded by the CHP staff on Form-FDA 1639a or FDA Form 3500 (6/93) and a sent to the ADCRR Pharmacy Director and or designee. The CHP Pharmacist will evaluate and forward appropriate reports to the FDA at:

3.1.2.1. Division of Epidemiology and Drug Experience (HFD-210) Food and Drug Administration
5600 Fishers Lane
Rockville, Maryland 20852-9787
or FAX to 1-800-FDA-0178

3.1.2.2. The CHP Pharmacist will report to the FDA by calling 1-800-FDA-1088.

4.0. Medication Error Reporting

4.1. A Medication Incident Report will be completed and submitted whenever there is a nursing delivery/administration error or a pharmacy error discovered after the prescription has been dispensed.

4.1.1. The Medication Incident Report shall be submitted to the CHP Facility Health Administrator (FHA) who will provide a copy to the CHP Pharmacy Director, CHP complex Director of Nursing (DON), CHP Regional Medical Director, and ADCRR Complex Compliance Monitor.

4.1.1.1. If the medication error is the result of a filling error from the CHP pharmacy or related to a controlled substance concern the medication error report must also be sent to the ADCRR Pharmacy Director.

4.1.2. The Medication Incident report will include:

4.1.2.1. Patient's name

4.1.2.2. Patient’s ADCRR inmate number

4.1.2.3. Date

4.1.2.4. Prescriber's name

4.1.2.5. Name or person that made the error

4.1.2.6. Name of person discovering the error

4.1.2.7. Description of error

4.1.2.8. Action taken after discovery of error, (patient and prescriber notification etc.)

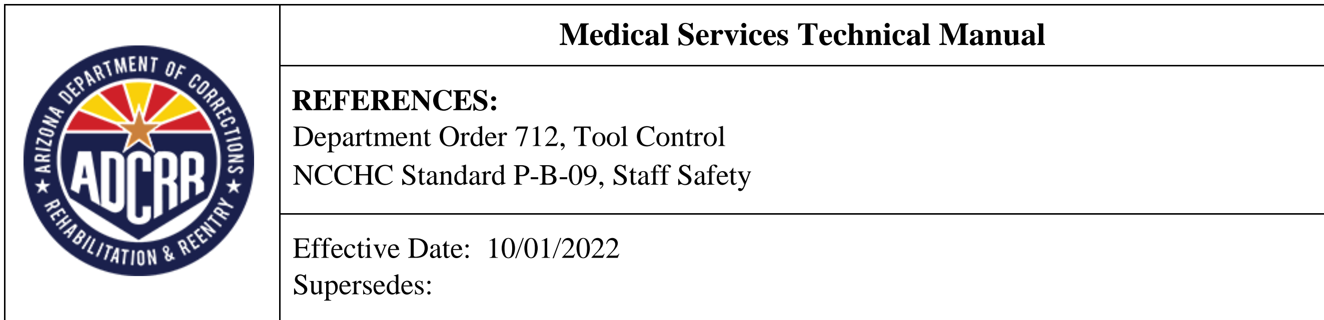
4.1.2.9. Other relevant information to the incident

4.2. When a patient has taken a medication that is in error, CHP staff finding the error must ensure that the CHP Pharmacy, ADCRR Pharmacy Director or designee are immediately informed. The CHP Pharmacist will notify the prescriber of the error and assist the CHP Practitioner to perform any corrective action. The individual identifying and/or reporting the error must document the incident in the patient’s health record.

4.3. The CHP FHA is responsible to direct CHP staff to complete an Information Report, Form 105-2 for all medication errors.

4.3.1. The individual identifying the error shall forward the Information Report and the Medication Incident Report to the CHP Pharmacy Director, ADCRR Pharmacy Director or designee, and FHA for review and inclusion of CQI.

4.4. The CHP Pharmacy shall review and act on the Medication Incident Reports. A copy of the Information Report will be kept on file indefinitely in the Pharmacy that fills prescriptions for the facility.



	Medical Services Technical Manual
	REFERENCES: Department Order 712, Tool Control NCCHC Standard P-B-09, Staff Safety
	Effective Date: 10/01/2022 Supersedes:

P-B-09.01 Staff Safety

PURPOSE: ADCRR implements measures to ensure a safe environment.

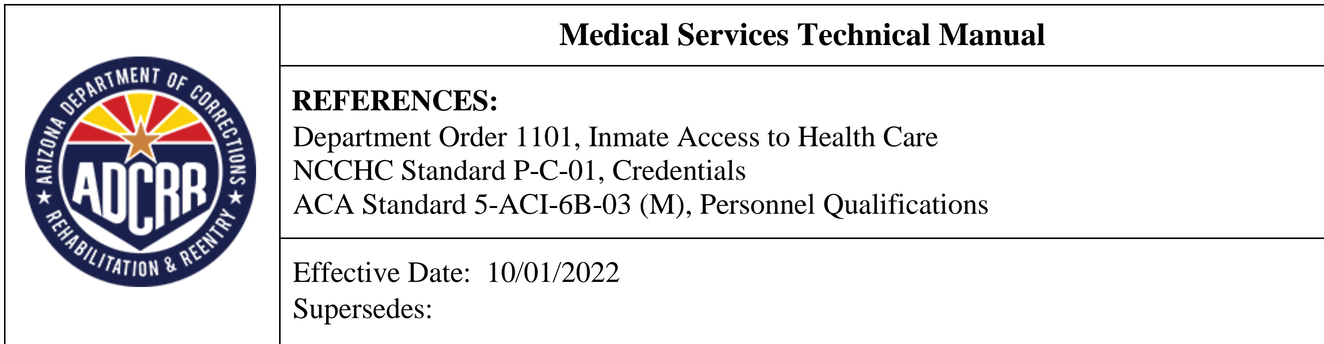
RESPONSIBILITY: It is the responsibility of the Warden and the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) to ensure health staff remains vigilant for personal safety and security issues and is aware of any actions that may compromise the safety of themselves, other staff, and the facility.

PROCEDURES:

1.0. Methods of communication (e.g., radio, panic button, voice proximity) between health staff and custody staff are available.

2.0. When a safety concern arises, custody staff are requested and readily available to health staff.
  - 2.1. Security personnel are present if the patient poses a probable risk to the safety of the healthcare Practitioner Provider or others.
  - 2.2. Security personnel are present to accompany contracted healthcare staff when entering housing locations.

3.0. On each shift where health staff are present, inventories are maintained on items subject to abuse (e.g., needles, scissors, and other sharp instruments) and discrepancies are immediately reported to the custody staff in accordance with Department Order #712, Tool Control.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-C-01, Credentials ACA Standard 5-ACI-6B-03 (M), Personnel Qualifications
	Effective Date: 10/01/2022 Supersedes:

P-C-01.01 Credentialing Responsibilities

PURPOSE: To validate the legal and performance qualifications of the Practitioners/Providers employed by the Contract Healthcare Provider (CHP). To ensure that all professional Contract Vendor staff providing care within the Arizona Department of Corrections Rehabilitation and Reentry are in good standing with their respective licensure/certification board to practice their profession.

RESPONSIBILITY: The CHP is responsible to ensure that professional staff continues to work within their expertise/training and that the work remains at a high level of quality. It is responsibility of the CHP Facility Health Administrator (FHA) or designee to ensure that all appropriate professional health staff have copies of current licensure/certification kept locally.

PROCEDURE:

1.0. The CHP shall ensure that professional health staff requiring licensure/certification to practice their profession obtain and maintain current licensure and certification within the State of Arizona are in compliance with standards of conduct for their profession.

   1.1. The CHP shall ensure that appropriate health staff submits copies of documentation that verifies licensure/certification. The CHP shall verify that the individual remains in good standing with their licensing board upon hiring and on an annual basis as required by State/Board regulation. The documentation will be maintained by the CHP FHA or designee.

2.0. Prior to expiration date of the licensure, the CHP shall receive a copy of renewal license/certificate from the individual. If initial request is ignored, a warning memo prior to expiration shall be directed to the employee.

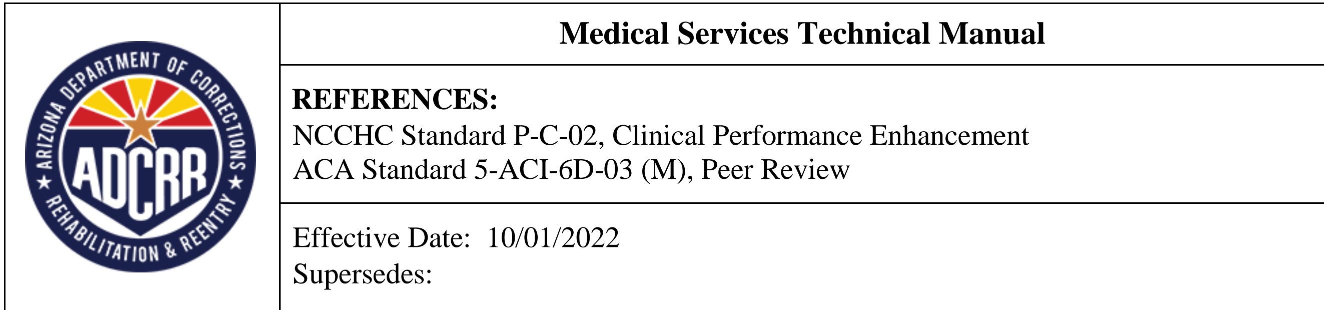
   2.1. The CHP shall immediately notify the ADCRR Complex Compliance Monitor and Program Evaluation Administrator or designee of employee who has not renewed their license/certification.

3.0. The CHP shall notify the ADCRR Complex Compliance Monitor and Program Evaluation Administrator or designee of any information received regarding revoked/suspended and/or restricted license/certification, license under investigation or an expired license.

4.0. If for any reason, a CHP professional comes under investigation, or has their license/certification revoked/suspended by their respective Board, the healthcare professional shall notify the CHP immediately and the CHP shall immediately notify the ADCRR Complex Compliance Monitor and Program Evaluation Administrator or designee and take the necessary appropriate actions.

5.0. The CHP shall ensure any CHP professional whose licensure expires is taken off the schedule and addressed appropriately.

6.0. Privileges for existing clinical staff many be denied, modified, or removed based on assessments of clinical competence or fitness for duty.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-C-02, Clinical Performance Enhancement
ACA Standard 5-ACI-6D-03 (M), Peer Review

Effective Date: 10/01/2022
Supersedes:

P-C-02.01 Peer Reviews of Professional Activities

PURPOSE: Individuals delivering patient care are reviewed through the clinical performance enhancement process.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Medical and Dental Directors (Physician and Dentist) shall ensure that processes are in place to ensure that peer reviews occur in a timely manner in an effort to ensure that quality of care is maintained.

PROCEDURE:

1.0. The clinical performance of the facility's direct care clinicians, and RN's, and LPNs, are reviewed at least annually.

- 1.1. Clinical performance enhancement reviews are kept confidential and incorporate at least the following elements:
  - 1.1.1. Name of the individual being reviewed
  - 1.1.2. Date of the review
  - 1.1.3. Name and credentials of the reviewer
  - 1.1.4. Confirmation that the review was shared with the clinician
  - 1.1.5. Summary of the findings
  - 1.1.6. Corrective action, if any
- 1.2. A log or other written record providing the names of the individuals and dates of their most recent reviews is to be made available to the Medical Services Contract Monitoring Bureau (MSCMB). This documentation may be shared for verification.
- 1.3. The Facility Health Administrator (FHA) implements an independent review when there is serious concern about a healthcare clinician's competence.
  - 1.3.1. The FHA implements procedures to improve an individual's competence when such action is necessary.

2.0. Site Level Reviews shall be conducted according to the following peer review procedures:

- 2.1. The records of the site CHP Medical Director, Dental Director and Director of Nursing (DON) shall be reviewed by the CHP Regional Director or designee of that discipline.
- 2.2. The complex CHP Medical Director or designee shall review the health record activity entries of all medical care Providers at the complex.
- 2.3. The complex CHP Dental Director or designee shall review the dental activity records of all dental care Providers at the complex.
- 2.4. For CHP Mental Health staff process, see Mental Health Technical Manual.
- 2.5. The complex CHP Director of Nursing (DON) or designee shall review the health record activity entries of all nursing staff (RNs and LPNs) at the complex.
- 2.6. Copies of the health record sections do not need to be made for local review.

2.7. For each health record reviewed, information gathered shall be recorded on the appropriate "Peer Review Form”. A separate form shall be utilized for each health record reviewed. The site CHP Medical Director and site CHP Dental Director in conjunction with the CHP FHA shall retain all copies of review reports for one year following the review.

3.0. If a formal peer review is deemed necessary:

3.1. A formal peer review or case review may be requested relative to patient healthcare by the Department’s Medical Service Assistant Director, ADCRR Medical Director, ADCRR Program Evaluation Administrator, or CHP.

3.2. Within ten working days of the written request for a Formal Peer review, the CHP shall convene a committee to conduct the initial review of the complete health record(s) of the case prompting the peer review.

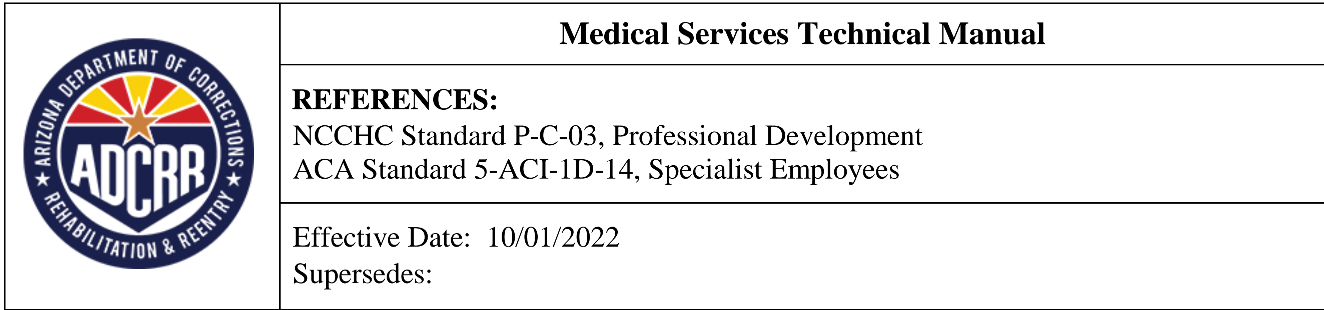
3.3. The committee shall include (as appropriate): CHP Facility Health Administrator; CHP Medical Provider(s); CHP Dental Provider, CHP Mental Health Provider; CHP Director of Nursing; and others as needed.

3.4. Upon completion of the peer review the committee findings and summary statement along with a cover letter must be forwarded through the appropriate ADCRR Complex Compliance Monitor or designee and to ADCRR Program Evaluation Administrator within ten working days following completion of the review.

3.5. Upon receipt of the items produced by the formal peer review, a “second level” peer review committee may be convened by the ADCRR Program Evaluation Administrator or designee within ten working days to review in a comprehensive manner all relevant materials, documents, and initial peer review findings.

3.6. The committee may include, as appropriate, the following: ADCRR Medical Director, ADCRR Program Evaluation Administrator and other members as required or directed by Department’s Assistant Director for Medical Services. The committee may seek input from other subject matter experts as appropriate and necessary to complete its function.

3.7. Upon completion of the second level peer review, a summary of findings shall be prepared by the ADCRR Medical Director or designee and submitted to the Department’s Assistant Director for Medical Services within ten working days.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-C-03, Professional Development
ACA Standard 5-ACI-1D-14, Specialist Employees

Effective Date: 10/01/2022
Supersedes:

P-C-03.01 Professional Development

PURPOSE: The facility's qualified healthcare professionals maintain current clinical knowledge and skills.

RESPONSIBILITY: It is the responsibility of each qualified healthcare professional to ensure they complete the continuing education necessary to maintain their license or certification, and/or to maintain facility accreditation by certifying organizations.

PROCEDURES:

1.0. Annual Continuing Professional Education

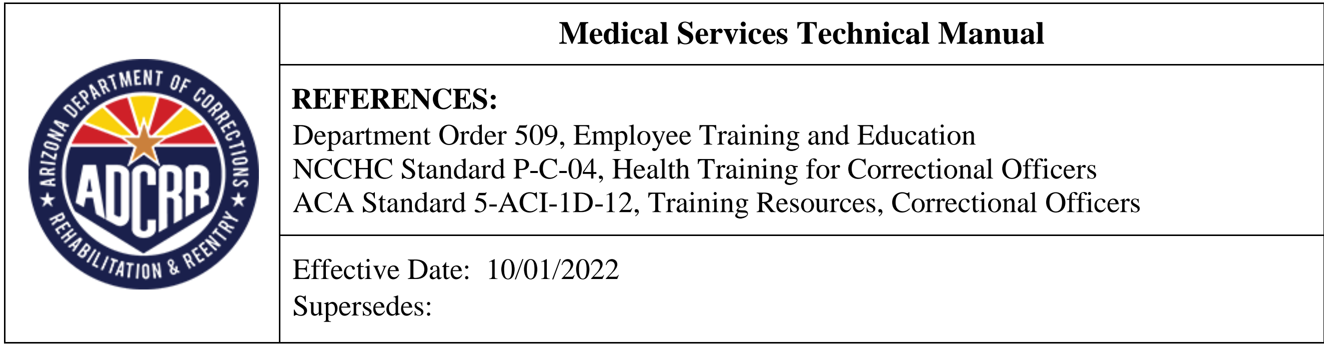
  1.1. Clinical Education is required for all staff in accordance with the ADCRR Annual Education Plan, NCCHC Accreditation standards, and American Correctional Association (ACA) standards.

2.0. All Contract Healthcare Provider (CHP) qualified healthcare professionals working for CHP in Arizona will show proof of at least 12 hours of continuing education averaged per year.

3.0. The Facility Health Administrator (FHA) documents compliance with continuing educating requirements.

4.0. The FHA maintains a list of Arizona's continuing education requirements for each category of licensure of all qualified healthcare professionals.

5.0. All CHP qualified healthcare professionals who have patient contact are current in cardiopulmonary resuscitation technique.



	Medical Services Technical Manual
	REFERENCES: Department Order 509, Employee Training and Education NCCHC Standard P-C-04, Health Training for Correctional Officers ACA Standard 5-ACI-1D-12, Training Resources, Correctional Officers
	Effective Date: 10/01/2022 Supersedes:

P-C-04.01 Training for Correctional Officers

PURPOSE: To provide guidance in the establishment of appropriate health related training for correctional officers so that they may recognize healthcare needs of inmates, provide care in life threatening situations, and refer an inmate to a healthcare professional when necessary.

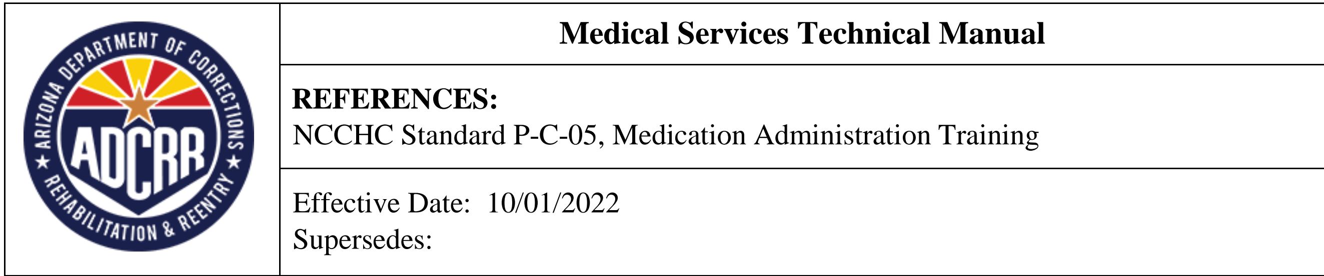
RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator or designee, in cooperation with the Warden, to see that an established and approved health-related training program is made available and completed by correctional officers who work with inmates.

PROCEDURES:

1.0. Correctional officers who work with inmates are to receive health-related training at least every two years.
   - 1.1. The training will include the following minimum information:
     - 1.1.1. Administration of first aid (BLS)
     - 1.1.2. Recognizing the need for emergency care and intervention in life threatening situations (i.e., heart attack)
     - 1.1.3. Recognizing acute manifestations of certain chronic illnesses (i.e., asthma, seizures)
     - 1.1.4. Intoxication and withdrawal
     - 1.1.5. Adverse reactions to medications
     - 1.1.6. Recognizing signs and symptoms of mental illness and procedures for suicide prevention
     - 1.1.7. Knowledge of procedures for appropriate referral on inmates with health complaints to health staff
     - 1.1.8. Knowledge of procedures and precautions with respect to infectious and communicable diseases
     - 1.1.9. Cardiopulmonary resuscitation (CPR)
     - 1.1.10. Dental emergencies
     - 1.1.11. Maintaining confidentiality

2.0. The appropriate nature of the health-related training is verified by an outline of the course length, course content and length of the course.
   - 2.1. Each Complex has a training officer who maintains original training records and associated rosters. A certificate of completion or other evidence of attendance is kept on site by the Complex or Unit Training Coordinator for each employee.

3.0. While it is expected that 100% of the correctional staff who work with inmates are trained in all these areas, compliance to the established ADCRR standards requires at least 75% of the staff present on each shift are current in their health-related training.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-C-05, Medication Administration Training
	Effective Date: 10/01/2022 Supersedes:

P-C-05.01 Medication Administration Training

PURPOSE: To establish a program to assure that staff that administer or deliver medications are appropriately trained.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) and Nursing Supervisors to ensure that CHP staff comply with this Procedure.

PROCEDURES:

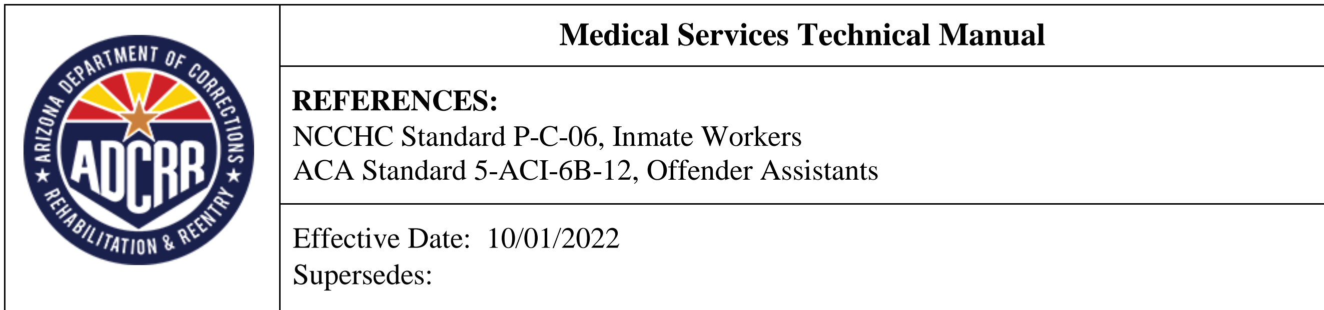
1.0. CHP must provide clinical staff for the medication administration that comply with the state of Arizona scope of practice and licensure requirements.

2.0. All new CHP staff that deliver and/or administer medication to patients must complete the Medication Administration Orientation Checklist within 30 days of hire.

- 2.1. The Nursing Supervisor, or preceptor, shall:
  - 2.1.1. Review medication procedures with each staff member.
  - 2.1.2. Evaluate the staff member's understanding of medication administration by documenting on the Medication Administration Orientation Checklist.
  - 2.1.3. Meet with the staff member upon completion of the Checklist, review findings, and counsel staff member as appropriate.
  - 2.1.4. Ensure the staff member receives instructions on security issues related to medication administration.
  - 2.1.5. Ensure that the staff member is oriented to the Medication Incident Reporting policy in accordance with Medical Services Technical Manual (MSTM) Chapter P-B-08.01, Patient Safety.

3.0. Training in the use of clinic stock medication shall be provided to any personnel permitted to access the clinic stock storage area.

4.0. The CHP Facility Health Administrator (FHA) or designee shall ensure that a completed copy of the Medication Administration Orientation and documented training and testing is maintained in each employee training file.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-C-06, Inmate Workers ACA Standard 5-ACI-6B-12, Offender Assistants
	Effective Date: 10/01/2022 Supersedes:

P-C-06.01 Inmate Workers

PURPOSE: Health services are provided by health staff and not inmate workers.

RESPONSIBILITY: It is the responsibility of the Warden and the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) or designee to ensure that inmates are not placed in a position of authority over their peers, including not delivering health services. Department Order #903, Inmate Work Activities provides guidance regarding authorized and prohibited duties of inmates.

PROCEDURE:

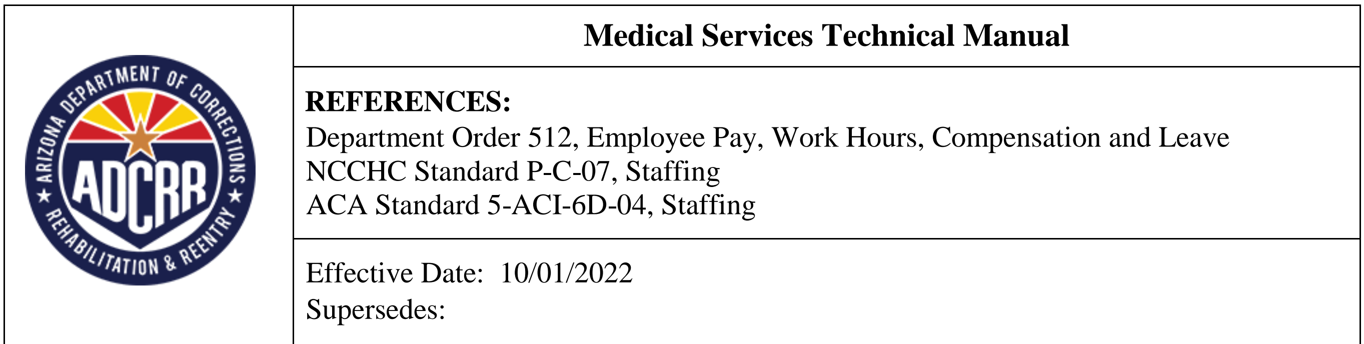
1.0. Inmates do not make treatment decisions or provide patient care.

2.0. Inmates are not substitutes for health staff, but may be involved in appropriate peer health-related programs or reentry healthcare training programs.

3.0. Other than those in a reentry healthcare training program, inmates are not permitted to:
- 3.1. Distribute or collect sick-call slips
- 3.2. Schedule appointments,
- 3.3. Transport or view health records
- 3.4. Handle or administer medications
- 3.5. Handle surgical instruments and sharps

4.0. Inmates in peer-health related programs are permitted to:
- 4.1. Assist patients in activities of daily living (except for infirmary-level care patients)
- 4.2. Participate in a buddy system for suicidal inmates without current suicidal ideation after documented training
- 4.3. Participate in hospice programs after documented training

5.0. Patients have the right to refuse care delivered by inmates who are in a reentry healthcare training program (e.g., dental assistant, nursing assistant)



	Medical Services Technical Manual
	REFERENCES: Department Order 512, Employee Pay, Work Hours, Compensation and Leave NCCHC Standard P-C-07, Staffing ACA Standard 5-ACI-6D-04, Staffing
	Effective Date: 10/01/2022 Supersedes:

P-C-07.01 Staffing Patterns

PURPOSE: To ensure that sufficient health staff of varying technical and professional specialties are available to provide adequate and timely evaluation and treatment to the inmate population.

RESPONSIBILITY: It is the Contract Healthcare Provider's (CHPs) responsibility to ensure sufficient numbers and types of health staff are available to care for the inmate population.

PROCEDURES:

1.0. Staffing Plans:

1.1. The CHP will develop and monitor a staffing plan that will ensure that a sufficient number of qualified health personnel assigned to disciplines, is available to provide timely evaluation and treatment consistent with the standard of care within the community.

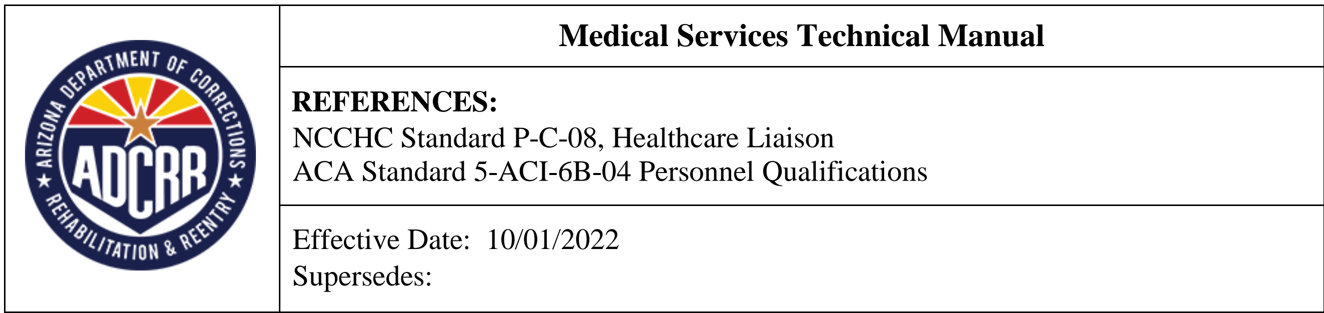
1.2. The staffing plan will be monitored in accordance with the ability to meet all patients' healthcare needs, and within a reasonable time frame, as determined by the Medical Services Contract Monitoring Bureau and the Contract.

1.3. Staffing will be determined by the size of the facility, types and scope of services delivered, and the needs of the inmate population. A staffing plan at each complex will be reviewed by the Medical Services Contract Monitoring Bureau (MSCMB) to address all disciplines and the services provided at each complex.

1.4. The CHP FHA shall ensure that there is a current urgent notification (after hours) schedule for all pertinent disciplines as set forth by this Manual and Department Order #512, Employee Pay, Work Hours, Compensation and Leave.

2.0. On Site Clinics:

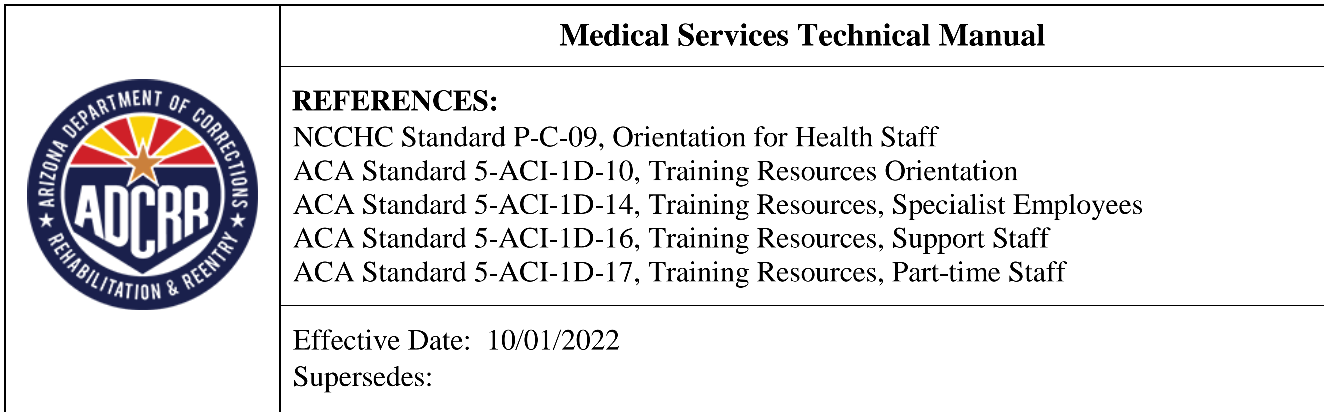
2.1. The CHP shall ensure that on-site clinics are scheduled in accordance with need and in compliance with the Contract.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-C-08, Healthcare Liaison ACA Standard 5-ACI-6B-04 Personnel Qualifications
	Effective Date: 10/01/2022 Supersedes:

P-C-08.01 Healthcare Liaison

PURPOSE: Healthcare Liaisons are not utilized by the Arizona Department of Corrections, Rehabilitation and Reentry, since qualified healthcare professionals are available 24 hours per day, seven days per week.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-C-09, Orientation for Health Staff ACA Standard 5-ACI-1D-10, Training Resources Orientation ACA Standard 5-ACI-1D-14, Training Resources, Specialist Employees ACA Standard 5-ACI-1D-16, Training Resources, Support Staff ACA Standard 5-ACI-1D-17, Training Resources, Part-time Staff
	Effective Date: 10/01/2022 Supersedes:

P-C-09.01 Orientation and Education for Health Staff

PURPOSE: Health staff is properly acclimated to work in the correctional environment and understand their roles and responsibilities.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure that all CHP staff completes an orientation to the correctional setting and to the health services delivery system.

PROCEDURES:

1.0. The orientation program is approved by the Medical Services Contract Monitoring Bureau and the Facility Health Administrator (FHA).

2.0. The orientation lesson plan is reviewed annually or more frequently, as needed.

3.0. All health staff receives a basic orientation on or before the first day of on-site service.

3.1. Initial Orientation for CHP staff is provided on the first day of employment. This orientation is required to provide information that will be necessary for the CHP staff member to function safely in the facility. The program should include a map of the facility and tour of the assigned unit as well as site specific New Employee Orientation.

3.1.1. At a minimum, orientation will include the review of the following directives, ADCRR Inmate Health Services Department Orders (DO):

3.1.1.1. DO #1101, Inmate Access to Healthcare
3.1.1.2. DO #1102, Communicable Disease and Infection Control
3.1.1.3. DO #1103, Inmate Mental Healthcare, Treatment and Programs
3.1.1.4. DO #1104, Inmate Medical Records
3.1.1.5. DO #1105, Inmate Mortality Review
3.1.1.6. DO #501, Employee Professionalism, Ethics and Conduct
3.1.1.7. DO #503, Employee Grooming and Dress
3.1.1.8. DO #509, Employee Training and Education
3.1.1.9. DO #916, Staff-Inmate Communications

3.1.2. The CHP employee shall sign acknowledging receipt of their orientation handbook. The CHP should provide a copy of Health Services Emergency Response Plan and the employee shall sign acknowledging receipt of their emergency response plan.

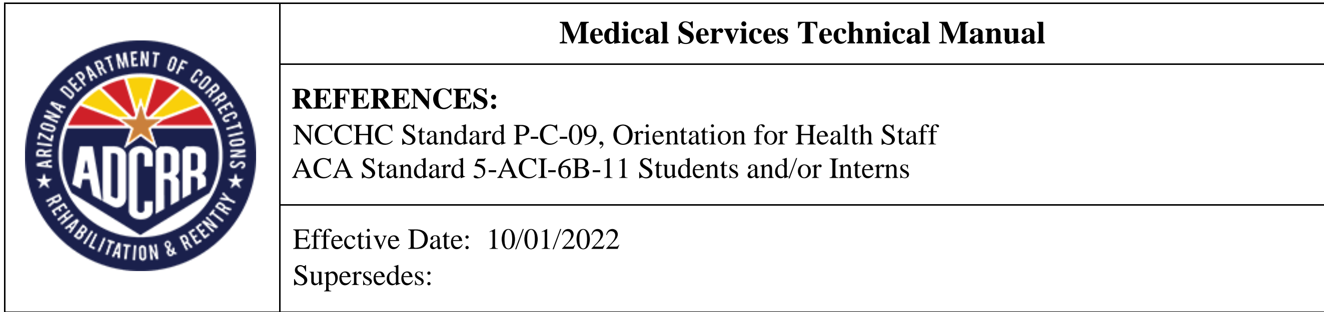
4.0. Within 90 days of employment, all health staff complete an in-depth orientation.

4.1. In-Depth Orientation will be conducted in a timely manner by the CHP's personnel to assure appropriate orientation to prison health delivery system.

4.1.1. CHP: Within 30 days of employment the new employee shall complete a discipline specific orientation which is documented and placed in their working personnel file upon completion.

4.1.2. Arizona Department of Corrections Rehabilitation & Reentry (ADCRR) Medical Services Contract Monitoring Bureau (MSCMB): Within 60 days of employment the new employee shall complete the Department's mandatory 40 hours New Employee Orientation. Provide new employees with department handouts on sexual harassment. Employee shall sign acknowledging receipt of sexual harassment handout. Health Service personnel comply with security regulations of the Department. Health Services personnel receive training and/or are notified of security regulations for which they are to comply.

5.0. It is the responsibility of the CHP to record and maintain records of completion of the orientation program and all educational activities for personnel within their human resource record.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-C-09, Orientation for Health Staff ACA Standard 5-ACI-6B-11 Students and/or Interns
	Effective Date: 10/01/2022 Supersedes:

P-C-09.02 Student and Extern Clinical Rotation Programs

PURPOSE: To establish a procedure for orientation and participation of students and externs serving a clinical rotation with the Arizona Department of Corrections Rehabilitation & Reentry (ADCRR). Specifics regarding the type of student/extern and the clinical rotation requirements are addressed in each of the agreements between the Universities and ADCRR.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure that all actions regarding students and externs are in accordance with ADCRR Department Orders, Technical Manuals, Personnel Rules and the Intergovernmental Education Agreement(s).

PROCEDURES:

1.0. At least 21 days prior to the starting date the university or college sponsoring the student/extern rotation will provide the information necessary to obtain a security clearance.

1.1. Upon completion of security clearance, the CHP or designee shall ensure a temporary contractor ID badge is issued.

2.0. The CHP Regional Leadership or designee, in conjunction with a representative from the university, will determine the rotation schedule for the students/externs.

2.1. At least one week prior to the beginning of the rotation, the clinical rotation list shall be provided to the appropriate site CHP Medical Director, the appropriate Complex CHP DON, and the appropriate CHP Facility Health Administrator(s).

3.0. The receiving CHP FHA shall designate an appropriate CHP Supervisor who shall ensure each student receive a proper orientation at the facility level to the correctional environment and role of healthcare provided to patients.

3.1. The orientation is to include, but is not limited to the following:

3.1.1. How health services meets the medical needs of the inmate population;

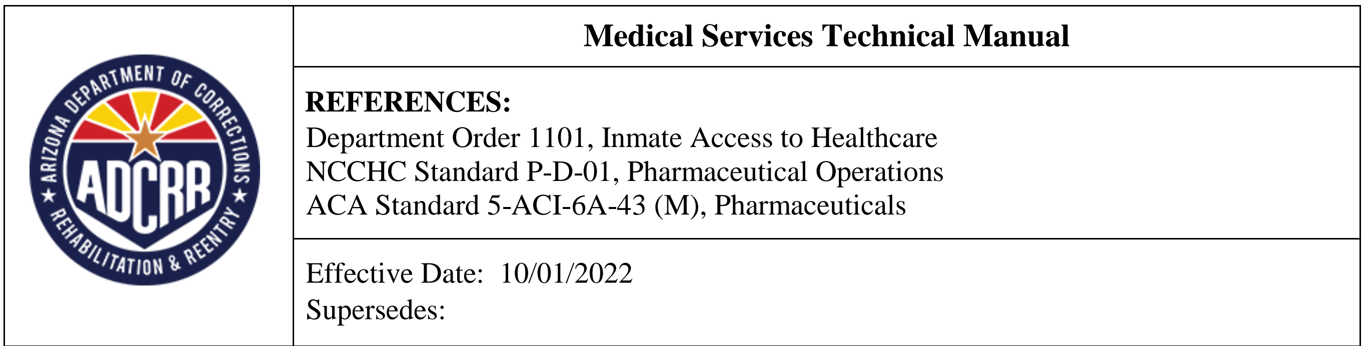
3.1.2. The philosophy of ADCRR with regard to the operations of the Health Unit;

3.1.3. The role of security in the delivery of healthcare;

3.1.4. Discussions of pertinent ADCRR Department Orders, Technical Manuals, and Post Orders.

3.2. ADCRR CHP Practitioners/Providers and professionals assigned as preceptors are to be familiar with the course objectives for the student/extern and are to be responsive to the student/extern to assist in achieving those objectives.

4.0. In the event of an injury or illness of a student they are to be referred to the sponsoring university for necessary care. Unless the condition is a threat to life or limb, they will not be referred to or treated by ADCRR Occupational Health.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Healthcare
NCCHC Standard P-D-01, Pharmaceutical Operations
ACA Standard 5-ACI-6A-43 (M), Pharmaceuticals

Effective Date: 10/01/2022
Supersedes:

P-D-01.01 Pharmacy Security and Inventory Control

PURPOSE: To ensure that all pharmaceuticals and medications in the facilities remain under the supervision and responsibilities of the Contract Healthcare Provider (CHP) pharmacy and CHP nursing and shall be handled in accordance with all applicable laws and the rules and regulations of the Arizona State Board of Pharmacy and the Arizona State Board of Nursing.

RESPONSIBILITY: It is the responsibility of the CHP Regional Pharmacist, and the CHP Director of Nursing (DON), to make sure that all procedures are followed to maintain the accountability of controlled substances, prescribed and over-the-counter (OTC) medications. The facility complies with all applicable state and federal regulations regarding prescribing, dispensing, administering, procuring, and disposing of pharmaceuticals and ensures reliable record keeping.

PROCEDURES:

1.0. Security
- 1.1. Only authorized persons shall have access to medication storage area, including clinic stock and all prescription medications.
- 1.2. A key control system shall be instituted by the Warden to control access and accountability each time a key is issued or returned which shall provide an exact accounting for all keys, in accordance with Department Order #702, Key Control.
  - 1.2.1. CHP employees shall be responsible for the safe-keeping and control of keys issued to them until the keys are formally relinquished and returned to the control area.
  - 1.2.2. CHP employees terminating employment or transferring to another work site shall return all keys on their last workday.
  - 1.2.3. Key control violations constitute a major breach of security. CHP employee negligence in key control may result in disciplinary action.
- 1.3. All missing keys shall be reported to security staff immediately.
- 1.4. Facility Security personnel may enter the medication area if a non-medical emergency situation threatens the pharmacy or adjacent buildings.
- 1.5. At the discretion of the Warden, emergency keys to areas where pharmaceuticals are stored may be authorized and held in a secure area. Emergency key rings shall:
  - 1.5.1. Enable staff to access every part of the complex/ facility rapidly to respond to a riot, fire, or any other crisis.
  - 1.5.2. Be clearly delineated from all other keys.
  - 1.5.3. Be stored separately from all other keys.
  - 1.5.4. Be designated as requiring that an Information Report (IR), Form 105-2 be written on every use.
- 1.6. No unauthorized keys shall be manufactured or duplicated to fit locks.

1.7. Agents of recognized law enforcement and regulatory agencies shall be allowed access to the medication areas, when an Arizona licensed pharmacist is in attendance, in order to carry out official business, during normal business hours (except as in emergency entrance as stated above).

1.8. At all times when authorized non licensed personnel are present in the medication rooms, all controlled substances shall remain under lock and key.

2.0. Storage

2.1. All medications must be stored in a climate controlled, properly ventilated medication room or storage area which shall be neat, organized, sanitary and double locked when not in use.

2.1.1. Room temperature between 65º to 85ºF or 18º to 29ºC.

2.1.2. Refrigerator temperature between 36º to 44ºF or 2º to 7ºC.

2.1.3. Documentation of a daily temperature log shall be done in the morning and evening for refrigerators and room temperatures.

2.1.3.1. If any temperature range exceeds the recommended range, appropriate action stated by the manufacturer shall be taken and documented.

2.1.3.2. Notification shall be made to the Facility Health Administrator (FHA), the ADCRR Pharmacy Director, the CHP Regional Pharmacist, and Warden or designee.

2.1.4. The poison control telephone number is posted in areas where overdoses or toxicological emergencies are likely.

2.2. Multi-Dose Vials: Multi-dose vials shall be dated on the label when opened and initialed by the user. All opened vials will be good for 30 days unless otherwise stated by manufacturer or the expiration date is less than 30 days. EXCEPTION: All insulin shall expire 28 days once opened and be destroyed unless stated otherwise by the manufacturer.

2.2.1. Noncompliance with this procedure shall be reported to the CHP Unit Assistant Director of Nursing (ADON), DON, FHA, and ADCRR Pharmacy Director.

2.3. Antiseptics, other medications for external use, and disinfectants are stored separately from internal and injectable medications.

2.4. An adequate and proper supply of antidotes and other emergency medications (e.g., naloxone, epinephrine) and related information are readily available to the staff.

2.5. Clinic stock storage areas shall be established in units deemed appropriate by CHP Pharmacist, approved by the Unit Deputy Warden or Warden, the facility's CHP supervising Physician/Dentist, the FHA, and ADCRR Pharmacy Director.

2.6. All narcotics including clinic stock and individually prescribed medication shall be segregated from all other medications.

2.6.1. All controlled substances shall be stored in a double locked wall mounted cabinet or location otherwise authorized by the department.

2.6.2. Only one designated licensed CHP Nurse shall be accountable for the narcotic cabinet keys and will be the contact person for accessing narcotics. The staff member with the narcotic keys shall be accountable for all narcotics removed from the narcotic storage area, however the CHP nurse administering the narcotic shall sign out the narcotic and document the administration on the patients medication administration record (MAR).

2.6.3. A back-up CHP staff member shall be designated in accordance with the complex security restricted key processes. EXCEPTION: If a facility has three or fewer licensed CHP Nurses on duty for the entire complex after hours and on weekends, then each CHP Nurse may be authorized by the CHP FHA or designee to carry a set of narcotic keys.

2.7. Needles and syringes will be signed for by receiving CHP nursing staff. CHP nursing staff shall be responsible for the distribution of needles and syringes and shall maintain all documentation.

2.7.1. Logs will be kept and available for review.

2.7.2. The CHP FHA, CHP DON, Warden and Department's Complex Monitor shall be notified of all discrepancies.

2.7.3. CHP Nursing Staff shall accurately maintain all documentation pertaining to receipt/distribution/return.

3.0. Inventory

3.1. Clinic stock medications shall be determined by the CHP Pharmacist with input from facility CHP Practitioner/Providers and limited to those authorized by the CHP Medical Director, CHP Regional Pharmacist, and approved by the P&T Committee. Stocked medications shall be governed by anticipated usage. Medications stocked shall include psychotropic bridge medications.

3.2. The clinic stock storage area shall be the only source of medication when the medication is not filled as a prescription by the CHP pharmacy, or obtained by an offsite pharmacy. All clinic stock and off site pharmacy fills will be considered direct observed therapy (DOT).

3.3. All clinic stock shall be provided for storage with accompanying perpetual inventories for accountability. The accurate maintenance of the perpetual inventory is the responsibility of CHP licensed nursing or the lead CHP Dentist.

3.3.1. The Perpetual Inventory Log shall be maintained with the following information: drug, strength, sub-unit of issue (i.e., tablet, capsule, vial etc.), date and time of transaction/administration, prescription number, quantity received/issued, balance, patient name, patient ADCRR inmate number, ordering CHP provider, name of healthcare professional accessing/issuing medication, and an accurate balance after each administration/receipt/return.

3.3.2. A perpetual inventory log shall be kept for/with each prescription and shall include a beginning total count and a record of each dose administered.

3.3.3. It is the responsibility of the CHP licensed nurse or CHP lead dentist to maintain accurate perpetual inventories. The CHP licensed nurse or CHP lead dentist shall sign the manifest that acknowledges clinical stock. Receipt of controlled clinic stock shall be documented on the control manifest and perpetual inventory and signed by two licensed nurses.

3.3.4. The addition of clinic stock shall be accurately noted on the perpetual inventory, as well as wasted or returned medications. Notation of clinic stock use shall be accurately noted in the patients' MAR or electronic health record (EHR) with each dose. The record shall include the administration source of medication (e.g., clinic stock), time administered, and accurate representation of the dose given, as compared to clinic stock removed and original prescription issued.

3.3.4.1. If the dose/quantity of the medication administered from clinic stock differs from the original prescription (dose/quantity), the prescription needs to be reordered until the patient specific medication arrives.

3.3.4.2. Perpetual inventories must maintain an accurate date sequence and all count-discrepancies (including corrected count, or otherwise) must be accompanied by an IR (Form 105-2) number located directly on the perpetual inventory where noted.

3.3.4.2.1. Following an IR a thorough investigation shall be conducted to correct any identified discrepancies. The CHP DON, CHP FHA, and site's Clinical Monitor shall be notified.

3.3.5. To dispense C-II through C-V from clinic stock a dispensing record shall be sent to the remote facility with accompanying Dispensing Records.

3.3.5.1. The dispensing record includes the following:

3.3.5.1.1. Date dispensed

3.3.5.1.2. The DEA number of the remote site receiving the controlled substance: the facility/yard; drug name; quantity/package size; pharmacy information; lot number information

3.3.5.1.3. The required patient and CHP staff information shall be filled in at the time of administration: date, patient name, patient ADCRR inmate number, ordered by, administered by, diagnosis, and allergies.

3.4. All clinic stock, perpetual inventory, 340B medication, controlled substances and stat medication are to be inventoried daily except when clinic stock storage area is sealed by safety seal.

3.4.1. Inventory shall be completed each time the seal is broken with any discrepancy reported to the CHP FHA for appropriate follow-up. A completion of incident report is expected.

3.5. Medications in the clinic stock storage area remain under the supervision and responsibility of the CHP Pharmacy and CHP nursing and shall be handled in accordance with all applicable laws and the Rules and Regulations of the Arizona State Board of Pharmacy.

3.6. Restock Levels: The CHP Pharmacy shall maintain adequate and appropriate stock to meet the need of the facility.

4.0. Controlled Substances/Narcotic Counts

4.1. The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency (DEA)-controlled substances.

4.2. A narcotic count book shall be kept on every unit that has narcotics, along with a narcotic log form for each individual narcotic. All narcotic clinic stock and patient specific medication administered will be recorded on the patient's medication record form, and on an internal narcotic perpetual inventory log.

4.2.1. As narcotics are removed from the narcotic stock, or a patient's narcotic prescription, the designated licensed personnel shall enter the patient's name and patient's ADCRR inmate number, the date, time, amount remaining via actual count, and the CHP Nurse's signature.

4.2.2. Narcotic inventory logs shall be legible, maintained in chronological order, and kept on file in the respective health units as per CHP guidelines and in compliance with all state and federal regulations (seven years).

4.3. Narcotics shall be counted according to the following criteria:

4.3.1. Narcotics shall be counted and documented in an onsite log at the beginning and the end of every shift by two licensed CHP Nurses upon arrival and departure from their assigned duty post.

4.3.2. Health units shall have a narcotic count prior to closing the unit for the evening. In health units that have an oncoming night shift, the day shift shall have a narcotic count prior to the end of shift.

4.3.2.1. The only exception to the rule of two licensed CHP Nurses counting narcotics is when only one licensed CHP Nurse is available on the unit. In this situation, security personnel may witness, verify, and sign the narcotic count with the licensed CHP Nurse.

4.3.3. If a closed health unit is opened for an emergency and narcotics are accessed, the licensed CHP Nurse shall count the narcotics with another CHP Nurse, or security personnel, prior to departure from the unit.

4.4. For discrepancies during count the CHP nursing staff shall notify the CHP DON and CHP FHA.

4.4.1. Any recording error in the records will be lined through (with one horizontal line), annotated with "error", and initialed by the person who made the error. The accurate entry will be recorded below the error entry. Errors will not be "blacked out" or written over.

4.4.2. The CHP FHA shall perform an internal investigation and send a final report to the CHP Pharmacy Director, ADCRR Pharmacy Director, and the Department's Assistant Director for Medical Services.

4.4.2.1. If the medication is accounted for, no further intervention is needed.

4.4.2.2. In the case of lost or stolen Controlled Substances, regardless of quantity or circumstances, the Arizona State Board of Pharmacy, as well as the DEA, shall be formally notified.

4.4.2.2.1. A Medication Incident Report form, an Information Report (IR) (Form 105-2), and a Drug Enforcement Administration (DEA) 106 Form shall be completed, and proof of formal notification to the respective governing authorities shall be supplied to the ADCRR Pharmacy Director.

5.0. Procuring

5.1. The CHP shall purchase, inventory, and control medications including prescribed and over-the-counter medications.

5.2. The CHP shall ensure a system is in place to acquire and distribute urgent, necessary medications ordered by CHP practitioners and ensure continuation of chronic medications if a delay in the refill would adversely compromise the patients' health.

5.3. The CHP FHA and the CHP Pharmacy Director shall work closely with the Warden and Institutional Records staff to monitor daily transportation of medications, including rescheduled transports or cancellations by the contracted delivery services. The CHP Pharmacy Director shall be notified by the CHP of any delays in shipments. If a prescribed medication is needed urgently/emergently a backup pharmacy shall be used.

5.3.1. Each medication tote shall contain the prepared medications and a packing slip noting the medications with respective patient/medical unit location and date of dispensing.

5.3.2. A member of the CHP staff shall be responsible for the receipt of the medication tote at the receiving facility. The person responsible shall be identified by the CHP FHA.

5.3.3. The CHP medication liaison or designee receiving the medication tote for distribution shall compare the contents of the medication tote with the packing slip. Non-licensed medical personnel shall only verify quantity of prescriptions received against the manifest. Any interpretation involving the original prescription (clinical or otherwise) shall be completed by CHP nursing.

5.3.4. Any discrepancies in tote contents shall be reported to the CHP sending pharmacy within one hour of receipt who shall take the necessary actions to address discrepancies and resolve the issue.

5.3.5. CHP licensed nursing staff shall review the prescription against the prescription copy that was maintained by the sending facility. This may also be accomplished via review of an EHR.

5.3.6. CHP nursing staff shall legibly sign (including credentials), date, and name stamp the accompanying manifest as assumption of responsibility for follow up on medication issues/concerns documented by the manifest or other utilized form of notification.

5.3.6.1. Two CHP licensed nurses shall sign controlled substance manifests or other documenting source of delivery/return and document the receipt/return of the controlled substance in the accepted controlled perpetual inventory or other ADCRR approved tracking system.

5.4. All medications receipt, distribution, and transfer (inter/intra-facility, outside agency) will be documented in the EHR. The record will include the date and time of receipt, distribution, and transfer as well as the medication name, medication strength, the quantity of the medication (unit count), and the authorized signature of the individual(s) performing the above functions.

5.4.1. Any receipt and/or transfer of controlled substances requires the signature of two licensed CHP nurses on the inventory form as well as the manifest substantiating the receipt of medication in accordance with state and federal law.

5.5. The EHR will also record, all medications and/or supplements obtained from a source outside the CHP's normal procurement process for medications and/or supplements obtained via a prescription (i.e., alternate pharmacy). The EHR will clearly record the origin of these medications and/or supplements.

6.0. Dispensing

6.1. <u>Authorized Prescribers:</u>

6.1.1. Only CHP employees legally licensed by the State of Arizona to prescribe medications shall be authorized to prescribe medications. Prescription orders written by consultants shall be considered "treatment plan recommendations" to the CHP Practitioner/Provider. The following CHP practitioners are required to have a Drug Enforcement Administration (DEA) number:

6.1.1.1. CHP Physicians (D.O.s and M.D.s) and CHP Mid-Level Practitioners/Providers (Nurse Practitioners and Physician Assistants) has authority to prescribe any medication approved by the Pharmacy and Therapeutics (P&T) Committee in accordance with the limits of State and Federal laws. Non-formulary drugs may be prescribed if prior approval for their use has been obtained.

6.1.1.2. CHP Dentists (D.D.S.s and D.M.D.s) may prescribe any formulary and non-formulary medication as above that is pertinent to their practice.

6.1.2. Provider DEA Numbers: The CHP FHA shall ensure at least one authorized CHP Provider has a DEA number specific to the physical address of the assigned work location and the DEA number is kept on file.

6.1.3. Obtaining Licensure: Perryville shall maintain their Pharmacy Hospital/Clinic DEA license for intake prescriptions. Alhambra shall maintain their Pharmacy Hospital/Clinic DEA license for intakes and Mental Health Hospital prescriptions. Tucson shall maintain their Pharmacy Hospital/Clinic DEA license for their facility and the Inpatient Component Facility.

6.1.4. CHP Pharmacists may write verbal orders from an authorized prescriber. All verbal order prescriptions shall be annotated to clearly indicate that the prescription is a verbal order.

6.1.5. CHP Nursing Staff may issue medications under approved and active Nursing Protocols, Nursing Encounter Tools (NETS), or Nursing Emergency Response Orders (EROs), as outlined in the Medical Services Technical Manual (MSTM).

6.2. <u>CHP Dispensing:</u>

6.2.1. Upon the receipt of a faxed, verbal, original, or electronic prescription from a CHP Provider, the CHP Pharmacy shall:

6.2.1.1. Dispense the medication for administration and/or delivery.

6.2.1.2. Comply with the cut-off time for receiving prescriptions that have been set by the CHP. Prescriptions received prior to that time are filled for next day delivery.

6.2.1.3. Maintain a copy of the faxed verbal, original, or electronic prescription and clinic stock orders for seven years, as mandated by federal and state laws for document preservation.

6.2.1.4. Issue clinic stock to healthcare unit if indicated.

6.2.2. CHP Nursing shall perform all quality checks to ensure that the product received corresponds to the prescription sent.

6.2.3. If a discrepancy occurs between the ordered and received prescription, the CHP nurse shall notify the CHP pharmacy on the same day and/or the prescription shall be resent or transmitted with an explanation of the discrepancy. The offsite back-up pharmacy or clinic stock shall be used if necessary to ensure continuity of care.

6.3. <u>Prescription Information:</u> The CHP Pharmacy shall maintain patient profiles/records on all patients receiving prescription medication, which must include a complete list of all medications prescribed to the patient.

6.3.1. All prescriptions shall be written on an ADCRR approved CHP prescription forms or electronically transmitted by the CHP Pharmacy Software system in compliance with all State and Federal regulations.

6.3.2. Prescriptions presented to the CHP Pharmacy shall contain all necessary information in a clear, concise format and comply with all State and Federal regulations (prescriptions NOT submitted in accordance with these requirements shall be returned to the CHP Healthcare Provider to correct or complete).

6.3.3. Clinic stock prescriptions shall be listed as "information only or profile only" in the CHP pharmacy system.

6.3.4. Prescription Quantities and Refill Information: Prescription quantities, duration, and dosages shall be in compliance with approved and active ADCRR Nursing Protocols, Nursing Encounter Tools (NETS), Nursing Emergency Response Orders (EROs), and the CHP Drug Formulary, unless approved otherwise via a Non Formulary Drug Request.

6.3.5. The final day of an individual prescription's duration as determined by the CHP provider upon issuing a written prescription (start date or effective date as determined by the CHP provider) shall constitute a STOP DATE for that drug order. The contraband date shall be the Stop Date of a prescription. Prescriptions shall not be filled beyond the Stop Date. Stop Dates (contraband dates) shall be printed on the label at the time of dispensing.

6.4. <u>Release Medications:</u>

6.4.1. Patient's pending discharge from ADCRR custody shall have release medication orders sent to the CHP pharmacy by CHP nursing at least one week prior (but no sooner than two weeks prior) to discharge for the medication to be filled by the CHP Pharmacy. Site specific procedures that are more stringent than the two week timeline are acceptable.

6.4.1.1. Patient profiles must be reviewed for accuracy (additions, deletions, change in dose, directions, etc.) immediately prior to release to ensure appropriate therapy is received upon release.

6.4.1.2. Late notification for discharge medications shall require using outside contracted pharmacy services to provide discharge medication.

6.4.2. CHP healthcare staff and correctional staff who are responsible for release medications shall comply with all rules and regulations of the state board of pharmacy, as well as maintenance of temperature logs in release medication storage areas.

6.4.2.1. All controlled release medications shall be inventoried as outlined in the MSTM (shift counts).

6.4.2.2. The controlled release medications shall also comply with the double-lock requirement as outlined in the MSTM and comply with existing CHP policy and procedure.

6.4.3. At the time of release to the community (Half-Way House, home arrest, or release) the CHP medical staff at the releasing facility shall provide a 30 day supply of all active medication (including as – needed medication) pursuant to a new prescription. Prescriptions for release medications shall comply with all State and Federal law and be accompanied by printed drug information sheets for all medications received.

6.4.3.1. Birth Control Pills may be prescribed and dispensed to female patients one month prior to release, with an additional month's supply given at time of release at the Healthcare Providers discretion.

6.4.3.2. In an effort to assist releasing patients to prepare for self-care, insulin dependent diabetics may be allowed to self-administer their insulin for up to a 30 day period prior to their confirmed release date. This must be initiated by a CHP provider's written order.

6.4.4. Release medications shall be browned bagged and have chain of custody maintained by the signing of an acknowledgement sheet by the CHP staff and security.

6.4.5. At the time of release, the patient will sign and be provided a copy of the approved release form to confirm receipt of medication, and this form will be uploaded into the patient's health record.

6.4.5.1. The release form shall contain patient name, ADCRR number, prescription number for each medication, acknowledgement of non-child proof caps (if applicable), access to consultation, and medication information sheets, including a phone number to contact the dispensing pharmacy.

6.4.5.2. Documentation of released medications for paroled patient(s) in the EHR shall include date and time of delivery, medication name, strength, and quantity and include the authorized signature of the individual issuing the release medication(s).

6.5. <u>Approved and active Nursing Protocols, Nursing Encounter Tools (NETS), or Nursing Emergency Response Orders (EROs):</u>

6.5.1. The CHP shall ensure properly labeled prepackaged medications are available and limited to those authorized for use according to approved Nursing Protocols, Nursing Encounter Tools (NETS), or Nursing Emergency Response Orders (EROs).

6.6. Processing New Prescriptions and Medical Orders:

6.6.1. All prescriptions received by the CHP pharmacy shall be reviewed for completeness and accuracy, potential interactions, therapeutics relevance, and other pertinent information necessary to fill the prescribed medication. All prescriptions received and filled by the CHP Pharmacy shall be in adherence to all State and Federal regulations. Discrepancies shall be resolved with the primary care provider before filling.

6.6.2. All information necessary for processing the prescription shall be entered into the CHP pharmacy database prescription program to generate a label in compliance with all State and Federal regulations.

6.6.2.1. Prescriptions for unit dose medications may be filled for up to a 30 day supply.

6.6.2.2. The prescription shall be delivered to the appropriate nursing unit for administration.

6.6.3. All medications shall be dispensed in plastic containers or ADCRR approved packaging that meets all state and federal guidelines. Whenever possible, avoid dispensing in glass or metal containers. Medications not packaged in ADCRR - approved packaging shall be considered DOT.

6.7. Telephone and Faxed Prescriptions and Telephone Prescribing:

6.7.1. For logistic situations that do not allow for routine processing of the prescriptions an order may be placed verbally to the CHP Pharmacist. Telephone orders to facilitate speed of medication delivery shall be immediately reduced to writing by the CHP Pharmacist.

6.7.2. Faxed prescriptions shall be sent to the pharmacy and prepared for administration and delivery to the patient. The faxed prescription is considered a legal document and shall be maintained by the pharmacy, as required by state and federal statutes. Schedule II medications shall adhere to state and federal guidelines concerning the transmission, processing, and dispensing of those medications.

6.8. Processing Prescription Refills:

6.8.1. Refills of chronic medications may not be written to exceed one year.

6.8.2. Prescriptions for Prenatal vitamins and iron can be valid for the duration of pregnancy plus two months.

6.8.3. Refill requests for non-chronic medications, including prn will be initiated by the patient by submitting a refill label or by completing a Health Needs Request form (HNR) and submitting it (along with their empty medication container when mandated) to CHP. The prescription shall be reviewed for proper use (compliance, expiration date, and refill status). Refills for chronic medications (not prn) shall be on auto refill and NOT require a HNR.

6.8.4. If appropriate, the medication shall be refilled through the following process:

6.8.4.1. The refill information entered into the CHP pharmacy computer database, and the HNR completed with the full name and signature of the healthcare staff processing the HNR.

6.8.4.2. If the patient's use of the medication is not in compliance with the written directions; the medication shall not be refilled and the following process followed:

6.8.4.2.1. The ordering CHP Practitioner/Provider shall be contacted and the concern communicated.

6.8.4.2.2. A note shall be made on the HNR to the patient with specifics as to why the medication was not refilled, and a copy of the HNR shall be filed in the patient's health record or otherwise annotated in an electronic format.

6.8.4.3. If a refill medication is of an immediate urgent/emergent nature, continuity of care must be maintained by utilizing an offsite pharmacy.

6.9. Medication expiration reports shall be reviewed weekly to provide information for continuity of care and prevent the expiration of a prescription. Once the prescription has expired, it is necessary to provide emergency coverage through clinic stock or offsite pharmacy.

6.10. Medications prepared by Contracted offsite CHP Pharmacy shall be securely packaged in a medication tote and delivered by contracted delivery services.

7.0. Disposal

7.1. Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications, except in a designated area for disposal.

7.2. Non controlled substances which are expired, contaminated, or partial drug stocks awaiting disposal shall be maintained in a separate area from current stock until returned to the pharmacy. A log of disposals shall be kept on file in the pharmacy.

7.2.1. All prefilled syringes (except Controlled Substances) shall be disposed of in an approved sharps container without emptying their contents.

7.2.2. All live virus vaccine containers, vials & syringes, shall be disposed of in an approved sharps container and included with bio-hazard waste for proper disposal as above in accordance with all State and Federal guidelines as well as EPA guidelines.

7.3. Controlled substances, CII-V which are expired, contaminated, or partial drug stocks awaiting disposal via an alternate reverse distribution entity shall be removed from active stock and placed in a separate area away from current active stock.

7.3.1. Adjusting entries shall be made in the controlled substances logbook in accordance with State and Federal laws. The sheet listing the controlled substances to be destroyed shall be signed and dated and the record maintained with the annual inventory.

7.3.2. Notations of wasted medication for controlled substances must be accompanied by two licensed CHP nurse signatures. Notations of waste for all other medications shall be noted by a licensed CHP nurse's signature. Information required on the inventory must be filled out accurately/completely and legibly in its entirety.

7.3.3. All controlled substances received from outside sources at an intake facility shall be sent to the CHP pharmacy for destruction or as per policy and mandated by state and federal law.

7.4. Items obtained from the CHP pharmacy that are found in a patient's possession/room/area are considered contraband after the STOP DATE printed on the medication label. These items are to be disposed in accordance with Federal, State, and local regulations.

7.5. Multi-dose vials shall be inspected quarterly by the CHP pharmacy staff, monthly by nursing staff and/or monthly by dental staff for evidence of deterioration and contamination. Vials with evidence of either will be removed from use.

7.6. All medication disposal, waste, or return will be documented in the EHR. The record will include the date and time of disposal, waste, or return as well as the medication name, strength, and quantity and include the authorized signature of the individual(s) performing the above function and document the reason for return.

8.0. Drug Recall

8.1. Upon receipt of a Drug Recall Notice the CHP pharmacy staff shall note the class of the recall (I, II, or III) and check all stock to determine if any of the recalled drugs are currently or have been stocked in the past.

8.1.1. For all Class I recalls identify and contact all patients that have received or may have received the drug product.

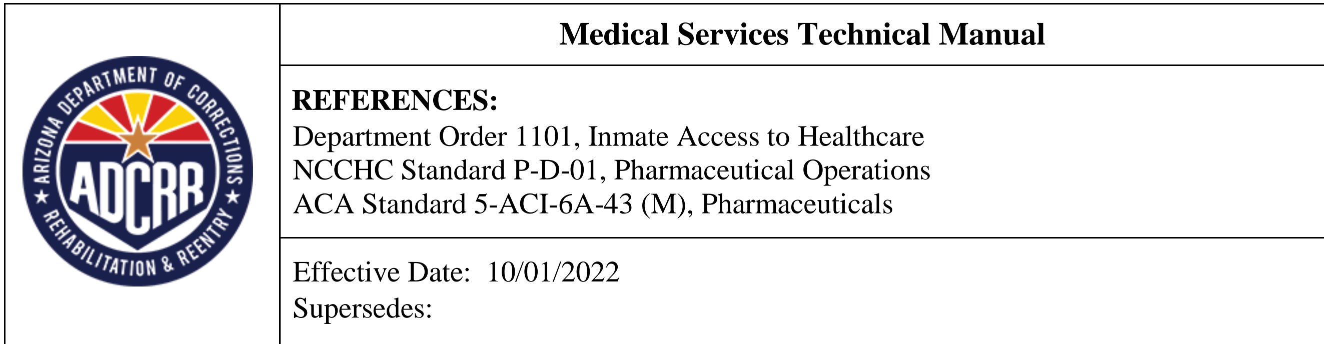
8.1.1.1. Patients shall be instructed to stop taking the medication and return it immediately to the pharmacy.

8.1.1.2. All Practitioner/Providers shall be notified and advised of the recall.

8.1.1.3. Comply with instructions in the Recall Notice.

8.1.1.4. Annotate on the Recall Notice the actions taken, date, and initials of responsible person.

8.1.1.5. File Recall Notice and retain for two years on file in the CHP pharmacy.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Healthcare NCCHC Standard P-D-01, Pharmaceutical Operations ACA Standard 5-ACI-6A-43 (M), Pharmaceuticals
	Effective Date: 10/01/2022 Supersedes:

P-D-01.02 Pharmacy Administration and Oversight

PURPOSE: To guide Contract Healthcare Provider (CHP) Pharmacy with administration and oversight to ensure operations meet the needs of the facility and conform to legal requirements.

RESPONSIBILITIES: The CHP ensures that pharmaceutical operations comply with all current State Board and Federal Regulations.

PROCEDURE:

1.0. The CHP Pharmacy shall comply with all State and Federal laws governing the practice of pharmacy.
- 1.1. Maintains records of compliance for licensure, Pharmacists' continuing education, inspections, and reporting.
- 1.2. Maintains a "signature file" of all staff authorized to prescribe medications and/or record on any required pharmacy form or record.
- 1.3. Obtains and/or maintains all records of State of Arizona Pharmacy Licensure and renewals.
- 1.4. Ensure that all prescriptions are dispensed in a timely manner so as not to contribute to morbidity or mortality.
- 1.5. The CHP pharmacy area and any additional authorized storage areas shall be of sufficient size to meet State Board of Pharmacy regulations and allow adequate workspace and storage to accommodate pharmacy staff personnel and supplies for at least seven days of operation and to ensure uninterrupted services.
- 1.6. Appropriate reference texts and journals will be maintained to provide up to date information for healthcare staff.
- 1.7. All perpetual inventories invoices, manifests, as well as any other documentation of receipt, distribution, administration, destruction, return, and waste shall be maintained on the respective unit for a period of not less than seven years.

2.0. Each pharmacy will maintain a DEA license through the Drug Enforcement Agency. The DEA license number will be used to identify clinic controlled substance activity by location and provider.
- 2.1. The following records shall be maintained:
  - 2.1.1. Official order forms (DEA Form 222)
  - 2.1.2. Power of Attorney authorization to sign order forms
  - 2.1.3. Receipts and invoices for schedule C-II thru V
  - 2.1.4. All inventory record of controlled substances, including the initial and biennial inventories
  - 2.1.5. Records of controlled substances distributed or dispensed
  - 2.1.6. Report of theft or loss (DEA Form 106)
  - 2.1.7. Inventory of drugs surrendered for disposal (DEA form 41)
  - 2.1.8. Records of transfers of controlled substances between pharmacies

2.1.9. DEA registration certificate

3.0. The CHP Director of Pharmacy is responsible for ensuring:

3.1. Daily pharmacy operations are conducted in accordance with State Law, Federal Law, ADCRR Department Orders, and the Medical Services Technical Manual and accepted standards for the practice of pharmacy.

3.2. Adheres to State and Federal Law when performing all controlled substance transactions.

3.3. Ensures proper storage and dispensing of all medications used in the institution; including inventory maintenance and pharmacy procurements. All record keeping associated with the procurement, storage, and dispensing of pharmaceuticals is monitored by the CHP Pharmacy Director.

3.4. Routinely inspects clinic emergency medications in the urgent care room, emergency kits, and clinical stock.

3.5. Procures, maintains, organizes storage, inventories, and keeps records on bulk supply syringes and needles.

3.6. Provides ongoing education for all health service staff and patients on medications and pharmacy policies. Plans and conducts training of clinic staff in pharmacology, pharmaceutical dosing, and pharmacy procedures.

3.7. Updates pharmacy publications including the CHP Pharmacy directives and CHP Formulary.

3.8. Assures that pharmacy/clinical directives issued by the MSCMB are carried out.

3.9. Performs audits and inspections of medications stored in all clinic/healthcare unit work areas and follow-up on any negative findings.

3.10. Participates in Facility Health Services' committees and meetings as they relate to drugs and drug therapy.

3.11. Maintains files of the combined MSCMB and CHP Pharmacy and Therapeutics Committee Meeting Minutes and maintains the Master Formulary. Ensuring all complex Providers are in possession of an up-to-date formulary.

4.0. CHP Practitioners shall:

4.1. Prescribe only those medications which are therapeutically correct.

4.2. Follow procedures for obtaining non-formulary medications as prescribed in CHP policy procedure.

4.3. Review medications prescribed by outside consultants and issue a prescription for the medication or substitute a therapeutically equivalent medication available from the CHP Formulary.

4.4. Controlled Substance (CII-CV) may not exceed 30 days to facilitate inventory tracking and control.

4.5. Phenobarbital used to treat seizure disorders may be prescribed for up to 6 months.

4.6. DEA Controlled Substances shall NOT be used for hypnotic purposes.

4.7. DEA Controlled Substances, used in cases of chronic or terminal illness resulting in unremitting pain not likely to abate in the short term, will be valid for one month.

4.8. Providers shall prescribe only as determined by their license privilege or restrictions.

4.9. Exceptions to policy must be submitted and approved through the Non-Formulary process.

5.0. Prescription Limits - General:

5.1. Prescriptions for chronic conditions may be prescribed for up to a one year time period if clinically appropriate.

5.1.1. The period of **one month** shall be interpreted as 30 days.

5.2. Antibiotics may be dispensed in up to 30-day increments.

5.3. Keep-on-Person (KOP) maximum quantities dispensed may not exceed a 30 day supply or 120 dosage units whichever is less, except for unit of use medications (e.g., eye drops, creams, lotions, etc.) which expire when the prescription expires.

5.4. Controlled Substance prescription authorization will be limited by Department Program Technical Manuals, not to exceed State and Federal limitations upon each class.

5.5. Patient product information is required to be provided to patients each time a new prescription is provided for the following medications:

5.5.1. Birth Control Pills

5.5.2. Oral Estrogen Products

5.5.3. Vaginal Estrogen Products

5.5.4. Oral Progesterone Products

6.0. Medication Liaison

6.1. A Medication Liaison may be designated by the CHP Facility Health Administrator (FHA). This individual may be a correctional Nurse or administrative assistant or other health services staff member. The Medication Liaison and at least two back-up staff will be trained in the following areas:

6.1.1. Preparation of medication for delivery and distribution to nursing staff.

6.1.2. Ordering and distribution of Over the Counter medication to Providers and Nursing staff.

6.1.3. Medication liaison shall not be permitted in areas that stores controlled substances unless supervised by a licensed nurse.

7.0. Medication Program Integrity: Practices, Audits, and Reporting

7.1. A complete audit trail for all medications issued by the CHP Pharmacy shall be maintained by the CHP for inspection by the Medical Services Contract Monitoring Bureau (MSCMB), as well as Federal and State enforcement, investigative and licensing agencies.

7.2. Audit and Inspection of the clinic stock storage area shall be conducted to ensure that all medications are properly packaged, stored, not expired, and that proper documentation and accountability is being maintained:

7.2.1. An inventory of the clinic stock storage area shall be conducted each time the safety seal is broken or a minimum of once per week.

7.2.2. The unit Charge Nurse (or designee) and CHP Lead Dentist or designee shall inspect monthly the contents of the clinic stock storage area.

7.3. Discrepancies found during audit shall be documented on a Medication Incident Report, 1101-53P with a copy sent to the CHP Pharmacy and ADCRR Pharmacy Director, CHP's DON, Lead Dentist, and the Facility Health Administrator and include notification of action taken.

7.3.1. Attempts to account for the medication discrepancy shall be made and the resolution noted on the Medication Incident Report and made available to the Pharmacy Contract Monitor.

7.4. All incidents involving medications which remain unaccounted for will be reported to the CHP Pharmacy Director and ADCRR Pharmacy Director, by the respective Supervisors for further investigation and action.

7.5. Medication Storage areas shall be subject to audit at any time (upon obtaining the necessary security clearance) by the Arizona State Board of Pharmacy, the Drug Enforcement Agency, other law enforcement or regulatory agency, and specific personnel appointed or authorized by ADCRR Assistant Director including the CHP Regional Leadership or designee, when such audit is within the legal purview of that authority.

7.5.1. The CHP Regional Leadership or designee may notify the Facility Health Administrator, who will notify the appropriate staff of the date of the onsite quality assurance audit.

7.5.2. The CHP's Pharmacist, Nursing Supervisor or Lead Dentist (or their designees) will provide assistance to, and/or presence with, the auditors in conducting their audits.

7.5.3. The results of the audit will be reported to the CHP Facility Health Administrator, who will report findings to the CHP Pharmacy Director, Nursing Supervisor and/or Lead Dentist for follow-up. Results of the audit shall be made available to the ADCRR Pharmacy Director.

7.6. Monthly inventory audits shall be conducted for all controlled substances, in addition to the daily shift change audits by the CHP Nursing staff.

7.6.1. Two CHP Nurses shall conduct the inventories.

7.6.1.1. The completed monthly inventory logs shall be kept on file by the CHP Director of Nursing (DON).

7.6.2. All discrepancies shall be reported on a Medication Incident Report, 1101-53P, to the Facility Health Administrator (FHA) for action.

7.6.2.1. The CHP FHA or designee shall make a written report of all discrepancies and resolutions to the CHP Pharmacy Director, DON and ADCRR Pharmacy Director.

7.6.3. For controlled substances, discrepancies warrant State Board notification as well as a DEA notification via the appropriate form.

7.7. Yearly Pharmacy Inventory, Quarterly Audits, Monthly Audits, Weekly Inventories of medication rooms and daily inventories of Clinic Stock Storage Areas (clinic stock) will be conducted of all pharmaceutical supplies, stocked within each healthcare unit by the CHP Pharmacy representative and a copy shall be made available to ADCRR Pharmacy Director.

7.7.1. The CHP FHA or designee shall review and approve the inventories to ensure completeness.

7.7.1.1. Any incomplete or absent inventory/audit will be considered non-compliant.

7.8. A compilation and reporting of all clinic stock storage area audits (daily, weekly, monthly, and quarterly) shall be the responsibility of the CHP for compliance monitoring

7.9. The CHP Arizona licensed Pharmacist will conduct and document a quarterly audit of all drug storage areas. This will include the following elements:

7.9.1. Inspection for neat, organized, and clean storage and work areas, and evidence of expired or contaminated drugs and to ensure that all medications are kept in clean, dry containers protected from extremes in temperature and damaging light and in compliance with manufacturer's storage instructions.

7.9.2. Review of stock levels of drug inventories.

7.9.3. Search for discontinued and outdated drugs; containers with worn, illegible, or missing labels. Found items shall be returned to the pharmacy for proper disposition.

7.9.4. Food, food products, and laboratory specimens will not be stored in refrigerators designated for storage of drugs and/or sterile laboratory stock.

7.10. An Arizona licensed CHP Pharmacist will be responsible for auditing the health unit quarterly and a copy of the report will be maintained on site by the CHP FHA or designee, and at the CHP Pharmacy with a copy to ADCRR Pharmacy Director.

7.10.1. Quarterly audit results are reported to Pharmaceutics and Therapeutics (P&T) Committee for discussion and follow-up by the identified discipline.

8.0. Quality Assurance at Healthcare sites clinic stock areas, nursing stations or where medications are stored: A CHP Lead Dentist or designee or CHP Director of Nursing (DON) (or designee) shall be responsible for conducting a monthly audit of their respective health unit and clinic stock storage.

8.1. A copy of the monthly Health Unit Audit Report is maintained on site.

8.2. A copy is sent to the ADCRR Pharmacy Director upon request.

8.3. Health Unit Audit results are reported at the next onsite Continuous Quality Improvement (CQI) Meeting for discussion and follow-up.

9.0. Drug enforcement Administration (DEA) 222 order forms are required for the transfer of all C-II drugs utilized for emergency stocking and dispensing from the Remote Drug Storage Area.

9.1. Active prescriptions (with patient name) dispensed by the CHP pharmacy do not require this tracking mechanism.

9.2. All prescriptions shall comply with state and federal law.

9.3. Initial Inventories: When issued a DEA registration, an initial actual physical count of all controlled substances in inventory must be taken and be maintained at the registered location for a minimum of two years. The inventory of Schedule II controlled substances shall be kept separate from all other controlled substances.

9.3.1. The inventory shall include:

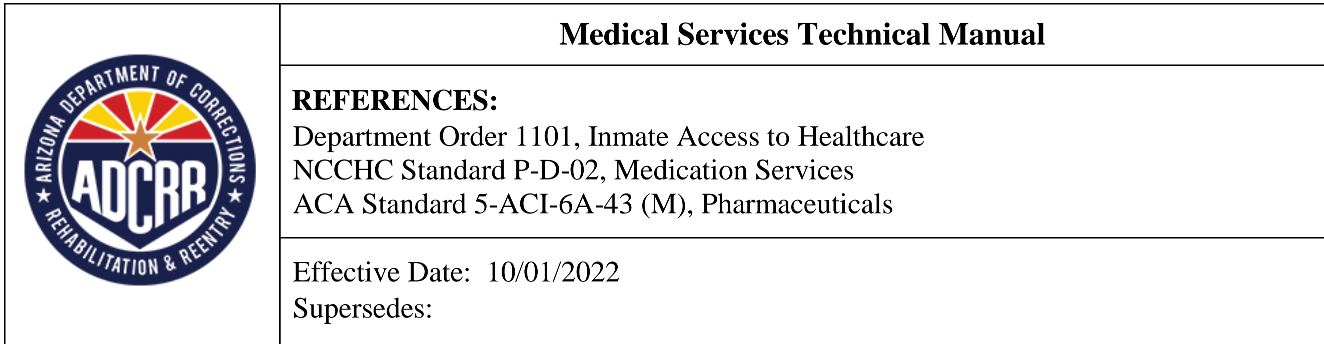
9.3.1.1. The inventory date and the time the inventory is taken

9.3.1.2. The drug name, strength, and form (e.g., tablet, capsule, etc.)

9.3.1.3. The number of units/volume; and the total quantity

9.3.1.4. The name, address, and DEA registration number of the registrant and the signature of the person or persons responsible for taking the inventory

9.4. Biennial Inventory. Following the initial inventory, the registrant is required to take a biennial inventory (every two years), and conducted in the same manner as the initial inventory of all clinic stock storage area controlled substances on hand. The biennial inventory may be taken on any date which is within two years of the previous inventory date. There is no requirement to submit a copy of the inventory to the DEA. When taking the inventory of Schedule II controlled substances, an actual physical count must be made. For the inventory of Schedules III, IV and V controlled substances, an estimated count may be made. A count of bottles must be made if the container holds more than 1,000 dosage units and has been opened.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Healthcare NCCHC Standard P-D-02, Medication Services ACA Standard 5-ACI-6A-43 (M), Pharmaceuticals
	Effective Date: 10/01/2022 Supersedes:

P-D-02.01 Medication Services

PURPOSE: To provide guidance in prescribing, ordering, administration, and delivery of all prescription medications and to define non-formulary process and procedure.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to establish and follow accepted prescribing and safety practices and delivery/administration procedures.

PROCEDURES:

1.0. Prescribing/Ordering

- 1.1. Prescription medications are given only upon the order of a CHP Medical Practitioner, Dentist, Psychiatric Provider, or other legally authorized individual and prescribed only when clinically indicated.
  - 1.1.1. All controlled substances as well as those medications determined by the Arizona Department of Corrections Rehabilitation and Reentry, CHP policy, or the Pharmacy and Therapeutics (P&T) committee that may necessitate Direct Observed Therapy (DOT) shall be prescribed as such.
    - 1.1.1.1. The CHP Practitioner will prescribe in accordance with the approved DOT medication list, maintained by the ADCRR with input from the P&T committee.
      - 1.1.1.1.1. Refer to the Medical Services Technical Manual Attachment P-D-02.01A, Direct Observed Therapy (DOT) Medication Listing.
  - 1.1.2. Medical and Psychiatric Providers can restrict use to DOT as necessary for specific individual patients.
  - 1.1.3. DOT drugs shall be prescribed at their least frequent dosing interval, when clinically appropriate (e.g., BID instead of TID or QID).
  - 1.1.4. Any medication may be "DOT" for security reasons, non-compliance, or suspected abuse/misuse until the CHP Provider can review and evaluate the patient.
  - 1.1.5. All information supporting the need to have a medication administered by "DOT" shall be documented in the patient's health record and the treating Provider shall be notified.
  - 1.1.6. Drug use parameters will be developed and approved by the combined Pharmacy & Therapeutics (P&T) Committee.
    - 1.1.6.1. Drug Utilization Review/Evaluation (DUR/DUE) will be reviewed and the results reported to the P&T Committee for evaluation and action if necessary.
    - 1.1.6.2. A file of DUR/DUEs will be maintained by CHP Pharmacy.
    - 1.1.6.3. Facilities may conduct additional DUR/DUEs to meet their needs.

1.1.7. CHP Practitioners with prescribing authority ensure all patients receive laboratory monitoring when placed on high risk medications.

1.2. The ordering CHP prescriber shall be notified of the impending expiration of an order so that the prescriber can determine whether the drug administration is to be continued or altered.

1.3. The CHP Pharmacy shall be notified of the any change in medication delivery/administration (KOP/DOT) by receiving a new order from the prescribing provider.

1.4. Patients entering the facility on verifiable prescription medication continue to receive the medication in a timely fashion, or justification for an alternate treatment plan is documented.

1.5. Transfer Medications: Patients transferring between ADCRR facilities will continue their current medications as ordered pending evaluation by a CHP Practitioner at the receiving institution.

1.5.1. Patients will self-carry their currently issued Keep On Person (KOP) prescriptions in accordance with this manual and pertinent ADCRR Department Orders.

1.5.2. Directly Observed Therapy (DOT) medications shall be placed in the chart for transport to the receiving complex/facility.

1.5.3. Patients transferring to a Private Prison facility shall retain and continue all KOP and DOT medications in order to maintain continuity of care until the patient is seen by a CHP healthcare practitioner.

1.6. Controlled Substances Schedule II-V will be transferable as per state and federal regulation.

2.0. Administration/Delivery

2.1. <u>DOT</u>

2.1.1. All patients housed in inpatient beds shall have all medications administered under DOT by CHP nursing staff. KOP medication not authorized in IPC setting.

2.1.1.1. The CHP nursing staff who prepares the medication for administration in the IPC is the person who is responsible for the delivery process of the unit dose delivery.

2.1.2. Patients housed in Complex Detention Units (CDUs) under mental health watch or suicide watch shall have all their medication administered by DOT with no exceptions.

2.2. <u>Medication Administration Lines for DOT medications (‘Med Lines’) and Insulin delivery:</u>

2.2.1. Med lines will be conducted at the healthcare units or other location mutually agreed upon at regularly scheduled times as determined by the CHP FHA in consultation with the unit Deputy Warden.

2.2.2. Patients housed in Lock-down Units shall have all medications, KOP and DOT delivered and administered by the CHP nursing staff.

2.2.2.1. All DOT medications shall be administered directly to the patients by CHP nursing staff.

2.2.3. The Medication Administration Record (MAR) must accompany the CHP nursing staff member during administration of the medication.

2.2.4. Medications shall be administered daily at a consistent time and location. The administration of medication is authorized to take place within two (2) hours before the designated time or two (2) hours after.

2.2.5. Prior to the medication being administered to the patient, the CHP Nursing Staff member must verify the medication against the MAR to ensure the appropriate person, dosage, time, route, and medication.

2.2.6. As soon as the medication is administered, the CHP nursing staff shall document the actual time of medication administration or non-administration of unit dose (DOT) medications on the MAR.

2.2.6.1. Pre-charting of medication administration on the MAR is not authorized.

2.2.6.2. Variances from the complete dose being administered will also be annotated on the MAR (e.g., "refused", "1 tab").

2.2.7. When unit security necessitates, medications may be administered through food traps in the cell door.

2.3. Insulin Administration Lines:

2.3.1. Insulin syringes will be signed out from the sharps inventory.

2.3.2. Insulin will be drawn up and administered by the CHP Nursing Staff.

2.3.2.1. The syringe will NOT be handed to the patient for self-injection.

2.3.2.2. The only exception to the above is in the case of discharge supplies and self-administration training for patients within 30 days of being released.

2.3.3. The syringe will be discarded by the staff member administering the injection in accordance with Occupation Safety Health Administration (OSHA) standards in an approved sharps container as soon as possible.

2.3.4. Medication refills and new medication orders may be picked up during insulin administration ONLY if authorized by the CHP FHA or designee.

2.4. Refusal of Medications:

2.4.1. The CHP Staff who attempted to administer the medications shall document the refusal immediately within the MAR.

2.4.1.1. CHP nursing staff shall obtain a signed refusal either electronically or by using Refusal to Submit to Treatment, Form 1101-4.

2.4.2. The refusal by a patient of prescribed medications for greater than a three (3) day period to include KOP medication must be reported to the CHP Practitioner.

2.4.3. Patients who refuse or no-show for prescribed medication shall be counseled by a CHP qualified healthcare provider after three consecutive refusals.

2.4.4. After a third missed medication dose of prescribed psychotropic medication CHP nursing staff shall notify CHP Mental Health personnel immediately upon returning from medication administration rounds.

2.4.4.1. If no Mental Health personnel are present on site, the urgent notification list for Mental Health personnel shall be utilized.

2.5. Keep-on-Person (KOP):

2.5.1. KOP maximum quantities dispensed may not exceed a 30-day supply or a maximum of 120 units (pills) per fill. “Unit of use” medications such as topical (e.g., creams, lotions), inhalers, eye drops, etc. may be dispensed and delivered to a patient in more than a one-month supply upon approval by the combined ADCRR/Contract Pharmacy and Therapeutics Committee.

2.5.2. The nursing staff receiving medications from the medication liaison shall complete the “sign-off” sheets acknowledging receipt and count.

2.5.3. CHP nursing staff may temporarily restrict a KOP medication to DOT with cause for a period not to exceed ten days. If the patient has not seen a CHP Practitioner by the tenth day, the restriction will end, unless extended by authorization of the site CHP Medical Director, in consultation with the CHP DON. The site CHP Medical Director shall document any decision to continue the medication in the patient’s health record.

2.5.3.1. For patients who are suspected hoarding or diverting KOP medications the medication nurse may require one-for-one exchange for KOP medication delivery.

2.5.4. KOP medications will be prepared for delivery to the patient by the CHP pharmacy, medication liaison, or designee, under the supervision of the Facility Health Administrator.

2.5.4.1. KOP medications shall be delivered to patients within 24 hours of receipt by CHP nursing staff.

2.5.4.1.1. CHP nursing staff shall document in the MAR patients receipt of KOP medication.

2.5.4.1.2. Undeliverable medications shall be documented in the patient’s health record and on the medication administration record (MAR).

2.5.4.1.3. If the patient refuses KOP medication, a Refusal to Submit to Treatment, Form 1101-4, must be completed and a CHP Practitioner must be notified.

2.5.5. Medication for patients who are out to court or in the hospital shall be maintained at the unit pending the patient's return to the facility unless the order has expired.

2.5.6. All discontinued medication shall be returned to the CHP pharmacy. See MSTM Chapter P-D-01.01, Pharmacy Security and Inventory Control, for disposal procedure.

2.6. Documenting Administration/Delivery: All medications administered, delivered, or refused will be documented in the EHR. The record will include the date and time of administration, delivery, or refusal as well as the medication name, medication strength, the quantity of the medication (unit count), and the authorized signature of the individual(s) performing the above functions.

3.0. Formulary/Non-Formulary

3.1. Newly prescribed formulary medications shall be provided to the patient within two business days after prescribed or on the same day if prescribed 'stat'.

3.2. Non-formulary drug requests (NFDR) must be approved, denied, or ATP (Alternate Treatment/therapy Plan) within 2 business days of submission.

3.2.1. If an ATP is issued the ATP must be reconciled by the CHP issuing provider within one business day of notification\issuance.

3.3. A NFDR need only be submitted one time if approved for continual use throughout incarceration. However, it may be approved for shorter periods of time, in which case continuation of therapy will be dependent upon re-approval.

3.4. The NFDR shall be initiated by the CHP attending primary care Physician, Dentist, Physician's Assistant, or Nurse Practitioner.

3.4.1. Documentation shall be submitted to fully support the request for the non-formulary medication. Incomplete entries shall be returned for completion before consideration.

3.4.2. NFDR will be submitted and approved prior to the procurement of any medication or other medical item that is managed under the ADCRR CHP Formulary Process. This includes compounded medications prepared for dispensing.

3.5. CHP Practitioner will provide formulary medication for continuity of care, if needed, while the NFDR is being processed.

3.5.1. If a non-formulary medication is an urgent request the process must be expedited and obtained by offsite backup pharmacy until the non-formulary is approved or denied.

3.5.2. Continuity of care must be maintained at all times.

3.6. The CHP shall maintain a file either electronically or in report form of all NFDRs which shall be accessible upon request or consistently to the ADCRR Pharmacy Director and other members of the MSCMB as necessary.

3.7. Compounding

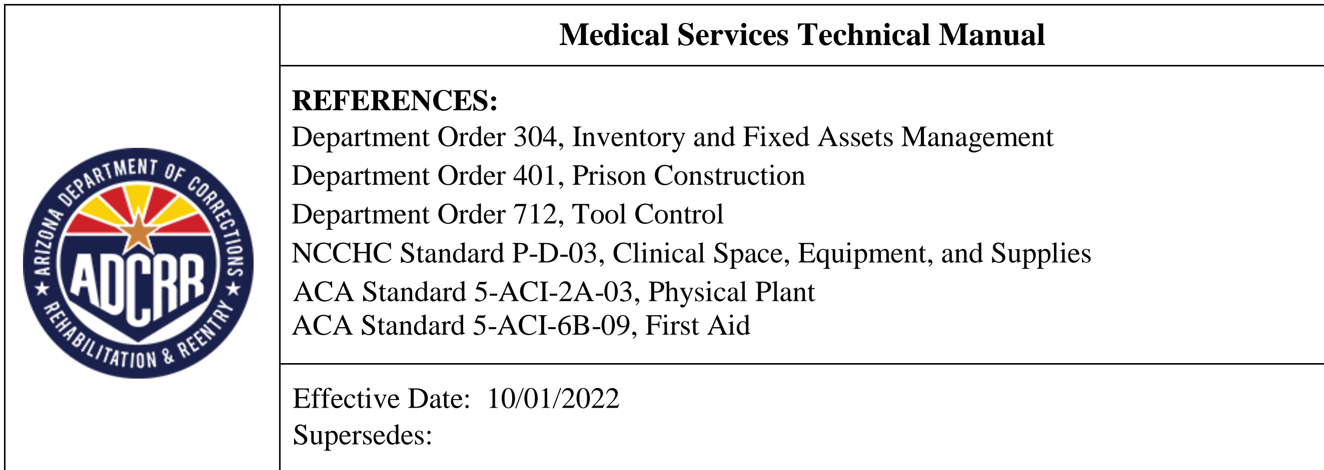
3.7.1. Unit-of-use compounding prescriptions shall only be done on an as ordered basis and will not be bulk compounded or stored.

3.7.1.1. Every attempt shall be made to substitute a commercially available formulary product whenever possible.

3.7.1.2. A compounded drug is NOT a formulary item and must be initiated via a Non-Formulary Drug Request Form.

3.7.1.3. All compounded medications will be accomplished in accordance with professional pharmaceutical arts and training.

3.7.2. All compounding information including drug (or chemicals), manufacturer, lot numbers, expiration dates, amounts, along with a short description of the technique used will be annotated on the back of the prescription as well as the compounding pharmacist's initials.



	Medical Services Technical Manual
	REFERENCES: Department Order 304, Inventory and Fixed Assets Management Department Order 401, Prison Construction Department Order 712, Tool Control NCCHC Standard P-D-03, Clinical Space, Equipment, and Supplies ACA Standard 5-ACI-2A-03, Physical Plant ACA Standard 5-ACI-6B-09, First Aid
	Effective Date: 10/01/2022 Supersedes:

P-D-03.01 Clinical Space, Equipment, and Supplies

PURPOSE: To ensure sufficient and suitable space, supplies, and equipment are available for the facility's medical, dental, and mental health services and provide guidance for administration of assigned and required resources. To provide guidance to the Contract Healthcare Provider (CHP) staff in controlling and documenting usage and inventory of equipment, tools, and supplies.

RESPONSIBILITY: It is the responsibility of the ADCRR CHP staff to manage resources and ensure that all of the equipment, tools, and supplies that are used in the provision of health services are properly accounted for and controlled.

PROCEDURES:

1.0. Clinic Space

1.1. The policies currently in effect under Department Order #401, Prison Construction, provide guidance in construction of health services spaces. Examination and treatment rooms must be large enough to accommodate the necessary equipment, supplies, and fixtures and to permit privacy during clinical encounters. Administrative files, health record storage space, and other clerical areas must be sufficient to provide unhindered healthcare. All ancillary areas must be sufficient to support provision of specialized diagnostic or medical activities. Waiting areas will be sufficiently designed and controlled to provide for adequate seating and access to drinking water and toilets.

1.2. The CHP Facility Health Administrator (FHA) or designee shall conduct periodic security inspections and regular tours through each health unit on his/her complex, and submit a report to the CHP Director of Operations.

1.3. A documented clinic inspection shall be conducted to ensure a clean and sanitary working environment. Areas inspected should include nurse's stations, storage areas, exam rooms, pharmacy/medication rooms, x-rays, lab, health records office, and other administrative clinic office areas. Documentation of results shall be maintained for one year from date of inspection.

2.0. Equipment

2.1. Equipment: The CHP FHA or designee is responsible to ensure that the facility has sufficient equipment, durable supplies, and consumable supplies to provide for examination and treatment of patients.

2.2. Basic equipment for medical services includes but is not limited to:

2.2.1. Computers, monitors, and internet access for documentation;

2.2.2. Hand washing facilities or other approved hand sanitation methods;

2.2.3. Examination tables and/or surfaces;
2.2.4. Adequate direct illumination lighting for clinical examinations;
2.2.5. Access to weight scales, thermometers, blood pressure measurement equipment, and stethoscopes;
2.2.6. Ophthalmoscopes;
2.2.7. Otoscopes;
2.2.8. Oxygen;
2.2.9. Wheeled transportation equipment for patients (i.e., wheelchair, stretcher);
2.2.10. Biohazard identified (i.e., red) material trash containers and puncture resistant sharps containers;
2.2.11. Personal protective equipment (e.g., gloves, eye protection, gowns, masks);
2.2.12. Equipment and supplies for pelvic examinations (female units only);
2.2.13. Automated External Defibrillator (AED)

2.3. Basic equipment for dental services includes but is not limited to:
2.3.1. Hand washing facilities or other approved hand sanitation methods;
2.3.2. Dental examination chairs and a dentist's stool;
2.3.3. Adequate direct illumination lighting for clinical examinations;
2.3.4. Sterilization equipment;
2.3.5. Blood pressure measurement equipment;
2.3.6. Dental electronic, hydraulic, or hand-powered equipment;
2.3.7. Biohazard identified (i.e., red) material trash containers;
2.3.8. Sharps (biohazard, puncture resistant) containers;
2.3.9. Dental care delivery equipment including:
2.3.10. Intraoral x-ray equipment w/developer and
2.3.11. Personal protective equipment
2.3.12. Oxygen

2.4. The Medical Services Contract Monitoring Bureau (MSCMB) Property Manager shall ensure that all inventorial equipment is assigned an ADCRR equipment tag number and shall affix the assigned tag to the appropriate piece of equipment.

2.5. The CHP FHA or designee is the overall property manager for the facility and shall ensure that all inventorial and non-inventorial equipment under their responsibility is accounted for at all times. The CHP FHA or designee may appoint a facility property custodian to assist in accounting for inventorial and non-inventorial equipment. The CHP shall ensure that the annual year-end equipment inventory is completed, signed, and returned in the specified period of time.

2.6. Reporting State Property Losses: The CHP shall contact the ADCRR Property Manager for forms, claim number, and any further reporting requirement instructions.

2.7. Movement of any ADCRR tagged equipment from one assigned location to another is not authorized without a Fixed Asset Transfer, Form 304-3, first being submitted to the ADCRR Complex Compliance Monitor for review and approval by the ADCRR Property Manager.

2.8. All computers which are surplus must have all information data/program removed prior to disposal.

3.0. Supplies

3.1. Health Services Tools

3.1.1. The CHP FHA or designee will identify and designate Health instruments and Sharps in accordance with Department Order #712, Tool Control and in consultation with the Complex Warden.

3.2. Health Services tools, sharps, and instruments are defined to consist of Class "A" (restricted) medical sharps. These include (but are not limited to) the items listed in Department Order #712, Tool Control.

3.3. A Master Tool Inventory report for all non-disposable surgical, dental instruments, devices and hand held tools must be maintained by the CHP FHA or designee.

3.4. Storage: Health Services sharps and tools shall be maintained in a secure area consistent with professional health services practice and in accordance with the appropriate Department Order, Medical Services Technical Manual (MSTM), or Facility Post Order.

3.5. All locking mechanisms used by ADCRR CHP to control access to CHP tools and sharps, must be approved and/or installed by ADCRR locksmiths.

3.6. Tools that are maintained in a location that is under constant observation (i.e.: dental tools placed on a dental tray during treatment and in the presence of dental staff) are accepted as controlled.

3.7. Bulk supplies of needles and disposable syringes should be stored in the area designated by the CHP Facility Health Administrator. These supplies shall be maintained under the supervision of the complex FHA and may be checked out by the CHP Personnel for use as needed.

3.8. Needles and syringes will be procured, received, and stored to assure a sufficient supply for normal clinic operations. Supplies on hand in a clinic will normally be limited to a one-week supply.

3.9. All receipt/issues of syringes/needles to and from the bulk supply inventory shall be maintained in a perpetual inventory log with a current balance.

3.10. Medical Units may requisition needles/syringes through Medical Liaison or designee on an as needed basis, per local policy. The original form shall be maintained for three years by the CHP FHA.

3.11. All needles and syringes issued to the medical units will be logged out of bulk supply and signed for by CHP nursing staff in the receiving medical unit per MSTM guidance.

3.12. The CHP FHA will determine in consultation with the Warden what classes or groups of infrequently used medical sharps/tools may be maintained on shadow board mechanisms.

3.13. Tools that cannot be engraved due to risk of alteration of clinical capability or decreased ability to sterilize will be identified by the FHA in accordance with Department Order #712, Tool Control.

3.14. Disposal and destruction of instruments shall be accomplished and documented in accordance with Department Order #712, Tool Control. Sharps are to be discarded in appropriate sharps containers that prevent puncture and inhibit retrieval from the container. The container shall be labeled to show the nature of its contents.

3.15. Infectious waste and hazardous materials are to be discarded in appropriately labeled containers (i.e., red bags, barrels, biohazard containers etc.) for the safe and efficient removal and destruction of such material.

4.0. Supply & Tool Inventory Control

4.1. The Master Tool Inventory, Form 712-5, shall be maintained by the CHP FHA. The Supervisor from each discipline with sharps and tools shall maintain a copy of their section of the Master Tool Inventory, Form 712-5, for their area of responsibility.

4.2. General Accounting Requirements include:

4.2.1. Tools used within the unit are not to be logged out but are to be returned to the secure location upon procedure completion.

4.2.2. A set of multiple instruments shall note the contents of the set on the outside of the container. The set shall be counted as one set and not the number of individual instruments.

4.2.3. During repair, medical/dental tools shall be removed from the inventory as directed in Department Order #712, Tool Control.

4.2.4. No loose instruments are to be stored in any health facility location; rather, extra instruments should be kept in areas off limits to inmates.

4.2.5. During clean up and sterilization, instruments should be verified by a visual check at the completion of each patient visit.

4.3. Daily Counts: An inventory shall be performed at the beginning and end of each shift that is staffed by CHP personnel. Well before the end of the CHP shift, the responsible staff member shall request (through locally negotiated procedures) a Correctional Officer (CO) to witness the count. If a CO is not available within a reasonable amount of time (i.e., less than 15 minutes), two CHP staff members will perform the inventory. If only one CHP staff member is available and a CO was not able to attend, the CHP staff member will perform the inventory and provide an Information Report (IR) to the FHA documenting the attempt to acquire a CO and the outcome of the inventory. The CHP FHA will share the IR with the appropriate Deputy Warden and develop systems to prevent future single count events.

4.3.1. A Daily Tools Inventory Count sheet(s) including disposable sharps are to be maintained within the clinic, lab, health unit, etc., where instruments are kept.

4.3.1.1. The count sheet must accurately reflect the number and type of instruments kept in the respective drawer, cupboard, etc.

4.3.2. The count will be maintained as a rolling total including all additions, removals, distributions, deletions, and disposals of the identified item.

4.3.3. The staff performing the inventory and one witness will sign the Health Unit End of Shift Summary Count. Each shift should be annotated on each line.

5.0. Month End Counts

5.1. At the end of each month, the CHP unit staff member responsible for the area will forward a copy of the individual Daily Tools Inventory Count to the CHP Supervisor for review and development of the Master Tool Inventory.

5.2. The CHP supervisor or designee of each discipline shall ensure that a Master Tool Inventory report for the prior month is completed and submitted to the CHP FHA no later than the third business day of the month for the immediately preceding month or more often as directed by the FHA.

5.3. The Inventory Control Clerk (IC) shall perform an inventory of all sharps and tools maintained in the clerk's area and submit this report to the CHP FHA no later than the third business day of the month for the immediately preceding month or more often as directed by the CHP FHA.

5.4. The CHP FHA or designee will on a monthly basis, review and collate the Master Tool Inventory and forward a copy to the Complex Chief of Security within the time frame of dates negotiated between the CHP FHA and the complex Warden. The Complex Chief of Security will review and distribute the inventory to the Unit Chiefs of Security. Since the CHP FHA maintains the Master Tool Inventory on a month-by-month basis, the units are not required to retain prior month inventories unless directed by the respective CHP FHA.

6.0. Emergency Response Medical Equipment

6.1. A stock of supplies (to be determined by the CHP Complex DON and site CHP Medical Director and approved for purchase by the CHP) must be created and maintained in a readily accessible area of the unsecure perimeter in an event that access to a yard is lost. The approved listing of stock supplies must take into account the needs of either multiple individual events or single site mass casualties.

6.2. Medical Equipment: All efforts shall be taken by the CHP nurse to retain equipment that is the property of ADCRR. This includes full and halfback boards, wheelchairs, stretchers and any other equipment that may be utilized by emergency transport services. In the event such equipment is taken, the nurse will complete an Incident Report noting the agency that took the equipment, and submit to the CHP FHA designee.

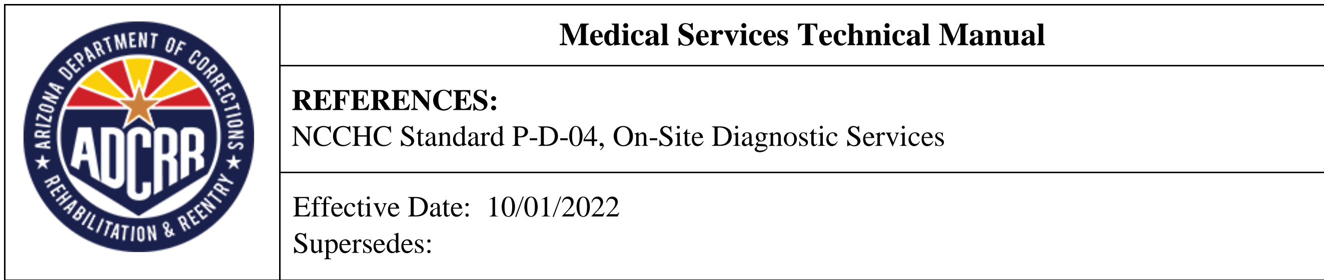
6.3. Automated External Defibrillators (AEDs) shall be maintained and readily accessible to CHP healthcare staff. Daily checks of the equipment shall be done with documentation in the daily log.

6.4. Portable oxygen and mask shall be readily available and accompany CHP staff responding to medical emergencies.

6.5. “Man-Down Bag/Box”: The purpose of the man-down bag/box is to provide immediate first aid to a patient in the field until they can be transferred to the triage room or the Emergency Medical Services (EMS) personal arrive.

6.5.1. MSTM Attachment P-D-03.01A, Man Down Bag Minimum Requirements, outlines the list of minimum requirements. Additional equipment may be added based on the need of the Complex and approval by the MSCMB.

6.5.2. A minimum of monthly inventory of man down bag/box to be conducted reflecting amount(s) of each item/medication on the MSTM Attachment P-D-03.01A, Man Down Bag Minimum Requirements listing.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-D-04, On-Site Diagnostic Services
	Effective Date: 10/01/2022 Supersedes:

P-D-04.01 On-Site Diagnostic Laboratory Procedures

PURPOSE: To provide necessary laboratory procedures to aid in assessment, diagnosis, and/or monitoring a patient's health.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) shall provide on-site diagnostic laboratory services for patient care.

PROCEDURES:

1.0. The CHP Facility Health Administrator (FHA) maintains documentation that on-site diagnostic laboratory services are certified or licensed to provide the service.

2.0. A procedure manual shall be in place for all laboratory services provided.

3.0. Laboratory specimens shall be collected upon receipt of a written or verbal order from a CHP Practitioner, qualified to make an order or upon receipt of a court order.

4.0. Necessary laboratory supplies and courier services shall be identified and provided by the contracted laboratory vendor.

5.0. Venipuncture and specimen collection, performed by authorized CHP health staff, shall be done in accordance with approved medical techniques and standards.
- 5.1. Refer to contract laboratory requirements for specimens that need special patient preparation.

6.0. Specimens shall be labeled, processed, and stored according to the contracted laboratory requirements.
- 6.1. Specimen preparation or storage and handling may require the use of the following equipment:
  - 6.1.1. A refrigerator, used for laboratory specimens ONLY, located in the lab area of each lab draw site and one is to be at the main collection point.
  - 6.1.2. A centrifuge for each lab draw site.
    - 6.1.2.1. Centrifuge calibration maintained by the Contract Vendor laboratory.
    - 6.1.2.2. The centrifuge routine cleaning will be maintained by the Vendor laboratory technician on-site.

7.0. Safety in the Laboratory:
- 7.1. Universal precautions shall be followed.
- 7.2. Personal Protective Equipment (PPE) including but not limited to gloves, protective eyewear, and face shield must be available and used as appropriate.
- 7.3. In case of an exposure to bio-hazardous materials or body fluids the CHP employee must follow the exposure control plan as provided by the CHP Facility Health Administrator or designee

8.0. On-Site Laboratory Testing

8.1. The following test may be performed on-site by CHP Nurse or designee, using the directions provided in the kit:

8.1.1. Blood glucose level by glucometer

8.1.2. Urinalysis by manual dipstick

8.1.3. Hemoccult testing of stool samples

8.1.4. Urine Pregnancy Test (hCG) for females

8.1.5. Urine drug screens when indicated medically

8.1.6. International Normalized Ratio (INR) measurement for warfarin therapy monitoring

8.1.7. COVID antigen tests

8.2. CHP staff shall be trained on utilization of onsite Point-of-Care Testing, with competencies verified at appropriate intervals.

9.0. Off-Site Laboratory Testing

9.1. All general laboratory services are provided by the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Contract Vendor utilizing the full service of a reference laboratory.

9.2. Paternity testing is ordered by a judge, processed by Central Office, and sent to the appropriate facility, where it is collected using guidelines provided with each kit.

10.0. All laboratory test results are to be reviewed by a CHP medical Practitioner/Provider, qualified Mental Health Practitioner, or Dentist.

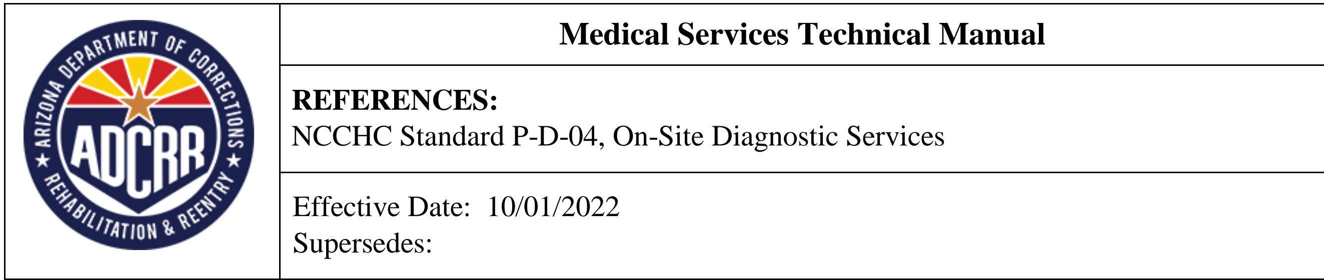
10.1. Abnormal values as outlined by ADCRR Vendor's contracted laboratory are to be reported to the appropriate Practitioner/Provider immediately for review and acted upon within five calendar days.

10.2. Routine test results are received by designated computer(s) or per Electronic Health Record (EHR) and are attached to the patient's health record, for Practitioner/Provider review, signature and disposition.

10.3. A CHP Practitioner shall communicate the results of the diagnostic study to the patient upon request and within seven calendar days of the date of the request.

11.0. Contaminated needles/materials shall be disposed of in appropriate bio-hazardous collection devices.

12.0. The lab work area shall be disinfected regularly and when a contamination occurs using the recommended cleaning agent.



REFERENCES:
NCCHC Standard P-D-04, On-Site Diagnostic Services

Effective Date: 10/01/2022
Supersedes:

P-D-04.02 On-Site Diagnostic Radiologic Imaging Procedure

PURPOSE: To provide ordered radiographic services to aid in assessment, diagnosis, and/or monitoring, as a component of clinical decision making.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) shall ensure that only appropriately trained, licensed, and credentialed CHP staff order and produce radiological studies within confines of the facility.

PROCEDURES:

1.0. The CHP Facility Health Administrator (FHA) maintains documentation that on-site radiology services are certified or licensed to provide that service and a procedure manual in place which includes protocols for the calibration of testing devices to ensure accuracy.

- 1.1. CHP is responsible for medical vendor clearance and to ensure no disruption in services.

2.0. An x-ray unit registration certification, issued by the Arizona Radiation Regulatory Agency (ARRA), must be posted for each machine on the complex.

3.0. Current certification from Arizona Medical Radiologic Technology Board of Examiners for all CHP Radiologic Technologist shall be posted in the work area.

4.0. X-ray Procedures

- 4.1. Radiographic procedures shall be ordered by a CHP Practitioner/Provider or CHP dental care Practitioner/Provider and require patient history and consultation generated by the Provider.
  - 4.1.1 Basic x-ray studies including but not limited to upper and lower extremities, hips, shoulders, bony thorax, pelvis, and head (i.e., sinuses, orbits, facial, mandible, mastoid, skull, TMJs) shall be performed on-site when possible.
  - 4.1.2 Other examinations that may be authorized at designated facilities and performed by a Vendor Radiologist may include the following studies:
    - 4.1.2.1 Esophagus: Barium swallow
    - 4.1.2.2 Stomach: Upper Gastrointestinal Series
    - 4.1.2.3 Small bowel follow-through
    - 4.1.2.4 Colon: Barium Enema.
- 4.2. During the x-ray procedure, the radiologic technologist shall be protected from radiation by standing in the protective designated area or wear appropriate lead protection.
- 4.3. The CHP technologist and dental staff shall wear radiation badges at all times to monitor x-ray exposure.
  - 4.3.1. Radiation badges are collected from all CHP personnel by the Vendor Radiologic Technologist or designee and forwarded by the CHP for processing and analysis with results made available for viewing by the Radiology Department.
  - 4.3.2. Any abnormal results are reported immediately to the individual, the individual's supervisor and the CHP FHA. The individual shall not be allowed to work in areas of possible radiation exposure until specifically authorized by the CHP FHA.

4.4. Reasonable precautions shall be taken to protect the patient in the radiology room. Pregnancy status must be determined prior to performing any radiographic procedure. A pregnant patient may not receive routine x-rays unless the healthcare Practitioner determines the existence of medical necessity.

4.5. Lead shielding including but not limited to lead aprons, gonad shield (used on all patients, male and female of child-bearing age), lead gloves, and thyroid shields are available and shall be used when appropriate.

5.0. Radiograph Interpreting and Reporting

5.1. The Radiologist interpreting and issuing reports must have a current license issued by the State of Arizona, Board of Medical Examiners or the Arizona Board of Osteopathic Examiners in Medicine and Surgery.

5.2. Upon completion of the radiologist review and receipt of the report, the CHP Practitioner/Provider shall review the diagnostic study and act upon any abnormal findings within five calendar days.

5.3. A CHP Practitioner shall communicate the results of the diagnostic study to the patient upon request and within seven calendar days of the date of the request.

6.0. Safety & Maintenance

6.1. Material safety data sheet (MSDS) specific to the processing fluids shall be available in the radiology department.

6.2. The door to the x-ray room must be closed during radiographic procedures to avoid inadvertent entry and radiation exposure.

6.3. A sign stating "Caution Radiation Area" with the three-blade radiation symbol shall be posted at all entrances to the radiology room.

7.0. Equipment Maintenance

7.1. X-ray units shall be calibrated and maintained regularly by Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) CHP Vendor. X-ray unit calibration is verified by the ARRA and posted within the x-ray department.

7.2. Processors maintenance shall be performed regularly by CHP or CHP subcontractor. This shall include:

7.2.1 Equipment cleaning and inspection

7.2.2 Changing of processing fluids

7.2.3 Disposal of processing fluids

7.2.4 Repairs as needed

8.0. Radiograph Storage & Transfers

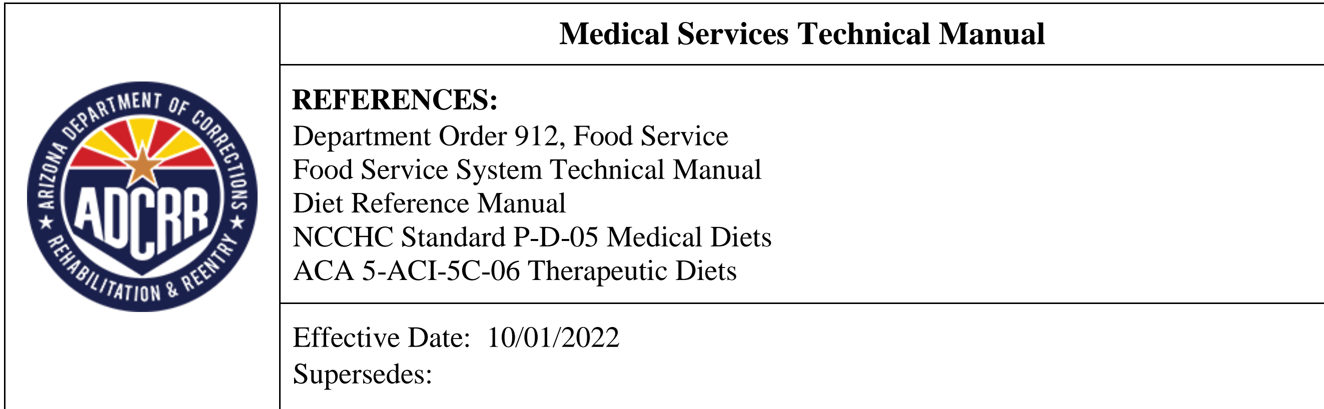
8.1. Active patient radiograph files are stored at the facility complex where the patient resides.

8.2. Facility Transfers: The CHP radiologic technologist is notified when a patient is transferred to another facility. The radiographs are packaged and given to the CHP health records staff or designee to accompany the patient along with the health record as appropriate (if paper records are utilized).

8.3. Consultations: If radiographs are necessary for a consultation (on-site or off-site) with a specialist, the CHP clinical coordinator advises the CHP radiologic technologist who then facilitates the delivery of the films for consultant review.

8.4. Release: The CHP radiologic technologist is notified of release from custody of a patient. Within 30 days following the release, all radiographs are retained at each prison complex for 3 months, processed in IHAS (Inmate Health Appointment System) or an equivalent electronic health record inventory system, then forward to the Contracted Storage Facility where they are retained for 6 years after which the films are destroyed.

8.5. Duplication of X-rays: Duplication of x-rays may be performed by the use of an x-ray copying machine which may be available at some complexes or utilizing a contracted hospital's radiology department.



REFERENCES:
Department Order 912, Food Service
Food Service System Technical Manual
Diet Reference Manual
NCCHC Standard P-D-05 Medical Diets
ACA 5-ACI-5C-06 Therapeutic Diets

Effective Date: 10/01/2022
Supersedes:

P-D-05.01 Medical Diets

PURPOSE: A daily diet, which incorporates the United States Department of Agriculture's (USDA) Recommendations and Dietary Guidelines, is available to all inmates. Inmates whose medical or dental condition requires nutritional adjustment shall be provided with a therapeutic diet according to orders of a prescribing practitioner.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) practitioners to ensure that the nutritional needs of inmates are met. The contracted dietitian is responsible to provide adequate foods to meet current industry standards of provision of nutrition.

PROCEDURES:

1.0. An order for a therapeutic diet must be communicated in writing to dietary staff, include the type of diet, the duration for which it needs to be provided, special instructions if any and be consistent with the therapeutic diets listed in the diet manual.
   - 1.1. Therapeutic diets shall be supported in the health record documentation by the prescribing CHP practitioner including diagnosis and treatment plan.

2.0. When patients refuse prescribed diets for three consecutive days, follow-up nutritional/medical counseling shall be provided by a CHP qualified healthcare professional. Patients who fail to adhere to medical diets are not disciplined, but counseled by CHP staff.

3.0. The clinician's decision to stop medical diets is a therapeutic decision and shall be accomplished in accordance with the Food Service System Technical Manual.
   - 3.1. The manual establishes a process for obtaining restricted medical diets, diet terms and conditions, diet order/diet card issue, and diet order/card revocation.
   - 3.2. The manual also provides requirements regarding a patient's removal from a restricted diet, the medical diet process, and the process for ensuring that patients who are on a restricted diet and who transfer continue to receive the diet at their new location.

4.0. Upon receipt of the CHP Practitioner's order, the health status shall be updated on the Arizona Correctional Information System (ACIS) to reflect the order.

5.0. Food services maintain a diet manual that contains the cyclical centralized menu and therapeutic diet menus. Medical diets conform as closely as possible to the centralized menu. A registered dietitian is notified whenever the medical diet menu is changed and evaluates all menus twice a year for nutritional adequacy.

6.0. Restricted diets shall be evaluated by a registered dietitian at least annually to ensure nutritional adequacy. A review must also take place whenever a substantial change in the menus is made and the review shall be documented by a letter to the ADCRR Medical Director or designee and the CHP Regional Medical Director or designee who shall distribute copies to all CHP Facility Health Administrators (FHA).

7.0. Restricted diets shall be prepared as outlined in the Food Service System Technical Manual and the Diet Reference Manual.

8.0. Food services managers shall ensure that workers who prepare regular and medical diets are trained in preparing the diets, including appropriate substitutions and portions.

9.0. Any medical diets not listed in the Diet Reference Manual may be prescribed on a case by case basis by the CHP Practitioner with the approval of the ADCRR Medical Director (or designee) in collaboration with the ADCRR Registered Dietician.

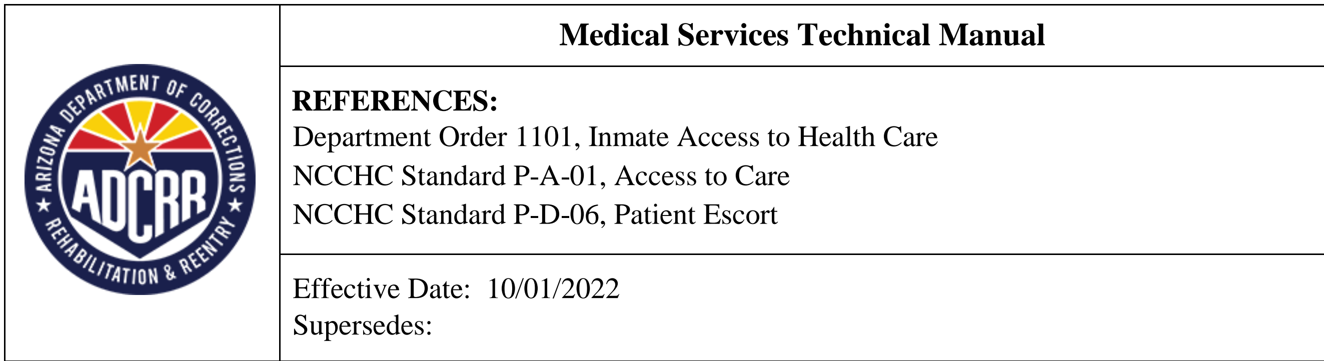
9.1. The following items must be addressed with that request:

9.1.1. Description of the desired diet, identification of the diagnosis that supports such a diet order. Include the negative impact seen as a result of lack of the special diet.

9.1.2. Describe all pertinent treatments to date provided to ameliorate the apparent negative impact of the current diet.

9.1.3. Document that a discussion was held with the patient regarding his diagnosis and that the patient understands the need for compliance with the requested diet.

9.1.4. Provide any specialist or consultative documents that support the recommendation.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
NCCHC Standard P-A-01, Access to Care
NCCHC Standard P-D-06, Patient Escort

Effective Date: 10/01/2022
Supersedes:

P-D-06.01 Patient Escort Onsite

PURPOSE: To provide Contract Healthcare Provider (CHP) information regarding the onsite patient escort process and to assure that patients have unimpeded access to healthcare services and visits irrespective of their housing location, temporary placement, and/or security classification.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) to monitor and respond to any potential impediments of the patient's access to care. This includes immediate notification to the Warden (or designee) to arrange time appropriate health services based on patients need. It is the responsibility of the FHA to ensure that all clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of health services.

PROCEDURE: The procedure of turning patients out (releasing from housing unit) to medical appointments may vary depending upon the classification of the patient, the level of custody on any given yard and/or whether or not the yard has open circulation versus controlled movement of inmates. In lockdown areas the traditional definition of escorting a patient may apply. Alternatively, some medical services may be delivered in satellite locations closer to the patient's housing unit. It is the responsibility of all CHP health staff to comply with this policy and report all potential or observed barriers to patient access to healthcare to the FHA.

1.0. On-Site Open Yard Escorting
  - 1.1. Movement on an Open Yard can take the form of unescorted movement, group movement (such as to the Chow Hall, or insulin medication turnout) up to a more restricted controlled movement. Healthcare movement whenever possible is prescheduled.
  - 1.2. Yards with closed or supervised movement only will have a security officer accompany the patient from their housing location, (or other location if they happen to be working or in school, etc.) to the health unit for their appointment. The patient will be turned over to the Security Officer working in the health unit.
  - 1.3. Security will provide escorts for emergency "add-ons" to the Appointment Lists for such things as urgent dental care, special lab/blood draws, urgent medical follow up due to new medical diagnostic information requiring immediate attention, etc. These types of turnouts would be requested by CHP personnel following the original submission of the appointment lists on the prior day.

1.4. If a patient feels the medical need for an unscheduled appointment/visit to medical his request will be reviewed by the Shift Commander on the respective yard (in accordance with Department Order #1101, Inmate Access to Healthcare), who will discuss with CHP medical personnel the circumstances, issues and symptoms of the patient making the request in order to determine the disposition of the patient (i.e., "bring the patient to medical on an emergency basis" or "have the patient submit an Health Needs Request (HNR)) to be triaged with other requesting patients in the routine manner.

2.0. On-Site Closed Yard/Lockdown Escorting

2.1. In lockdown areas such as Complex Detention Unit's (CDU) the patient is escorted by an officer to the health unit for medical attention. Patients will be restrained according to the risk assigned by Security as they are escorted to the health unit and while in the health unit. At the CHP Practitioner's request, alternate methods of restraint may be arranged with security to permit the physical examination of the inmate and/or testing. In all cases staff safety will be a major consideration.

2.2. Multiple disciplines may have appointment turnouts at the same time. CHP staff will work with security to minimize the number of escorts required on any given day by coordinating the variety of turnout requests to avoid conflicting scheduling as reasonably possible. The provision of an appropriate number of escorts to provide patient access to health services is the responsibility of security and the Warden or designee over all shifts when patients need to be seen.

2.3. Health services (i.e., administering PPD's, insulin injections and glucose monitoring, delivery and administration of Direct Observe Therapy (DOT) medications, pre-scheduled injections, and delivery of Keep On Person (KOP) medications and personal eyeglasses) may be delivered in satellite locations from the main health unit in lockdown areas. In these situations, security will provide an escort of the patients from their individual cells to the satellite treatment area that provides a measure of security, medical confidentiality and convenience for both health and security personnel.

3.0. Telemedicine Services

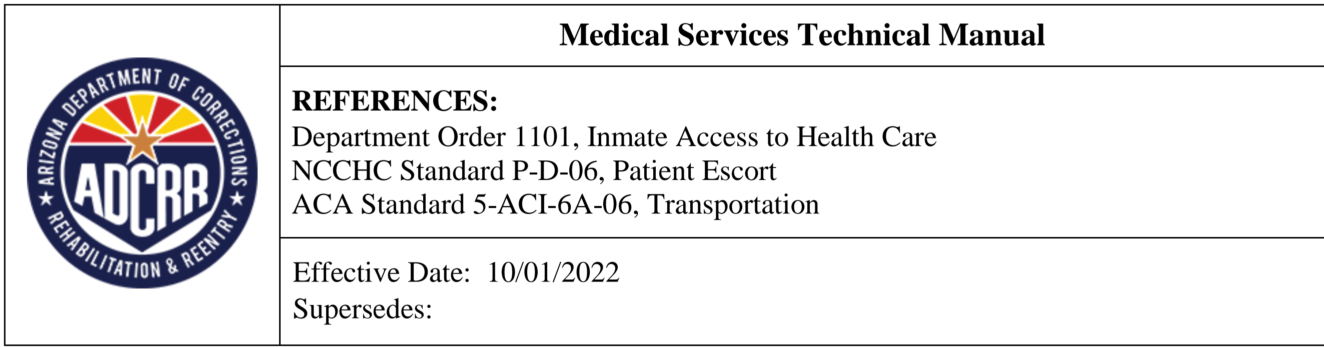
3.1. The CHP shall provide Telemedicine Services on all complexes, as appropriate as medically indicated.

3.2. Telemedicine Services are prescheduled by medical specialty each month and need to occur on a timely basis as the complexes are scheduled in a predetermined rotation.

3.3. Security will provide escorts and transportation from the various yards and housing locations to the health services unit and will maintain escort supervision over the patient during the telemedicine appointments.

3.4. Telemedicine Services will be pre-scheduled similar to offsite medical appointments to allow Security optimum notice to plan for escorting the patients to their appointments. It is up to Security to determine the staffing and assignment of Officers to do the escorting of patients from the various housing locations and how to provide continuous escort supervision during the appointment.

3.5. Telemedicine appointments will not be canceled due to a lack of escorts, but will be referred to the appropriate Deputy Warden and/or Warden, if necessary, to assist in providing adequate escort personnel.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-D-06, Patient Escort ACA Standard 5-ACI-6A-06, Transportation
	Effective Date: 10/01/2022 Supersedes:

P-D-06.02 Patient Escort Offsite

PURPOSE: To assure that inmates have unimpeded access to healthcare services and visits irrespective of their housing location, temporary placement, and/or security classification.

RESPONSIBILITY: The Contract Healthcare Provider Facility Health Administrator (FHA) and the Warden shall operationalize processes to ensure continuity of care takes place while the patient is transported to offsite health services.

PROCEDURES:

1.0. Security staff shall provide support and transfer patients safely and in a timely manner for medical, dental, and mental health clinic appointments both inside and outside the facility.

2.0. Escort officers for offsite appointments are responsible for maintaining confidentiality, transporting confidential health record information and securing any medications that may be involved during the day or upon discharge from the hospital and/or the patient's appointment.

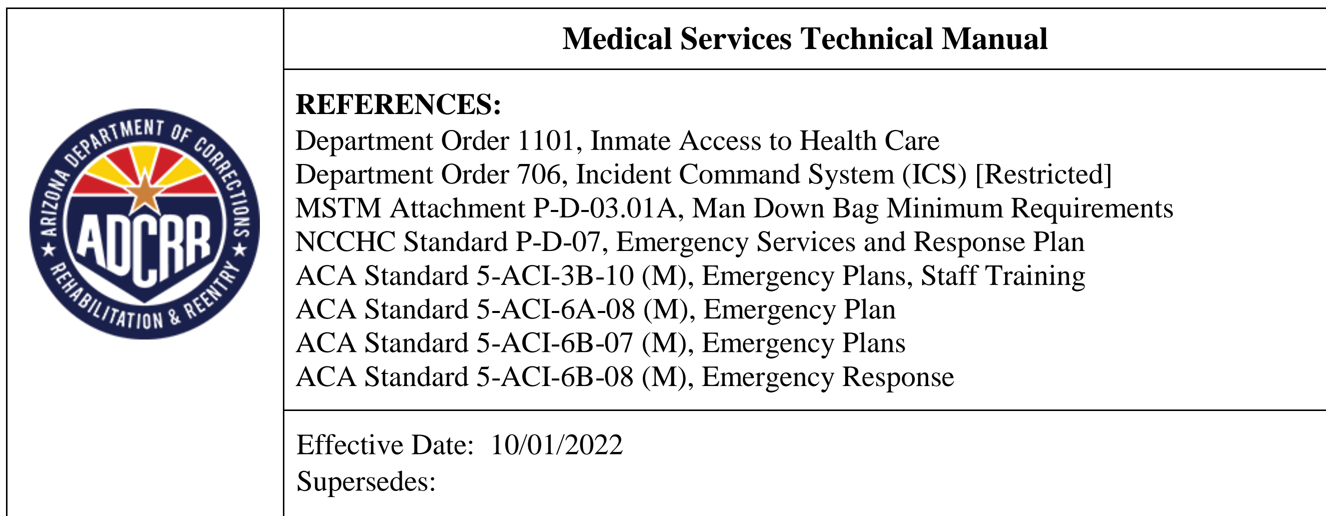
3.0. Upon return to the complex, escorting officers shall bring the patient into the designated complex health unit for review of the medical information, assessment of the patient, and determination of any additional medications and/or interventions that area required for the patient.

4.0. Patient with special needs (e.g., diabetes, wheelchair) shall have needs met through communication between the CHP Clinical Coordinator or medical staff designee and the Operations Transportation Group.

5.0. State-wide non-medically directed transportation of patients: When the medical unit is informed that a patients is scheduled for travel from their current complex (due to non-medical reasons such as transfer, court date, security interview, etc.) the transportation team must be informed of the patient's known dietary or special travel (i.e., wheelchair) requirements during his/her offsite travels.

6.0. Statewide medically directed transportation of patients: The CHP Offsite Consultation Request form, or an electronic equivalent, is the primary document that directs the need for offsite special medical care that is not available on complex or at a local unit. Therefore, this document, or an equivalent electronic version, shall note all special needs of the patient.

7.0. The sending complex transportation Supervisor shall ensure the necessary accommodations and meals are provided to patients as specified in accordance with the CHP Clinical Coordinator's orders and current transportation policy. The sending Supervisor shall ensure that these orders are transmitted to the transportation hub staff.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care Department Order 706, Incident Command System (ICS) [Restricted] MSTM Attachment P-D-03.01A, Man Down Bag Minimum Requirements NCCHC Standard P-D-07, Emergency Services and Response Plan ACA Standard 5-ACI-3B-10 (M), Emergency Plans, Staff Training ACA Standard 5-ACI-6A-08 (M), Emergency Plan ACA Standard 5-ACI-6B-07 (M), Emergency Plans ACA Standard 5-ACI-6B-08 (M), Emergency Response
	Effective Date: 10/01/2022 Supersedes:

P-D-07.01 Emergency Services and Response Plan

PURPOSE: To establish and plan for the Contract Healthcare Provider (CHP) response during emergencies. To identify roles and responsibilities of CHP staff during urgent or emergent situations.

RESPONSIBILITY: It is the responsibility of the CHP to establish a written emergency response plan, create and provide a current on-call/urgent notification list, and participate in regularly scheduled mass disaster and man down drills with follow-up critique.

PROCEDURES:

1.0. Emergency Services

- 1.1. The facility provides 24-hour emergency medical, dental, and mental health services.
- 1.2. The CHP staff must respond to medical emergencies involving security staff and visitors. The emergency support provided by CHP staff may include such things as advice in contacting emergency first responders; application of basic first aid and CPR while waiting for emergency response personnel to arrive; or serving as on-scene medical managers of acute situations.
- 1.3. Each ADCRR prison complex shall, in collaboration with CHP FHA and ADCRR complex Warden identify personnel responsible to respond to medical emergencies. If the arrival of CHP medical staff is delayed, security staff may contact 911 directly to ensure vital health services necessary for the preservation of life is maintained.
- 1.4. Emergency Supplies: At least one "man-down" bag shall be kept in a readily accessible area, to be used in the event of the activation of the incident command system (ICS). The contents of the "man-down" bag shall be monitored routinely in accordance with MSTM Attachment P-D-03.01A, Man Down Bag Minimum Requirements.
- 1.5. Medication Administration in a Disturbance. The CHP FHA or designee shall develop a local response for each incident with the input of the site CHP Medical Director, CHP DON, and other supporting personnel as needed. The plan must include the following elements:
  - 1.5.1. Methods for identification of patients in varying need of medications or treatment.
  - 1.5.2. Methods of delivery of medication and treatment in highly controlled or unsecured areas.
  - 1.5.3. Coordination of communication under ICS restrictions.
  - 1.5.4. Methods of control and monitoring of staff safety.
  - 1.5.5. Personnel relief plans should the ICS overlap shifts.

1.6. Individual emergencies: It is the standard of the ADCRR to assess and render aid to all medical emergencies, including suicide attempts, within THREE MINUTES of becoming aware of a non-responsive patient or a patients in medical crisis. In the event that a patient is found non-responsive, in a state of medical emergency, or in the act of attempting suicide, staff shall assess the situation and render aid within three minutes of becoming aware. In the instance where a patient is secured in a cell, a minimum of two staff (including non-security staff) may access a cell to respond and initiate aid. Where a patient is in a single cell, one staff member may access the cell to respond and initiate aid. Assembling a team to remove a patient from a cell is not required. It is not required that a supervisor be present prior to cell access or before initiating aid to a patient.

1.7. For all emergency responses, staff shall assess the situation and proceed as follows within the THREE MINUTE time frame:

1.7.1. Activate Incident Command System (ICS) to notify supervisory staff and medical responders as required.

1.7.2. All CHP staff shall assess scene safety before entering an area to provide treatment or triage.

1.7.3. In the case of a non-responsive patient, issue two loud orders for the patient to respond.

1.7.4. Conduct a visual sweep of the area to determine that no weapons are present or accessible.

1.7.5. If a patient's hands cannot be seen and he/she is non-responsive, an immediate judgment must be made by a first responder to determine whether the patient's condition outweighs the potential risk involved in entering the cell/living area.

1.7.6. Remove other inmates from the cell/living area.

1.7.7. While ideally all situations of this type should be videotaped whenever possible, the availability or arrival of a video camera should never delay entry into a cell/living area or the initiation of aid to a patient.

1.7.8. The CHP Nurse coordinating off-site emergency transfers will assure that the unit shift commander is immediately informed of the emergency so that security escort staff can be assigned.

1.8. Process for ICS involving multiple events simultaneously:

1.8.1. Triage: The Logistics Section Leader will determine where triage will occur. When possible, staff members shall be triaged in separate areas from patients. The Primary Triage Officer is the person with the most appropriate healthcare skill and experience on the scene. The Primary Triage Officer is subject to change as more experienced medical personnel arrive on the scene. Upon changing Primary Triage Officers, a status briefing shall be given by the initial triage officer to the new person assuming this responsibility. Triage tags shall be used to triage victims of an emergency. The triage tags need to identify treatment and transportation needs of victims based on a four level classification scheme such as the following:

1.8.1.1. Priority 1: Patients needing immediate care that have a high likelihood of survival. Examples include patients with airway obstruction and early signs of hemorrhagic shock.

1.8.1.2. Priority 2: Patients whose transport and treatment can be delayed for a few hours. Examples include patients with fractures or sprains and soft tissue injuries.

1.8.1.3. Priority 3: Patients whose injuries do not threaten life or functions.

1.8.1.4. Priority 0: Patients who are dead or whose injuries are so severe that prognosis is poor.

1.9. The following guidelines can be used to triage victims:

1.9.1. Treatment Location: When possible, treatment areas should be kept separate from triage areas. Separate treatment areas will be established for injured patients and staff. A log shall be kept indicating disposition of victims in an emergency. A separate form is to be used for staff and for patients. The Logistics Section Leader is responsible to determine who will accompany patients transferred to off-site medical resources.

1.9.2. Management of Fatalities: Deceased victims shall be removed from triage or treatment areas and placed in a holding area determined by the Logistics Section Leader. If possible, separate holding areas should be established for staff and patient bodies.

2.0. Emergency Response Plan

2.1. The CHP FHA shall maintain an up-to-date emergency phone numbers list to include physicians, dentists, and mental health providers and distribute this phone list to their supervisory staff.

2.2. The CHP FHA or designee shall be notified of the activation of an ICS by the CHP medical staff onsite. The CHP FHA or designee must be available by cell phone at all times in case of an emergency.

2.3. During an ICS, CHP staff fall under the administrative coordination of the Logistics Section of the ICS Control organization. This group is called OPAL (Operations, Planning, Administration, and Logistics).

2.4. Any ICS response requires notification of the CHP Regional Leadership or designee by the CHP FHA or designee.

2.5. Urgent Notifications

2.5.1. Urgent Notification List (UNL): The UNL shall be created, published, and provided by the CHP FHA and must include CHP Medical, Dental, Nursing and Mental Health staff.

2.5.2. UNL Development Process: The UNL will identify both a Primary and a Secondary staff member responsible for coverage of assigned complexes and shall include current contact numbers including cell number, home phone number.

2.5.2.1. The UNL will include contact numbers for the site CHP Medical Director, CHP FHA, CHP Mental Health Director, CHP DON, CHP Dental Director, CHP Pharmacy Director, CHP Regional Leadership or designee, and CHP Director of Operations.

2.5.3. The UNL will identify the dates that each staff member is providing coverage.

2.5.3.1. Coverage will be identified for each calendar month.

2.5.3.2. The UNL will be provided to all CHP staff.

2.5.3.3. Any changes to a published UNL will require notification to all CHP staff to prevent any lapse in coverage.

2.5.3.4. Calls to CHP UNL staff members are to be documented in the health record for any patient indicating the time the call was placed, and the time of the response.

2.6. Emergency Transportation

2.6.1. Emergency Medical Transportation Services may be provided either ground-transport ambulance or air ambulance.

2.6.2. If a medical emergency is considered life threatening, 911 should be immediately contacted.

2.6.3. After hours, CHP nursing personnel shall immediately ask that 911 be called if an emergency medical condition is determined to be life threatening.

2.6.3.1. If the medical emergency is not immediately life threatening, the CHP Nurse shall contact the CHP Provider on call in accordance with local policies and procedures.

2.6.4. Security shall provide the required number of escorts for all send outs. Escorts will be identified by security as quickly as possible to avoid any delay in the initiation of the offsite emergency send out. The CHP Nurse will continually monitor and attend to the needs of the patient in an emergency until patient departs.

2.6.5. Any change to type of transport or destination by CHP staff or by the accepting EMS responders shall be communicated to the chase vehicle officer who will advise the sending complex of the altered change in plans. This could also involve an upgrade to a helicopter transport if the patient's condition becomes more critical.

2.6.6. The CHP Nurse shall immediately notify CHP FHA if emergency medical personnel (fire or paramedics) determine that a patient must be flown by air ambulance to a destination hospital or the patient expires after off-site medical transportation is initiated.

2.6.7. Any significant delay in the transportation of an emergency send out will be reported to the complex Warden for follow up and review.

2.6.8. After hours, following the departure of a patient by emergency medical transportation, the CHP nurse will contact the CHP FHA or designee by approved local process.

2.6.9. CHP Nurse shall notify the CHP Clinical Coordinator and CHP DON by approved local process.

2.7. Emergency Health Record Package

2.7.1. Specific portions of the health records must be transported with a patient when emergency transportation is utilized. The following will be packaged:

2.7.1.1. Transfer Summary Continuity of Care (1101-8P)

2.7.1.2. Request for Medical Records (1104-1)

2.7.1.3. Outside Consult Request (1101-63P)

2.7.1.4. Declaration of Intent to Limit Life-Support Procedures-copy, if established (1101-9P)

2.7.1.5. For pregnant patients, copies of the Pregnancy Packet

3.0. Mass Disaster and Health Emergency Drills

3.1. Wardens and CHP staff are expected to coordinate emergency response exercise scenarios that require emergency response within the time frame and response described in ADCRR Directives into existing emergency exercise plans. Post orders must reflect procedures to support the three-minute response required and to reduce the response time of CHP staff to the minimum time possible.

3.2. Simulations and Plan Evaluation: The Emergency Plan developed in coordination with the Warden must be practiced, documented and critiqued at least annually by security and CHP staff.

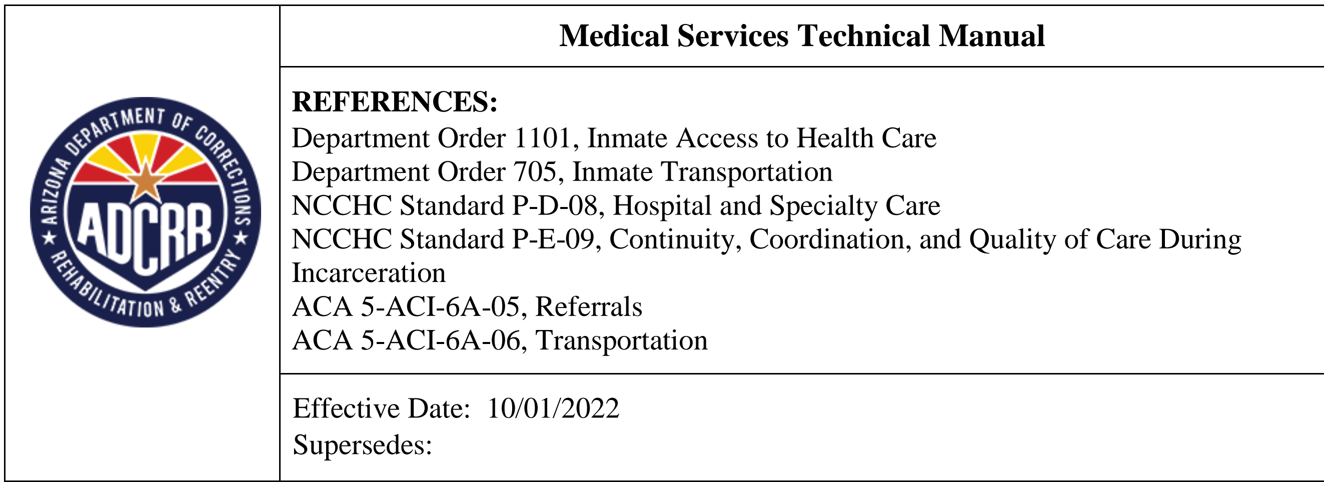
3.3. Wardens and CHP FHA shall conduct exercises and drills that test staff response time to emergent situations.

3.3.1. “Man-Down” drills must simulate an emergency affecting one individual and must be practiced once per year per shift on each unit where medical staff is regularly assigned.

3.3.2. “Mass disaster” drills, affecting more than one individual must involve staff on all shifts and must be practiced so that over a 3-year period each shift has participated.

3.3.3. Prior to any drill/simulation, the CHP FHA shall appoint 1-3 people to serve as evaluators of the ICS simulation. One evaluator shall be a representative from Prison Operations. The evaluators are to fill out the ICS critique and submit it to the CHP FHA. The results of the critique shall be shared with involved CHP staff and incorporated into future ICS training sessions. The FHA will forward a copy of the critique to the CHP Regional leadership or designee and ADCRR Complex Compliance Monitor.

3.3.4. For actual ICS critiques, the FHA or designee shall complete the ICS critique within five business days with a copy of this critique provided to the CHP Regional Leadership or designee and ADCRR Complex Compliance Monitor by the end of the fifth business day. The Continuous Quality Improvement Committee (CQI) must review the written evaluation at the next meeting.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
Department Order 705, Inmate Transportation
NCCHC Standard P-D-08, Hospital and Specialty Care
NCCHC Standard P-E-09, Continuity, Coordination, and Quality of Care During Incarceration
ACA 5-ACI-6A-05, Referrals
ACA 5-ACI-6A-06, Transportation

Effective Date: 10/01/2022
Supersedes:

P-D-08.01 Hospital and Specialty Care

PURPOSE: To provide access to hospital services and specialty care as necessary or medically ordered as part of the patient's treatment plan.

RESPONSIBILITY: It is the responsibility of the CHP Facility Health Administrator (FHA) to develop and implement processes for management of specialty care and to be aware of local and regional options available in the community to accept continued medical care of all patients.

PROCEDURES:

1.0. Specialty Care and Clinics

- 1.1. The CHP FHA or designee in conjunction with the CHP Practitioner shall ensure that all requests for specialty medical services submitted are accurate and complete.
  - 1.1.1. The CHP FHA neither approves nor denies any requests for medical services.
- 1.2. The Clinical Coordinator (CC) shall serve as the facilitator and utilize a system that tracks and monitors requests for specialty care both on and offsite.
- 1.3. All consult requests are entered into a database by the CHP CC.
  - 1.3.1. The CHP CC is shall ensure all pertinent information regarding the patients' health need is communicated with Utilization Management (UM) and the outside entity upon referral for care to facilitate timely approval and scheduling.
  - 1.3.2. Any consult or referral for care with a recommended Alternative Treatment Plan (ATP) made by UM shall be communicated in writing to CHP Practitioner requesting consult within 14 calendar days.
  - 1.3.3. The CHP CC will follow up with the CHP UM approving authority on any outstanding consultation requests that remain in a "pending approval" status after five business days.
  - 1.3.4. At the time of approval of a specialty consult, a case appropriate "medical hold" will be placed on the Arizona Correctional Information System (ACIS) system in accordance with Medical Services Technical Manual (MSTM) guidance and complex procedures to guarantee that the patient is not moved to another facility prior to the consultation appointment.
  - 1.3.5. Urgent specialty consultations and urgent specialty diagnostic services, shall be scheduled and completed within 30 calendar days of the consultation request from the CHP Practitioner.
  - 1.3.6. Routine specialty consultations shall be scheduled and completed within 60 calendar days of the consultation request from the CHP Practitioner.

1.3.7. For routine specialty care/request for follow up outside of the 60 day timeframe the CHP CC shall generate a Provider appointment in the electronic health record to ensure the CHP Provider is reminded to place a consult request for the routine specialty care.

1.3.8. Documentation of consult approval(s) or denial(s) including reasons for denial for specialty consultations shall be sent to the requesting Practitioner in writing within 14 calendar days and documented in the health record.

1.3.8.1. A patient for whom a CHP Practitioner's request for specialty services is denied shall be told of the denial by CHP Practitioner at the patient's next scheduled appointment, or no more than 30 days after the denial has been received with CHP Practitioner follow-up to the denial.

1.3.9. The CHP CC shall make appropriate documentation in the health record of scheduled, rescheduled, and completed consults noting reasons for postponements if any.

1.3.10. The CC is responsible for all travel arrangements and appropriate documentation preparation to accompany the patient for any consultations.

1.4. The CHP CC shall maintain required statistical reports as defined in the Contract and provide to Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) Medical Services Contract Monitoring Bureau (MSCMB).

1.5. Upon completion of any offsite specialty care appointment the patient shall be evaluated by CHP medical staff prior to returning to their housing location. The CHP nurse completing the evaluation shall note the date the patient was seen, complete an assessment and forward any accompanying health records received to the CHP provider and CHP CC for review.

1.6. Military veterans shall be provided care by ADCRR Contracted Healthcare Provider and shall not be referred out to Veterans Administration (VA) Hospitals or clinics for medical care.

1.6.1. The VA Representatives may be authorized, (with the appropriate security clearance); to provide on-site benefits evaluation or delegate such benefits evaluations to the ADCRR Contracted Healthcare Provider.

1.7. Interstate Compacts: The CHP FHA, CHP health record staff, and CHP CC shall jointly be monitoring the existence of interstate compact inmates within their complex. In the event that a costly medical procedure becomes necessary, the sending state should be consulted ahead of the appointment. The CHP FHA in conjunction with the Interstate Compact Administrator in Phoenix, Central Office shall facilitate this consultation.

2.0. Hospitalization

2.1. ADCRR CHP shall coordinate the development and maintenance of written contracts for hospitalization of patients beyond the confines of the prison complexes. The contract documents will specify the agreed upon reimbursement arrangements and billing practices.

2.1.1. Copies of contracts detailing local arrangements shall be provided to the ADCRR Assistant Director for Medical Services.

2.2. Responsibility for medical care will be transferred to the Medical Practitioners licensed to practice medicine in the state and credentialed in good standing by the contracted hospitals.

2.2.1. The CHP is responsible to brief the Assistant Director for Medical Services or designee, ADCRR Medical Director, and MSCMB Program Evaluation Administrator on issues of impending death, unusual medical complications, end of life treatment issues, and public or high profile cases.

2.2.2. Hospital admissions may occur from pre-scheduled surgeries or procedures, from the emergency department, and/or from immediate admission/referral from a consulting Physician/Licensed Practitioner of the patient who may have been seen as an outpatient visit on a particular day.

2.2.2.1. Direct Admission to the hospital may also be made in an urgent situation by the CHP Practitioner/Provider on the prison complex working directly with the hospital-based Specialist to admit the patient under the care of the Specialist directly to the hospital, thereby, circumventing a clinically unnecessary stop in the Emergency Department.

2.2.2.2. Emergent admissions may be made by transporting the patient to the Emergency Department of the receiving hospital where the patient will be examined, treated, and triaged for admission to the hospital, as medically necessary.

2.2.2.3. For pre-scheduled admissions the CHP Practitioner shall, in language the patient can understand, explain the hospitalization, procedure, test, treatment, etc., to include: the nature and purpose of the referral; the risks/side effects and benefits; alternative methods/options that were or can be considered with this discussion documented on the consent form signed by the patient. This onsite consent is done in addition to the informed consent obtained by the specialist or hospital.

2.2.3. As a general rule, patients will not be transported off-complex to outside hospitals without the acknowledgment and/or direction of a CHP medical Practitioner employed by ADCRR CHP. The CHP FHA or designee shall be notified of any "send outs" to the hospital or emergency facilities. During a medical emergency the FHA, in consultation with the nursing staff, may authorize a medically-related transport to the hospital if a continued delay in waiting for an after-hours response from the Practitioner may negatively impact the appropriate care of the patient.

2.2.3.1. CHP nursing staff shall prepare and send pertinent recent progress notes, a list (or printout) of the patient's current medications and a Continuity of Care/Transfer Summary (Form 1101-8) for significant other medical issues if indicated.

2.2.3.2. The CHP FHA, or designee, shall provide notification to the appropriate individual(s) of any non-scheduled transports for medical care in accordance with ADCRR security / CHP local communications policies.

2.2.3.3. In emergency situations, the CHP Practitioner (or attending CHP Nurse) shall contact the receiving hospital facility to advise of the impending transfer.

2.2.4. CHP UM staff shall monitor the inpatient care of the patient and will determine authorization of any additional procedures that the hospital and/or specialist may propose following admission.

2.2.4.1. Daily ED/Inpatient reports shall be provided by the CHP to the MSCMB.

2.2.5. Following the initial notification provided by the complex chaplain, the CHP FHA or designee shall continue to respond to requests and inquiries from the patient's designated emergency contact in accordance with current release of information form(s) on file.

2.3. Return to the Prison Complex

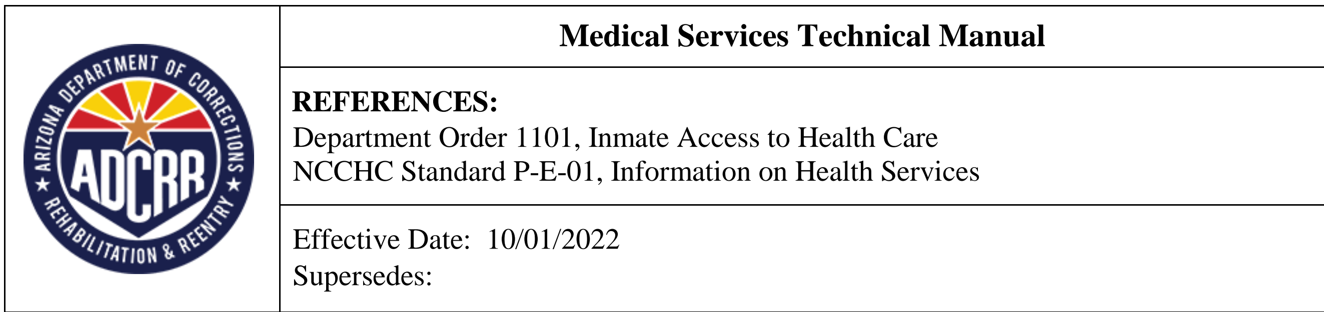
2.3.1. Discharge planning and the return of the patient to the prison facility shall be coordinated by the CHP Utilization Review staff, the hospital, and the receiving facility. Additional medical needs following discharge may determine alternate placement in an in-patient component (IPC/infirmary) or special needs bed.

2.3.2. Security shall bring the patient directly to the health unit of the patient's assigned housing yard upon return. The CHP nurse shall assess the patient upon return to identify recommendations made by the hospital and/or any continuity of care issues.

2.3.2.1. Patients returning after regular health services clinic hours shall be taken directly to the facility's identified health unit for evaluation and review of discharge paperwork.

2.3.3. Patients returning from a hospitalization or ER transport with discharge recommendations from the hospital shall have the hospital treatment recommendations reviewed and acted upon within 24 hours.

2.3.4. Patients returning from a hospitalization or ER transport shall be scheduled for and receive a face-to-face CHP Provider appointment the next day a CHP provider is on-site.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
NCCHC Standard P-E-01, Information on Health Services

Effective Date: 10/01/2022
Supersedes:

P-E-01.01 Information on Health Services

PURPOSE: To ensure that upon arrival all inmates are informed of the availability of healthcare services and how to access them.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to advise inmates in a way they understand that healthcare services are available and how to access them.

PROCEDURES:

1.0. Inmates shall be notified on how to access healthcare.

- 1.1. Reception Centers shall provide every inmate information on how to access healthcare in a format or manner they understand within 24 hours of their arrival.
  - 1.1.1. CHP shall ensure procedures are in place for patients who have difficulty communicating (e.g., non-English speaking, intellectually or developmentally disabled, illiterate, mentally ill, visually impaired, deaf) and provide education on how to access health services, which shall include:
    - 1.1.1.1. How to access emergency and routine medical, dental, and mental health services
    - 1.1.1.2. The fee-for-service program, if one exists
    - 1.1.1.3. The grievance process for health-related complaints
- 1.2. Each prison complex will:
  - 1.2.1. Upon transfer of a patient from another complex, the receiving complex shall provide the patient an orientation packet which contains information on how to access healthcare and is in a format the inmate is able to understand. Any printed handouts or orientation packets shall be available in English and Spanish.

2.0. Access to Healthcare Signs:

- 2.1. Ensure the approved signs are posted in the Intake/Processing area and throughout the complex. At a minimum, signs shall be posted at intake and on yard bulletin boards. Where possible, post signs in housing areas.
- 2.2. Approved sign located in Medical Services Technical Manual Attachment P-E-01.01A, Preventive Health Services and Screenings.
- 2.3. Ensure all signs are available in Spanish and English.

3.0. Charges:

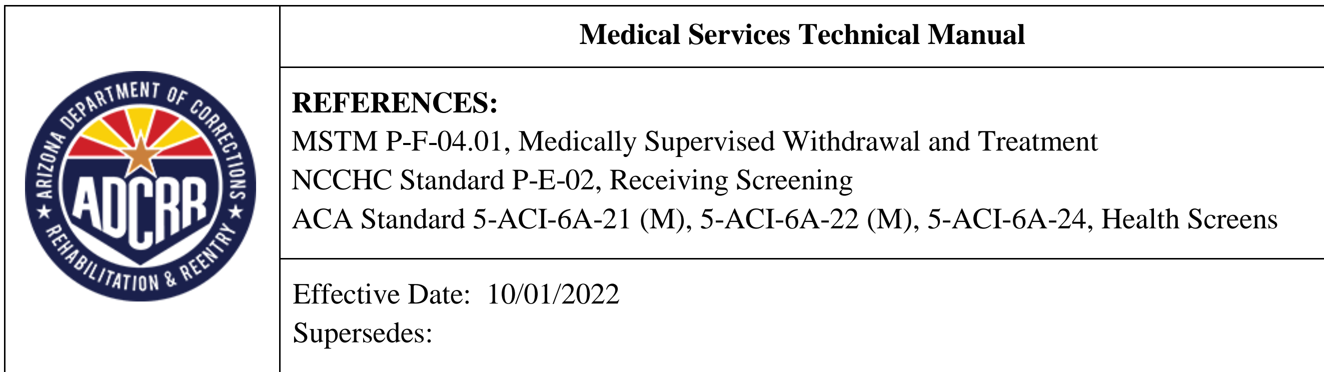
- 3.1. Patients may be charged $4.00 co-pay for their healthcare visit in accordance with Department Order #1101, Inmate Access to Healthcare.
- 3.2. Every patient may be charged a reasonable medical and health services fee for each medical visit an inmate makes pursuant to a health needs request form or for emergency treatment. Exceptions are noted in Department Order #1101, Inmate Access to Healthcare.
- 3.3. No patient shall be denied care due to being indigent. He/she will be seen by CHP staff.

3.4. CHP Nursing staff shall complete an Appointment List, Form 1101-13P or an electronic equivalent prior to the visit.

3.4.1. At the time of visit the charge status will be indicated and the patient must sign before being seen for treatment.

3.5. The completed original of the appointment list will be submitted to the complex Business Office within 72 hours of completion of the health services appointment and the copy retained on the health unit for 1 year.

3.5.1. Should an inmate dispute any charge he/she can have it reviewed by submitting an Inmate Letter, Form 916-1, to the CHP FHA.



Medical Services Technical Manual

REFERENCES:
MSTM P-F-04.01, Medically Supervised Withdrawal and Treatment
NCCHC Standard P-E-02, Receiving Screening
ACA Standard 5-ACI-6A-21 (M), 5-ACI-6A-22 (M), 5-ACI-6A-24, Health Screens

Effective Date: 10/01/2022
Supersedes:

P-E-02.01 Receiving Screening

PURPOSE: To provide guidance on the receiving screening process for all incoming inmates to identify healthcare need and where applicable, provide continuity of care.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure all arriving inmates are screened for the presence of emergent, urgent, and ongoing health needs on arrival.

PROCEDURE:

1.0. Receiving Screening at a Reception Center (Intake Facility)

- 1.1. Receiving screening by CHP nursing staff takes place as soon as possible upon arrival.
  - 1.1.1. Receiving screening documentation is completed on approved form(s) and documented in the patient's health record.
- 1.2. Patients who present with a possible life-threatening condition or otherwise urgently in need of medical attention are referred immediately for care and medical clearance into the facility, or transported to the appropriate level of care.
  - 1.2.1. If they are referred to a community hospital and then returned, admission to the facility is predicated on written medical clearance from the hospital.
  - 1.2.2. After normal business hours, the CHP nurse shall contact the CHP Practitioner on the Urgent Notification List for orders to send the patient to the emergency room.
- 1.3. The CHP nursing staff shall complete Reception Center Screening documentation, to include the following:
  - 1.3.1. Observations of the patient's appearance (e.g., sweating, tremors, anxious, disheveled), behavior (e.g., disorderly, appropriate, insensible), state of consciousness (e.g., alert, responsive, lethargic), ease of movement (e.g., body deformities, gait), breathing (e.g., persistent cough, hyperventilation), and skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).
  - 1.3.2. Drug and alcohol history and evaluation for current drug or alcohol intoxication in accordance with MSTM P-F-04.01, Medically Supervised Withdrawal and Treatment.
  - 1.3.3. Inquiries as to the patients:
    - 1.3.3.1. Current and past illnesses, infectious diseases, health conditions, or special health requirements (e.g., hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine)

1.3.3.2. Recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats)

1.3.3.2.1. Any patients identified as being potentially infectious are reported to complex security personnel and isolated from the general inmate population.

1.3.3.3. Past or current mental illness, including hospitalizations

1.3.3.4. History of or current suicidal ideation

1.3.3.5. Dental problems (decay, gum disease, abscess)

1.3.3.6. Allergies

1.3.3.7. Dietary needs

1.3.3.8. Prescription medications (including type, amount, and time of last use)

1.3.3.9. Legal and illegal drug use (including type, amount, and time of last use)

1.3.3.10. Current or prior withdrawal symptoms

1.3.3.11. Possible, current, or recent pregnancy

1.3.3.12. Other health problems as specified by the responsible physician

1.3.4. A full set of vital signs shall be performed including the patient's weight.

1.4. All arriving inmates must receive the Purified Protein Derivative (PPD) test at the reception center unless a PPD was administered and the results were read along with the measurements of the reaction site documented on a transfer summary from the sending County.

1.4.1. The applied PPD skin test must be read between 48 to 72 hours following administration.

1.4.2. If the administered PPD test is inconclusive upon reading, order a repeat PPD in 7 to 12 days.

1.4.3. If indicated, the patient may be transferred prior to the completion of the repeat PPD and the Transfer Summary should note that a repeat PPD is required.

1.4.4. Completion of a tuberculosis (TB) symptomology checklist shall be completed.

1.5. Intake and Return to Custody inmates who arrive with documented current prescriptions shall be bridged or continued on their medications for up to 42 days.

1.5.1. The CHP Practitioner shall have the authority to discontinue/change existing therapy upon a face-to-face documented evaluation of the patient.

1.6. CHP staff regularly monitors receiving screenings to determine the safety and effectiveness of the process.

2.0. Receiving Screening at a Non-Reception Center

2.1. The CHP Facility Health Administrator (FHA) and Warden of all non-Reception Center complexes shall develop local policy to ensure that the CHP staff is informed when a new inmate arrives at the complex.

2.2. Parole Violators must be screened by CHP nursing staff, as soon as possible upon arrival.

2.3. All receiving screening directions indicated above shall be completed with the following modifications or additional guidance:

2.3.1. A repeat PPD test is not required if less than 90 days have passed from the prior release.

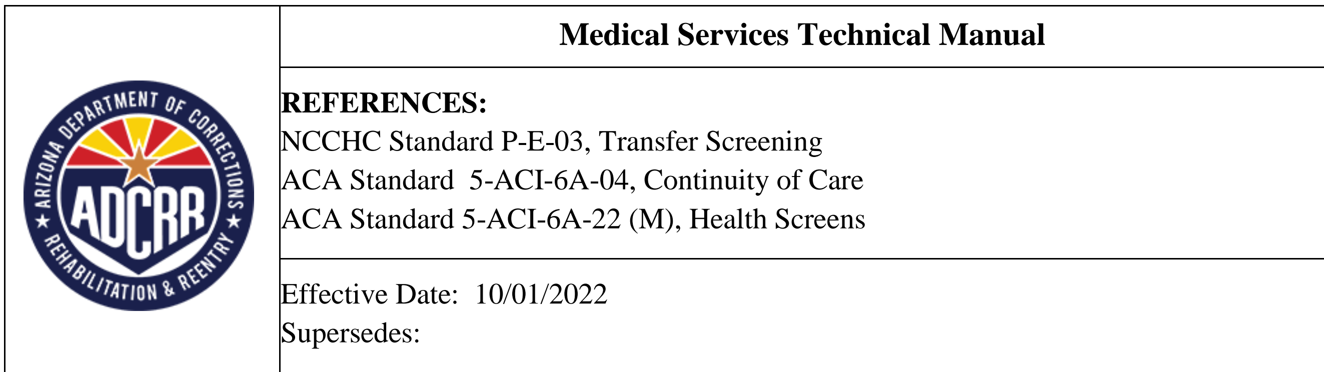
2.3.2. All return to custody patients with a history of positive PPD will have a chest x-ray completed. A repeat chest X-ray is not required if 90 days or less have passed since release.

2.3.3. Cervical cancer screening is not required for inmates who are returning to custody and are documented to have had a negative cervical cancer screening within the past year.

2.3.4. Routine intake labs are not required for inmates who are returning to custody within 90 days of their previous release from ADCRR custody.

2.4. Parole violators in need of medical care/prescription medication shall be seen by the CHP Practitioner or a verbal order may be obtained at the time of reception and assessment.

2.5. CHP staff regularly monitors receiving screenings to determine the safety and effectiveness of the process.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-E-03, Transfer Screening ACA Standard 5-ACI-6A-04, Continuity of Care ACA Standard 5-ACI-6A-22 (M), Health Screens
	Effective Date: 10/01/2022 Supersedes:

P-E-03.01 Transfer Screening

PURPOSE: To provide guidance for ensuring continuity of care for patients transferring between facilities within the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) system.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) staff to review patient's health record at the time of transfer to ensure continuity of care and medications.

PROCEDURE:

1.0. Transfer Sending: All patients shall have their needs communicated from the sending facility to the receiving facility by the continuity of care format (and verbally if necessary) at the time of transfer.

- 1.1. The sending facility CHP nursing staff is responsible for reviewing the transferring patient's health record and completing the Continuity of Care/Transfer Summary available in the electronic health record or using the approved Continuity of Care/Transfer Summary, Form 1101-8, prior to transfer.
- 1.2. Sending facility CHP nursing staff shall review current medication orders and ensure all Directly Observed Therapy (DOT) medications as well as any Keep-On-Person (KOP) medications accompany the patient at time of transfer.
  - 1.2.1. A minimum of a seven day supply of all prescription medications shall accompany all patients transferred.
- 1.3. Sending facility CHP health record staff shall package any volumes of paper health records of patients who are being transferred in a sealed container clearly addressed to the receiving facility and deliver packaged health records to designated location where security and/or Transportation staff shall pick up the health records of transferring patients.
- 1.4. Patients transferring for County court appointments or any other legal actions shall have their medical needs communicated via a continuity of care form available in the electronic health record or using the approved Continuity of Care, Form 1101-8, and a minimum of a seven day supply of all active medications shall accompany any patient who goes out to court.

2.0. Transfer Receiving

- 2.1. Receiving facility CHP nursing staff is responsible for performing a chart review within 12 hours of arrival and documenting continuity of care and medication administration in the patient's electronic health record.
  - 2.1.1. CHP nursing staff shall verify that the patient has all required medical equipment, medication, and supplies.

2.1.2. CHP nursing staff shall ensure all patient medications DOT and KOP were received upon arrival and shall be provided according to prescription without interruption.

2.2. The receiving facility CHP nursing staff shall physically assess the arriving patient(s) within 24 hours of arrival at a permanently assigned facility.

2.2.1. When transferred from an intake facility, patients who do not have initial medical, dental, or mental health assessments shall be evaluated at the receiving facility in a timely manner.

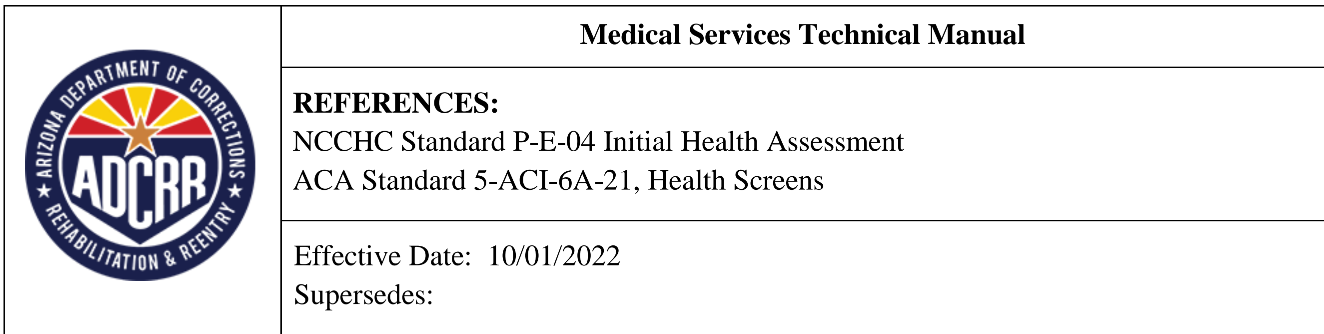
2.3. The CHP nursing staff shall complete the Initial/Inter-Facility Assessment within the electronic health record or approved Initial/Inter-Facility Assessment, Form 1101-67.

2.3.1. CHP nursing staff shall refer the patient for appropriate emergency or routine healthcare service as determined by the chart review and assessment.

2.4. Receiving CHP nursing services may continue a patient's medication order up to the date of the prescriptions expiration.

2.4.1. A CHP Provider must renew required prescriptions within a ten working day period.

2.5. If the needs of an arriving patient exceed the level of care that a receiving facility can provide, CHP nursing staff shall report immediately to the CHP Facility Health Administrator who shall take appropriate action as necessary.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-E-04 Initial Health Assessment ACA Standard 5-ACI-6A-21, Health Screens
	Effective Date: 10/01/2022 Supersedes:

P-E-04.01 Initial Health Assessment

PURPOSE: To provide guidance in the completion of required initial health assessment for new arriving inmates.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to complete an initial health assessment and physical examination to identify a patient health needs and establish a plan for meeting those needs.

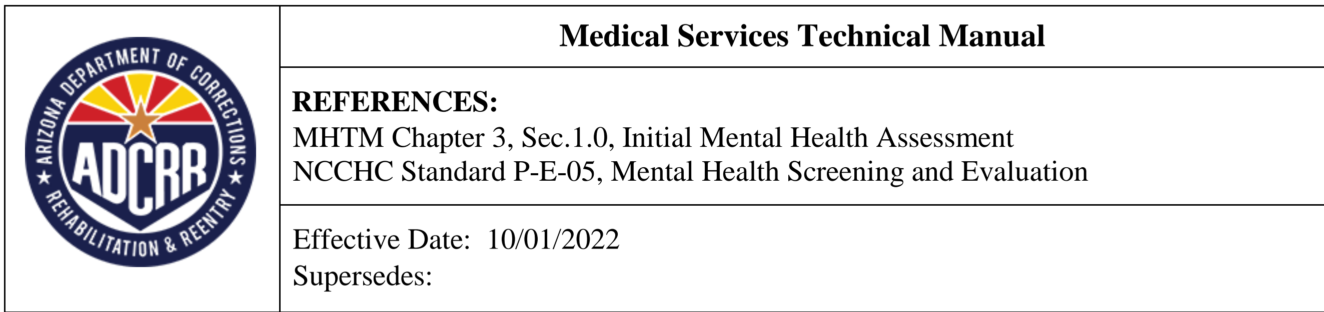
PROCEDURE:

1.0. CHP Practitioner shall review receiving screening results done in accordance with MSTM P-E-02, Receiving Screening, by the end of the second full day of the patient's arrival, sooner if immediate healthcare needs are identified.

2.0. All inmates receive an initial health assessment/physical exam as soon as possible, but no later than the end of the second full day after arrival.

- 2.1. Initial health assessments include, at a minimum:
  - 2.1.1. A CHP qualified healthcare professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from abnormal findings obtained during the receiving screening and subsequent encounters.
  - 2.1.2. A CHP qualified healthcare professional recording vital signs (including height and weight).
  - 2.1.3. A physical examination (as indicated by the patient's gender, age, and risk factors) performed by a CHP physician, physician assistant, nurse practitioner, or registered nurse.
  - 2.1.4. When clinically indicated, a pelvic exam, or referral for a pelvic exam, with or without cervical cancer screening.
  - 2.1.5. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the CHP provider.
  - 2.1.6. Specific problems are integrated into an initial problem list.
  - 2.1.7. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.

3.0. The CHP responsible physician reviews the required components of the initial health assessment to determine the effectiveness of this process.



Medical Services Technical Manual

REFERENCES:
MHTM Chapter 3, Sec.1.0, Initial Mental Health Assessment
NCCHC Standard P-E-05, Mental Health Screening and Evaluation

Effective Date: 10/01/2022
Supersedes:

P-E-05.01 Mental Health Screening and Evaluation

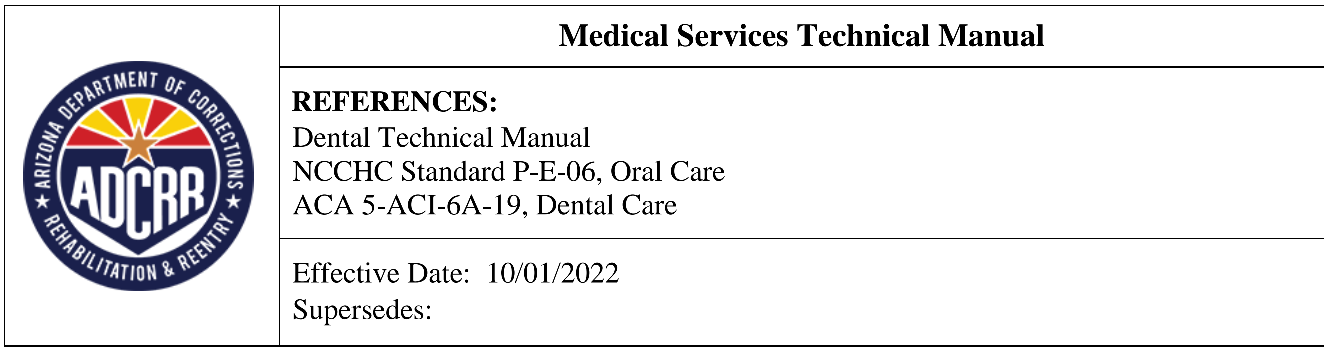
PURPOSE: To ensure that all inmate upon their arrival to ADCRR have an initial mental health assessment completes to assist in decisions regarding classification, placement, and future needs for further mental health services and/or programming.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) mental health staff are responsible for completing a mental health assessment to determine individual mental health needs.

PROCEDURES:

1.0. A mental health receiving screening is performed in accordance with the Mental Health Technical Manual (MHTM) Chapter 3, Sec. 1.0, Initial Mental Health Assessment.

2.0. A mental health screening may be conducted by CHP qualified mental health professionals or CHP qualified healthcare professionals who have received documented training as outlined in MHTM Chapter 3, Sec. 1.0, Initial Mental Health Assessment.
   - 2.1. The initial mental health screening is conducted by CHP staff using the Initial Mental Health Assessment, Form 1103-27, and is documented in the patient's health record.
   - 2.2. Patients who screen positive for mental health problems are referred to CHP qualified mental health professionals for further evaluation as outlined in MHTM Chapter 3, Sec. 1.0, Initial Mental Health Assessment.



	Medical Services Technical Manual
	REFERENCES: Dental Technical Manual NCCHC Standard P-E-06, Oral Care ACA 5-ACI-6A-19, Dental Care
	Effective Date: 10/01/2022 Supersedes:

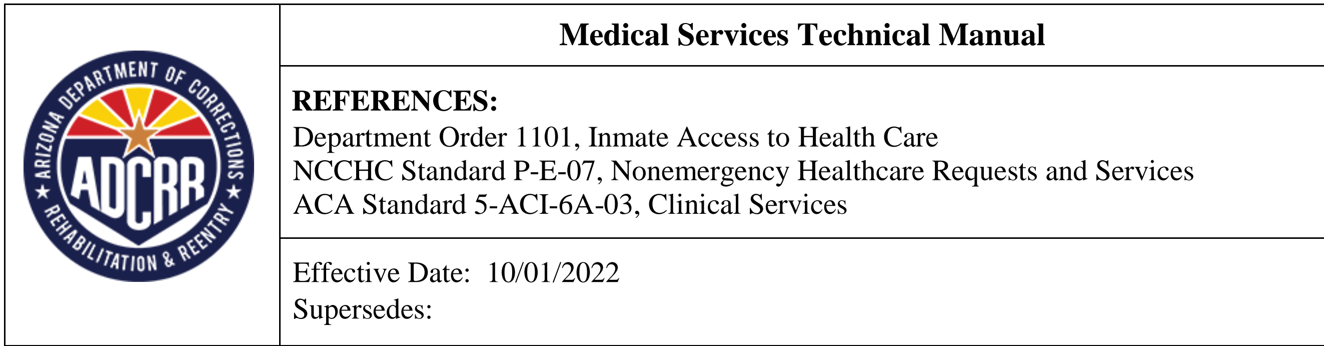
P-E-06.01 Oral Care

PURPOSE: Expectations for the provision of quality oral healthcare to incarcerated patients.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide quality oral healthcare to incarcerated patients for emergent, specialty, and ongoing dental needs. It is the responsibility of the ADCRR Dental Director to provide oversight and guidance to ADCRR Medical Services Contract Monitoring Bureau (MSCMB) in the monitoring of the oral healthcare being provided.

PROCEDURES:

1.0. Guidance in the provision of oral healthcare is found in the MSCMB Dental Technical Manual.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
NCCHC Standard P-E-07, Nonemergency Healthcare Requests and Services
ACA Standard 5-ACI-6A-03, Clinical Services

Effective Date: 10/01/2022
Supersedes:

P-E-07.01 Non-Emergency Healthcare Requests and Services

PURPOSE: To ensure all inmates have the opportunities to request healthcare services on a daily basis and to be seen in an appropriate timeframe by the most appropriate and qualified healthcare professional consistent with identified medical needs.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) through the CHP complex Director of Nursing (DON) to maintain the system and flow of Health Needs Requests. This includes the provision for collecting, triaging, distributing and scheduling appointments in the patient electronic health record (EHR).

PROCEDURES:

1.0. Non-Emergency Health Needs Request (HNR)

1.1. All inmates will initiate a request for a nonemergency healthcare appointment by completing a Non-emergency Health Needs Request (HNR), Form 1101-10ES, or by submitting an electronic HNR 1101-10(e), via the inmate tablet program.

1.1.1. Security is responsible for maintaining a supply of the paper HNR forms and assuring that every inmate on all yards and housing areas, including lockdowns, will have access to the forms, either in written or electronic format.

1.1.2. Completed paper HNRs are deposited in the appropriately labeled box, and collected by CHP staff daily.

1.1.2.1. On a daily basis, seven days per week, CHP health staff will pick up the paper HNRs from the collection boxes on the open yards and monitor inmates in a "Lock-down/lockup" status to ensure that access to healthcare is not obstructed.

1.1.2.2. Security, in consultation with CHP, will assure that appropriate weather proof collection boxes are available for daily use either on the yards or in the housing areas of the open yards. In the lockdown areas, the collection of HNRs will be done in such a manner as to assure medical confidentiality. There shall be coordination with complex Warden, to ensure that an HNR "Drop Box" is available.

1.1.3. CHP staff will access daily the HNRs submitted electronically through the inmate tablet program.

1.1.4. The frequency and duration of response to HNRs is sufficient to meet the health needs of the inmate population.

1.1.5. HNRs should be handled as a confidential correspondence between CHP staff and the patient. Security staff are not authorized to access or read completed HNRs.

1.2. On the same day the HNR form is received either paper or electronically, CHP nursing staff shall triage to sort and classify the HNRs to determine the priority of need and the proper place for care to be rendered.

1.2.1. CHP Registered Nurses with training in the HNR process shall be assigned to triage requests. The date and time of collection by nursing will be indicated on the top right corner of the form. Electronically submitted forms are automatically time-stamped and shall be triaged to ensure a face-to-face visit within the required 24 hours for healthcare requests including all medical, mental health, and dental requests.

1.2.2. Following collection of all of the HNRs CHP Nursing will sort them into disciplines, such as dental, mental health, nursing lines and provider lines.

1.2.3. A face-to-face encounter for a healthcare request (medical, mental health, or dental) shall be conducted in a clinical setting as indicated by a Registered Nurse (RN) within 24 hours of receipt by CHP staff.

1.2.3.1. A healthcare request may include non-urgent requests for a face-to-face visit with a medical provider, mental health provider, or dentist.

1.2.3.2. Requests for dental cleaning qualify as healthcare requests if the patient has a clinical complaint.

1.2.3.3. HNRs that are not healthcare requests do not require a face-to-face evaluation (e.g., extra blanket or co-payment question).

1.2.4. Non-emergency mental health and dental requests shall then be provided to the relevant discipline within 24 hours of the face-to-face encounter by the RN.

1.2.5. Face-to-face encounters for the healthcare requests require that vital signs be obtained, including temperature, blood pressure, pulse, respirations, pulse oximetry, and weight each time a patient is seen during sick call. This includes telehealth visits.

1.2.6. HNRs that document or indicate that the patient may be suffering from an emergent medical, mental health or dental condition shall be seen for a face-to-face encounter by a CHP RN immediately, and notification of the appropriate discipline shall occur.

1.2.7. HNRs that document or indicate that the patient may be suffering from an urgent medical, mental health or dental condition shall be seen for a face-to-face encounter by an RN on the same day that the HNR is received. If the situation requires that the patient be seen by another discipline, the triaging nurse will immediately initiate a referral to the appropriate discipline.

1.2.8. HNRs requesting only information may be returned to the patient with the appropriate response without the need to make an appointment.

1.2.9. If the HNR is unclear or lacks sufficient information to formulate a response, the CHP qualified health professional shall clearly state the reason for return in Section III and return the HNR form to the patient via the mail system.

1.2.10. If the CHP triaging nurse is able to acquire/provide/schedule an immediate response to the patient’s needs (e.g., medications update, blanket, diet comment, review of lab/x-ray report, or creating an inmate communiqué), he/she should do so. If the CHP triaging nurse cannot either determine what the patient needs or cannot provide what the patient requests, the patient shall be seen within 24 hours.

1.3. Documentation: All documentation of HNR responses or visits pertaining to HNR submissions shall be entered into the electronic health record by a CHP qualified healthcare professional. Electronically submitted HNRs shall be exported from the HNR program and entered into the electronic health record.

1.4. Refusals: If, on the scheduled appointment day, the patient refuses to go to the appointment or refuses to be seen, the patient will sign the Refusal to Submit to Treatment (Form 1101-4) in accordance with Department Order #1101, Inmate Access to Healthcare.

1.4.1. Patient who refused treatment shall be counseled on possible health risks and/or consequences related to refusal.

2.0. Nurse Line

2.1. Patients shall be seen for sick call on nurses line by a CHP RN within 24 hours of placing a HNR or immediately if identified with an emergency need or on the same day if identified of having an urgent need.

2.2. Nurses' line shall include follow-up encounters as ordered by the Provider as well as routine services such as annual TB testing, vital sign checks, educational services, and wound care.

2.3. At the discretion of the CHP health staff and with consideration of time constraints and other patients, at a given scheduled appointment more than one medical issue or complaint may be addressed or attended to.

2.4. Nurse's line shall not be canceled except for security reasons.

2.4.1. When canceled or disrupted for security reasons, the CHP nursing staff will immediately review scheduled patients' primary complaint. If determined that a delay would jeopardize the health of specific patients, CHP nursing shall coordinate with the Major of Security/Shift Commander to arrange for examination and treatment of the patient(s) within the bounds of safety.

2.5. Vital signs, including weight, shall be taken and documented in the health record on all urgent/emergent/routine patient encounters for both medical and dental.

2.6. Nurse line referrals to CHP Practitioner shall be evaluated on Provider Line within fourteen days of referral date.

3.0. Scheduling and recording Routine Appointments

3.1. All appointments shall be scheduled using the EHR appointment system.

3.1.1. Information required shall include the following:

3.1.1.1. Time the appointment was entered

3.1.1.2. Date and time of scheduled appointment

3.1.1.3. The appointment location

3.1.1.4. The appointing discipline (e.g., nursing line, provider line, lab, mental health)

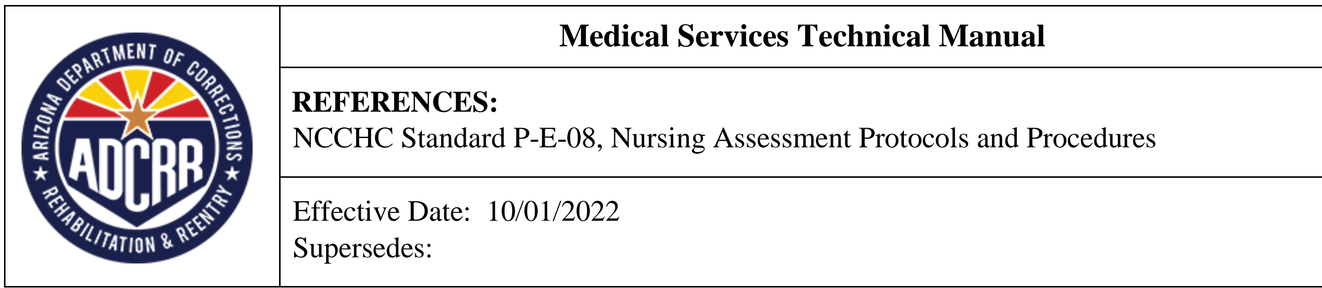
3.1.1.5. The reason for the appointment

4.0. Missed Appointments

4.1. If the CHP personnel are unable to see all of the patients on a day's appointment list, any patients that were not seen shall be rescheduled and seen as early as possible at the next available appointment time.

4.2. If security is unable to release patient from housing area or escort the patient, as previously scheduled, CHP staff shall make immediate notification to the Warden or designee.

4.2.1. If after notification health services is still unable to see the patient an Information Report, Form 105-2, shall be written to the Deputy Warden of the respective yard.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-E-08, Nursing Assessment Protocols and Procedures

Effective Date: 10/01/2022
Supersedes:

P-E-08.01 Nursing Assessment Protocols and Procedures

PURPOSE: To provide the Contract Healthcare Provider (CHP) nursing staff with standardized nursing practices based on the nursing statutes and regulations to deliver quality nursing care to the inmate population.

RESPONSIBILITY: It is the responsibility of the CHP to ensure that all licensed CHP nurses are competent with the nursing Emergency Response Orders (EROs), Nursing Assessment Protocols, and Nursing Encounter Tools (NETs) and are trained in providing emergency nursing care, health maintenance, and prevention to the patient.

PROCEDURES:

1.0. All health units will have the EROs, NETs and Nursing Assessment Protocols manual available to all CHP staff. Original manual shall be kept in the CHP Facility Health Administrator's (FHAs) office.

2.0. The NETs and Nursing Assessment Protocols provide the CHP nurse a step-by-step guideline in the management and treatment of the patient, which may include recommended over-the-counter medications.
  - 2.1. NETs and Nursing Assessment Protocols are divided into triage and assessment for use by a CHP Licensed Practical Nurse (LPN) while performing triage tasks to report findings to a CHP Registered Nurse (RN) or CHP Practitioner per the nursing scope of practice.

3.0. The Emergency Response Orders (EROs) are step-by-step written instructions from the CHP Practitioner to assist the CHP licensed nurse while providing emergency acute care to a patient during life-threatening event.
  - 3.1. The ERO assists the CHP licensed nurse with nursing assessment or triage to stabilize or maintain the patient until Emergency Medical Services have responded and/or the CHP Practitioner is contacted to provide further instructions.
  - 3.2. Approved assessment protocols pertaining to emergency life-threatening conditions (e.g., chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.
  - 3.3. Emergency administration of prescription medications requires a provider's order before or immediately after administration.

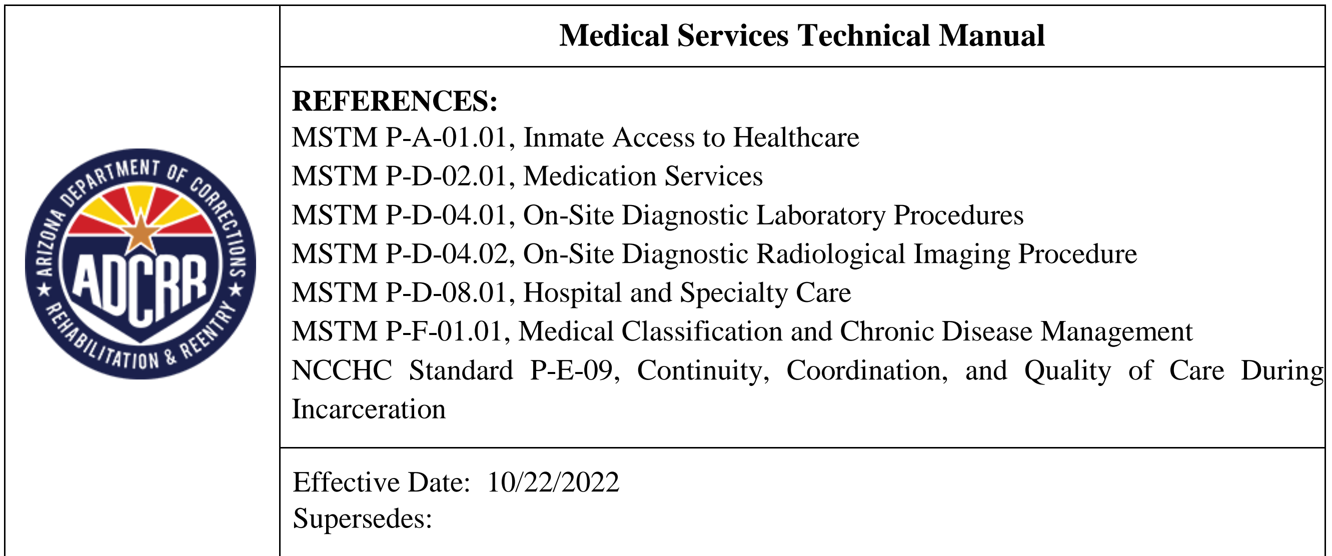
4.0. When new or revised NETS/EROS/Nursing Assessment Protocols are introduced, it is the responsibility of the CHP to introduce them and evaluate competency.

5.0. The content of the NETs/EROs Protocol/Nursing Assessment Protocols will be reviewed and signed annually by the ADCRR Medical Director or designee, CHP Regional Medical Director, CHP FHAs, site CHP Medical Director, CHP Regional Director of Nursing, DON (Private Prisons), and CHP DON at the assigned facilities.
  - 5.1. Yearly renewal of signatures annotating review of the documents will be the responsibility of the CHP and the CHP FHAs. The updated signature sheet shall be kept in original manual.

6.0. Training requirements of Nursing Encounter Tools/EROS/Nursing Assessment Protocols:

6.1. CHP DON and CHP FHA are responsible to ensure all CHP licensed nurses receive training annually applicable to their scope of practice on EROs, NETs, and Nursing Assessment Protocols.

6.2. Demonstration of skills, competency, and knowledge regarding NETs, EROs and Nursing Assessment Protocols (Private Prison facilities), shall be performed annually by all CHP licensed nurses with documentation kept in the CHP employee's personnel file.



	Medical Services Technical Manual
	REFERENCES: MSTM P-A-01.01, Inmate Access to Healthcare MSTM P-D-02.01, Medication Services MSTM P-D-04.01, On-Site Diagnostic Laboratory Procedures MSTM P-D-04.02, On-Site Diagnostic Radiological Imaging Procedure MSTM P-D-08.01, Hospital and Specialty Care MSTM P-F-01.01, Medical Classification and Chronic Disease Management NCCHC Standard P-E-09, Continuity, Coordination, and Quality of Care During Incarceration
	Effective Date: 10/22/2022 Supersedes:

P-E-09.01 Continuity, Coordination, and Quality of Care During Incarceration

PURPOSE: To provide guidance in the coordination and monitoring of medical, dental, and mental healthcare being provided to patients from admission to discharge.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide evidence-based medical, dental, and mental healthcare to the inmate population throughout the duration of their incarceration.

PROCEDURE:

1.0. Patients receive medical, dental, and mental health services from admission to discharge per CHP prescribers' recommendations, orders, and evidence-based practices as stated in Medical Services Technical Manual (MSTM) P-A-01.01, Access to Healthcare.

2.0. CHP Practitioner orders are implemented in a timely manner as stated in MSTM P-D-02.01, Medication Services and MSTM P-D-08.01, Hospital and Specialty Care.

3.0. If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody is documented as stated in MSTM P-D-02.01, Medication Services, MSTM P-D-08.01, Hospital and Specialty Care, and MSTM P-F-01.01, Medical Classification and Chronic Disease Management.

4.0. Diagnostic tests are reviewed by the CHP Practitioner in a timely manner as stated in MSTM P-D-04.01, On-Site Diagnostic Laboratory Procedures and MSTM P-D-04.02, On-Site Diagnostic Radiological Imaging Procedure.

5.0. Treatment plans are modified by the CHP Provider in the electronic health record as clinically indicated by diagnostic tests and treatment results.

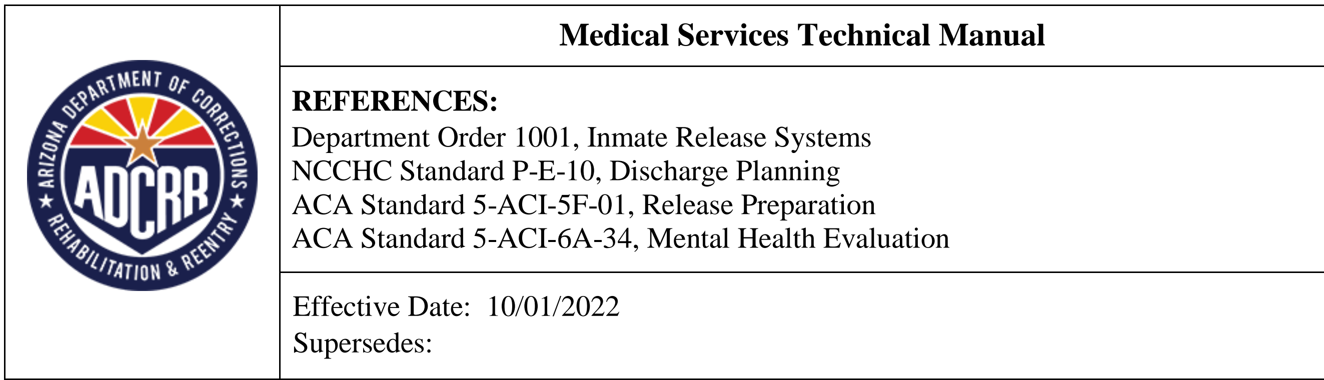
6.0. Treatment plans, including test results, are shared with patients as appropriate.

7.0. For hospitalization, urgent care, emergency department, or specialty visits all below requirements are addressed in MSTM P-D-08.01, Hospital and Specialty Care:

7.1. Patients are seen by a CHP qualified healthcare professional upon return.

7.2. Recommendations are reviewed for appropriateness of use in the correctional environment.

7.3. A CHP Practitioner is contacted in a timely manner to ensure proper implementation of any orders and to arrange appropriate follow-up.



	Medical Services Technical Manual
	REFERENCES: Department Order 1001, Inmate Release Systems NCCHC Standard P-E-10, Discharge Planning ACA Standard 5-ACI-5F-01, Release Preparation ACA Standard 5-ACI-6A-34, Mental Health Evaluation
	Effective Date: 10/01/2022 Supersedes:

P-E-10.01 Discharge Planning/Transition to the Community

PURPOSE: To provide guidance in supporting patients who are approaching the end of their incarceration.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Discharge Planner and the CHP Facility Health Administrator (FHA) to ensure that patients with serious health needs are provided support, planning, and assistance as their release becomes imminent.

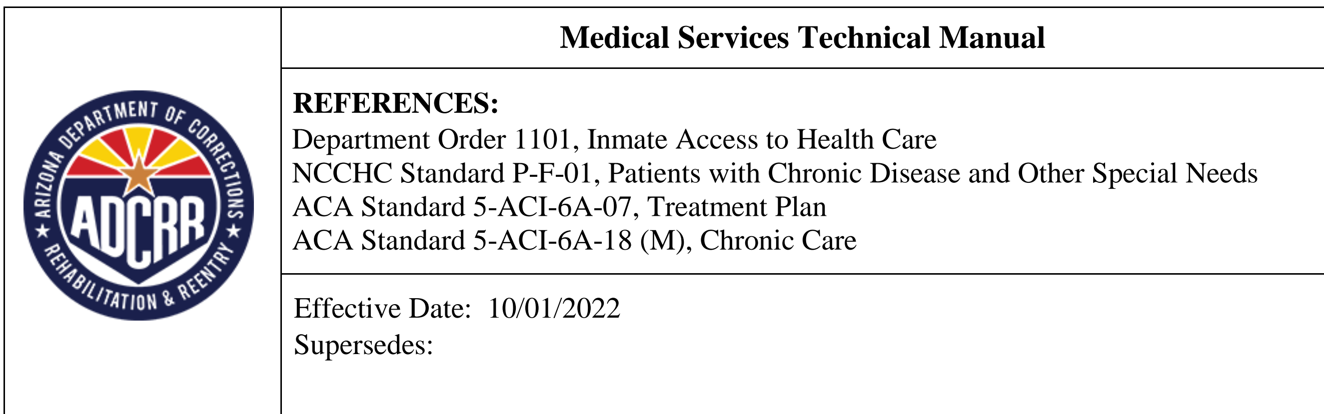
PROCEDURE:

1.0. Department Order #1001, Inmate Release Systems provides guidance in the process of informing CHP staff of an impending release.

- 1.1. The CHP staff will review the patient's health record and provide support services including, but not limited to:
  - 1.1.1. Arranging for sufficient discharge medications as described in the Medical Services Technical Manual (MSTM) P-D-01.01, Pharmacy Security Inventory Control.
  - 1.1.2. Arranging for necessary durable medical equipment and medication delivery supplies such as insulin needles/syringes.
  - 1.1.3. Coordinating transfer of health records to a releasing patient's accepting Provider to ensure continuity of care upon release.
  - 1.1.4. Assisting releasing patients undergoing lifelong treatment such as dialysis with locating facilities in the community to continue care.
  - 1.1.5. Assisting the patient in applying for Arizona Healthcare Cost Containment System (AHCCCS) applications.
    - 1.1.5.1. All AIDS Drug Assistance Programs (ADAP) applications and orders will be completed through the CHP Discharge/Release Planner.
  - 1.1.6. The releasing patient shall be provided points of contact to acquire state, county, or local services.
- 1.2. Actions and follow-up care for patients released while an inpatient will be coordinated by the CHP Discharge/Release Planner, CHP Utilization Management, and the treating hospital.

2.0. CHP mental health staff may also provide assistance in helping released patients to gain access to Regional Behavioral Health Provider or other "outside" mental health providers.

3.0. All aspects of discharge planning shall be documented in the patients' health record.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs ACA Standard 5-ACI-6A-07, Treatment Plan ACA Standard 5-ACI-6A-18 (M), Chronic Care
	Effective Date: 10/01/2022 Supersedes:

P-F-01.01 Medical Classification and Chronic Disease Management

PURPOSE: To provide consistent criteria and guidance to the Contract Healthcare Provider (CHP) Practitioner while assigning medical scores that correspond to the patient's health condition, informs housing, and identifies patients receiving ongoing multidisciplinary care.

RESPONSIBILITY: It is the responsibility of the CHP Practitioner to evaluate and assign an appropriate medical score corresponding with a patient's medical condition and to develop individualized treatment plans for patients with chronic conditions.

PROCEDURES:

1.0. Medical Classification Scores

1.1. Medical Score (M) score will be annotated in each patient's health record problem list. Each patient's medical needs assessment score will be updated when there is a change in the patient's medical condition that warrants a change in their medical score.

1.2. The following medical scoring system with the accompanying guidance and examples shall be utilized in the medical evaluation of the patient. Completion of functional assessment may apply.

1.2.1. M-1 Maximum sustained physical capacity consistent with age; no special requirements.

1.2.2. M-2 Sustained physical capacity consistent with age; stable physical illness or chronic condition; no special requirements.

1.2.3. M-3 Restricted physical capacity; requires special housing or reasonable accommodations.

1.2.4. M-4 Limited physical capacity and stamina; severe physical illness or chronic condition. May require housing in an Infirmary or Special Needs Unit (SNU).

1.2.5. M-5 Severely limited physical capacity and stamina; requires assistance with activities of daily living (ADLs); requires housing in an Infirmary or SNU.

1.3. Mental Health Scores shall be assigned and updated in accordance with the Mental Health Technical Manual, Chapter 3, Section 5, Levels of Mental Health Services Delivery.

1.4. CHP staff must update and advise Correctional and Classification staff accurately of patient's medical and mental health scores via the Arizona Correctional Information System (ACIS) as these reflect special needs that may affect housing, work, and program assignments, disciplinary measures and admissions to and transfer from other institutions.

2.0. Chronic Diseases, Conditions, and Special Needs

2.1. Chronic diseases persist over an extended period of time and are conditions that require ongoing monitoring and management by the healthcare team.

2.2. Chronic disease include but are not limited to the following:

2.2.1. ADA Qualified Inmates
2.2.2. Blood Diseases including anticoagulant therapy
2.2.3. Cancer
2.2.4. Cardiac/Heart Disease
2.2.5. Coccidiomycosis (Valley Fever)
2.2.6. Crohn’s Disease
2.2.7. Diabetes Mellitus
2.2.8. End-stage Liver Disease
2.2.9. Hepatitis C
2.2.10. HIV/AIDS
2.2.11. Hyperlipidemia
2.2.12. Hypertension
2.2.13. Hyperthyroidism and hypothyroidism
2.2.14. Latent Tuberculosis Infection
2.2.15. Neurological Disorders (Parkinson’s, Multiple Sclerosis, Myasthenia Gravis)
2.2.16. Renal Diseases
2.2.17. Respiratory Disease (COPD, Asthma, Cystic Fibrosis)
2.2.18. Rheumatological Disorders (Lupus, Rheumatoid Arthritis)
2.2.19. Seizure Disorder
2.2.20. Sickle Cell Disease
2.2.21. Tuberculosis

2.3. All chronic condition patients shall receive routine visits conducted by a medical Provider as specified in the patient’s treatment plan at least every 90 days, unless a Provider documents a reason why a longer time frame can be implemented.

2.4. Chronic illnesses and other special needs requiring a treatment plan are listed on the master problem list/health problems/conditions section of the electronic health record.

3.0. Treatment Plans

3.1. The Medical Services Contract Monitoring Bureau (MSCMB) have established ADCRR chronic condition clinical practice guidelines/treatment plans that are consistent with selected national evidence practices and reviewed annually for approval.

3.1.1. Compliance with established ADCRR treatment guidelines is required to ensure continuity of care in the correctional medical environment.

3.1.1.1. If a patient’s condition and circumstance precludes compliance with the treatment plan, the CHP Practitioner must clearly document the justification for deviation and outline the proposed Alternative Treatment Plan (ATP) in the patient’s health record.

3.1.1.2. CHP Practitioner shall submit the case for review to CHP Regional Medical Director or designee prior to initiation of any ATP.

3.1.2. A treatment plan shall be developed and documented in the health record by a healthcare CHP Practitioner within 30 calendar days of identification of the chronic condition.

3.1.3. Patients who have been identified with chronic conditions will have a treatment plan that includes:

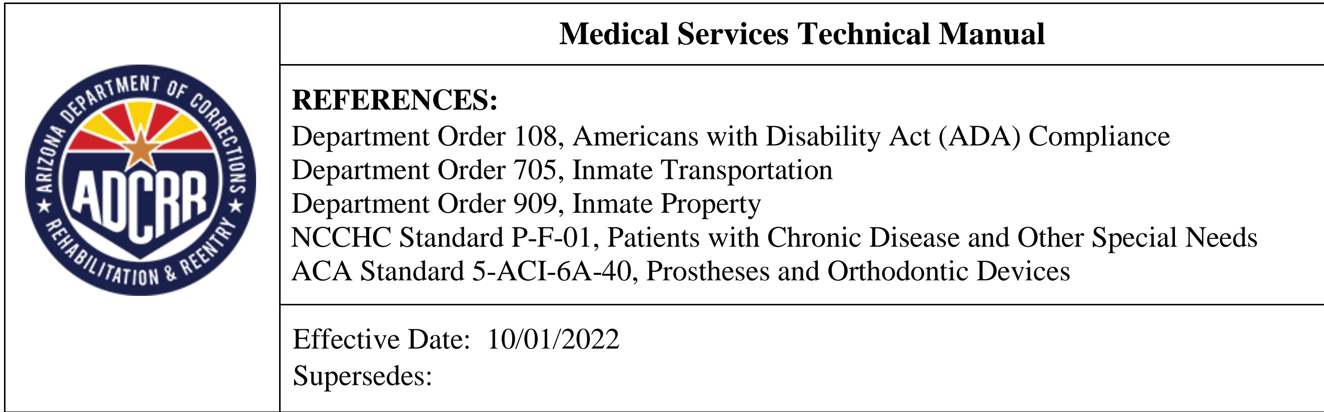
3.1.3.1. Frequency of follow-up examinations.
3.1.3.2. Type and frequency of diagnostic testing.
3.1.3.3. Therapeutic medications and modalities.
3.1.3.4. Patient education given.

3.1.4. Certain medical conditions, if deemed stable by the CHP Practitioner, (i.e. stable, controlled hypertension) may be followed up at longer intervals consistent with good medical practice but not to exceed 12 months.

4.0. Documentation

4.1. Documentation in the health record confirms that CHP providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:

4.1.1. Determining the frequency of follow-up for medical evaluation based on disease control
4.1.2. Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome
4.1.3. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication)
4.1.4. Documenting patient education (e.g. diet, exercise, medication)
4.1.5. Clinically justifying any deviation from the protocol



	Medical Services Technical Manual
	REFERENCES: Department Order 108, Americans with Disability Act (ADA) Compliance Department Order 705, Inmate Transportation Department Order 909, Inmate Property NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs ACA Standard 5-ACI-6A-40, Prostheses and Orthodontic Devices
	Effective Date: 10/01/2022 Supersedes:

P-F-01.02 Special Needs Management

PURPOSE: To ensure removal of barriers to programs, services, and processes for patients with qualifying disabilities and to ensure reasonable accommodation are made. To provide guidance in the use of orthoses, prosthesis, and other aids to impairment, to preserve the health and safety of the patient.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to consider the needs and limitation of the patients and to share that pertinent information with correctional staff. It is the responsibility of the CHP to develop and monitor systems to support provisions of medically necessary supplies, orthotics, and prosthetics.

PROCEDURES

1.0. Americans with Disability Act (ADA)

- 1.1. An Assistant Deputy Warden designated at each complex/institution to be the ADA Institutional Liaison is responsible for coordinating the implementation of all ADA related issues at the complex/institution.
  - 1.1.1. The CHP Regional Medical Director or designee is authorized to override a patient's request to waive transfer to an ADA-accessible facility, and to revoke a previously approved waiver.
- 1.2. Procedures at the Reception Center and during any future assessments resulting in the subsequent transfer of a patient with disabilities to an ADA-accessible facility are provided in Department Order #108, Americans with Disability Act (ADA) Compliance.
  - 1.2.1. During an assessment if a CHP Medical Provider identifies a patient who meets the designated criteria for transfer/placement of disabled patients, they shall perform a functional assessment examination and document on the Functional Assessment, Form 108-1, and offer the patient an opportunity to sign a voluntary ADCRR Waiver of Liability by an Inmate with a Disability, Form 108-2.
  - 1.2.2. If a patient is identified outside of a regularly scheduled assessment the complex CHP Director of Nursing (DON) or designee shall ensure a Functional Assessment, Form 108-1, is completed within seven work days after the patient is identified or a request received for evaluation.
  - 1.2.3. The CHP Facility Health Administrator or designee will immediately forward all related documentation to the CHP Regional Director of Nursing (RDON), for review by the CHP Regional Medical Director to verify that the criteria is met.
    - 1.2.3.1. If criteria is met, the CHP RDON or designee will complete a request for Inmate Transfer for Medical Reasons, Form 108-3. Upon approval, the CHP RDON will forward the request to Central Classification for transfer orders.

- 1.3. The CHP DON or designee will complete a periodic reassessment and reevaluation of patients with temporary disabilities who are assigned to an ADA-accessible facility.
  - 1.3.1. On a case-by-case basis and in order to follow-up on a chronic condition, perform at least a quarterly re-assessment of the medical and disability needs of each patient with disabilities.
  - 1.3.2. Ensure the revised disability needs information is entered on the patient's problem list in the health record.
  - 1.3.3. Immediately after receiving a revised M score and related [changed] disability needs information from the CHP Medical Provider, notify the CHP RDON.
  - 1.3.4. If needs change based on reassessment, the CHP RDON or designee shall complete the Transfer for Medical Reasons, and forward the form to Central Classification.
- 1.4. Auxiliary Aids and Services
  - 1.4.1. As described in Department Order #108, <u>Americans with Disability Act (ADA) Compliance,</u> as consistent with security requirements, ADCRR CHP shall provide or allow auxiliary aids and services to individuals with disabilities to enable them to communicate effectively and to participate in or to receive services, programs, and activities, provided that doing so will not result in undue hardship or cause a fundamental alteration to a service, program or activity.
  - 1.4.2. If a request cannot be accommodated, the Complex ADA Coordinator shall be contacted for advice and technical assistance in making appropriate auxiliary aids available for patients at designated ADA facilities, special services beds and complexes.
  - 1.4.3. CHP Practitioner/Providers, in considering work restrictions are informed that ADA-qualified patients shall be eligible to apply for work, provided that their participation does not pose a direct threat to the health or safety of themselves or others.

2.0. Special Needs Consideration and Orders

- 2.1. Healthcare needs shall be considered in decisions regarding the patient's housing, work assignment, and programming. In order to ensure a patient who has restrictions is not at risk of further injury or illness.
- 2.2. Correctional and Classification staff shall be advised of an patient's special needs that may affect housing, work, and program assignments; disciplinary measures; and transfers via a Special Needs Order, Form 1101-60, that does not compromise confidentiality of health information.
- 2.3. CHP staff are prohibited from providing clinical services to increase comfort unless there is a direct, foreseeable, and documentable relationship to the patient's clinical state of health.
  - 2.3.1. Such individual circumstances must be fully evaluated and documented as having negative clinical impact on this specific patient.
    - 2.3.1.1. An example of this is lower bunk assignment request that is based on clinical necessity and not on the patient's preference.
- 2.4. Alternative methods of restraint are not to be directed or ordered by CHP staff, for further guidance refer to Department Order #705, <u>Inmate Transportation</u>.
- 2.5. Patients with either a pacemaker or Implantable Cardioverter Defibrillator (ICD) will be provided with a Special Needs Order, Form 1101-60, indicating such:
  - 2.5.1. Hand wanding or other alternatives to walking through a metal detector should be utilized if available."
  - 2.5.2. The duration of the SNO can be written "for the duration" or "indefinite."

3.0. Medical Supplies, Orthotic Devices, and Aids

- 3.1. Security clearance for necessary medical property is completed in accordance with Department Order #909, <u>Inmate Property.</u>
- 3.2. <u>Intravenous (IV) catheters:</u> Patients with a temporary IV catheter, including a dialysis ports and PICC lines, shall be housed in a Special Needs Unit (SNU) or Inpatient Component (IPC).

3.2.1. When permanent intravascular access is established then housing in a SNU or IPC is no longer required.

3.3. Continuous oxygen delivery equipment poses safety and security risks in an open yard environment. Patients who require continuous use of oxygen shall be housed in a SNU or in the IPC.

3.3.1. Oxygen concentrators are allowed on open yards for patients with as needed oxygen needs.

3.3.2. Continuous positive airway pressure (C-PAP) may be issued and utilized by patients on open yards.

3.4. Self-Catheterization and Colostomy: Patient shall be provided adequate supplies to meet specific needs such as but not limited to self-catheterization or colostomy supplies as ordered by the CHP Practitioner.

3.5. Wheelchair/Walker/Cane: Patients with identified medical needs that require assistance with ambulation shall be evaluated by a CHP Practitioner and ordered an assistive medical device such as a cane, walker, or wheelchair to aid in mobility as indicated.

3.5.1. Assistive medical devices issued for patients for long-term use shall be added to the patient's personal property.

3.5.2. Maintenance, repair, and replacement shall be completed as necessary by the CHP.

3.6. Footwear: Patients with medical disorders, which may require special foot care, shall be scheduled with a CHP Practitioner for evaluation of the medical problem.

3.6.1. Medical Shoes as prescribed treatment shall be provided to patients with the following conditions:

3.6.1.1. Diagnosed Type 1 and Type 2 diabetics with loss of toes due to diabetes, foot ulceration, poor integrity of feet, circulatory compromise, or peripheral neuropathy.

3.6.1.2. Diagnosed Peripheral Vascular Disease.

3.6.1.3. Patients possessing prescribed orthotic inserts that require tennis shoe or other accommodating foot wear which cannot be appropriately utilized in a deck shoe.

3.6.2. A CHP Practitioner order for specialty shoes must be supported in the progress notes including diagnosis and treatment plan according to the criteria above.

3.6.3. After authorization, the order for modified or specialty shoes will be implemented by the CHP Facility Health Administrator or designee and sent to the appropriate purchasing agent.

3.6.4. Shoes authorized by the above process and deemed "medically necessary" will not be denied due to indigence.

3.6.5. Requests for specialty athletic shoes are not a medical issue and should not be scheduled for practitioner examination.

3.6.6. Patients with a complaint about shoes that is not clinically related to an existing medical disorder, should be directed to appropriate operations staff for assistance.

3.7. Vision/Eyewear: Unless there is a clear clinical indication to do otherwise, CHP shall offer refractive eye examinations for each patient a maximum of once every two years.

3.7.1. Eyeglasses become the patient's real property and are handled according to the procedure outlined by Department Order #909, Inmate Property.

3.7.2. Medical eye examinations will not be denied due to indigence.

3.7.3. Willful destruction or mistreatment of glasses will be responded to in accordance with Department guidance regarding destruction of state provided or state owned property.

3.7.4. Eyeglass frames will be provided in accordance with the styles and material described by individual optician contract. Patients may not choose different styles of frames beyond that offered by the optician in accordance with the ADCRR contract.

3.7.5. Specialty optical aids, such as photo gray glasses, sunglasses, or contact lenses are considered medically optional unless ordered by an ophthalmologist as part of a medical treatment plan and not based on the patient's desire.

3.8. Other appropriate orthoses, prostheses, and aids to impairment such as: dentures, dental prosthetics (e.g., partials, flippers, etc.), artificial eye, artificial limb, knee/ankle/foot braces or splints, ace wrap, hernia support belt, hearing aids, special support hose, transcutaneous electrical nerve stimulation (TENS) units, and suspenders are issued to patients with a chronic or ongoing medical condition.

3.8.1. These items are generally for chronic use and become the personal property of the patient.

3.8.2. The CHP shall provide maintenance, including battery replacement, and/or repair of any approved orthotic device or aid.

3.9. Medical aids issued by CHP Practitioner as part of acute treatment for a medical condition such as casts, short-term usage of canes/crutches/braces, etc., are routinely authorized for temporary use and do not become the personal property of the patient.

3.10. The following guidance is provided in consideration of bed wedges:

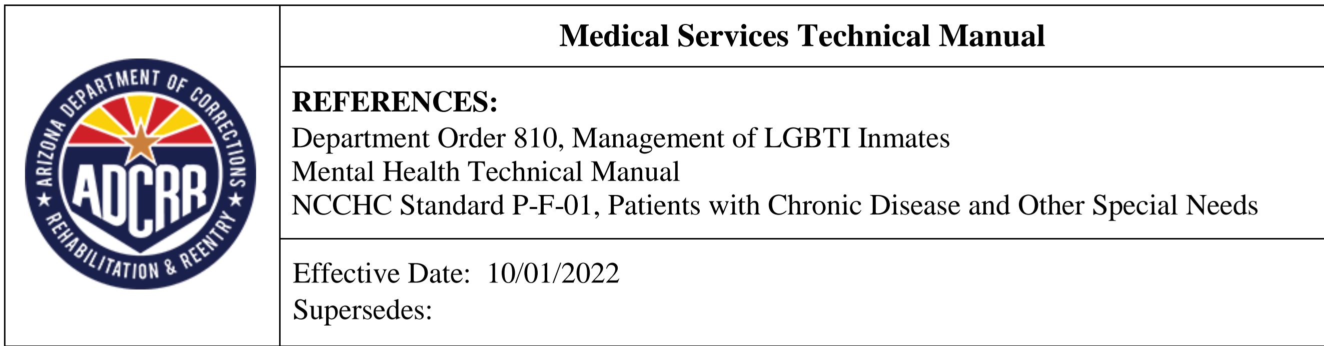
3.10.1. Bed wedges may be prescribed for documented, current, symptomatic congestive heart failure with orthopnea or severe symptomatic Chronic Obstructive Pulmonary Disease (COPD).

3.10.2. CHP Practitioners will not prescribe a bed wedge via a Special Needs Order process or renew a Special Needs Order for a bed wedge for the treatment of GERD without the authorization of the CHP Regional Medical Director or designee.

3.10.3. Any other consideration of bed wedge prescription must be approved by the CHP Regional Medical Director or designee in accordance with the CHP's established procedures.

3.11. Any specialized treatment devices such as bone stimulators shall be made available for use by the patient in the health unit.

3.12. Any durable medical equipment and supplies issued to or ordered for use by a patient shall be issued to the patient upon release with the exception of bed wedges and any rental equipment.



Medical Services Technical Manual

REFERENCES:
Department Order 810, Management of LGBTI Inmates
Mental Health Technical Manual
NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs

Effective Date: 10/01/2022
Supersedes:

P-F-01.03 Management of Transgender, Intersex, and Gender Nonconforming Inmates

PURPOSE: To provide guidance in coordinating needs of transgender, intersex, and gender nonconforming inmates entering the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) system.

RESPONSIBILITIES: It is the responsibility of the Contract Healthcare Provider (CHP) to identify, assess, monitor, and treat appropriately, inmates who identify as transgender, intersex, or are gender nonconforming.

PROCEDURES

1.0. The Transgender Committee is a multi-disciplinary team composed of all persons listed in Department Order #810, Management of LGBTI Inmates.
   - 1.1. The Transgender Committee shall convene and perform services in accordance with the procedures outlines in Department Order #810, Management of LGBTI Inmates.

2.0. CHP staff who identify at intake or receive a request from an inmate for any form of consideration or accommodations for gender dysphoria (GD), shall forward the request to the CHP Mental Health Director.
   - 2.1. CHP Mental Health Director shall schedule the initial evaluation with CHP Psychiatrist or Psychologist, in accordance with Mental Health Technical Manual (MHTM).
   - 2.2. The evaluating CHP Psychiatrist or Psychologist shall submit a report to the ADCRR Medical Director or designee within fifteen days.

3.0. Hormone Replacement Medication
   - 3.1. An patient who is receiving hormonal medication at the time of intake in ADCRR shall be continued on hormonal medications provided the following conditions are met:
     - 3.1.1. The hormonal medication is part of an established treatment that has been prescribed under the supervision of a qualified Physician.
     - 3.1.2. The patient cooperates with the CHP staff in obtaining written records or other necessary documentation of his or her previous treatment.
     - 3.1.3. CHP staff determines that the hormones are medically necessary and not contraindicated.
     - 3.1.4. Hormonal therapy shall be managed by the CHP Practitioner and outside consultation will be obtained when necessary.

   - 3.2. As per Department Order #810, Management of LGBTI Inmates, a patient who is NOT receiving hormonal medication at the time of ADCRR intake could receive treatment, if deemed medically necessary.

4.0. Diagnosed GD

4.1. Patients diagnosed with GD shall have access to:

4.1.1. Appropriate psychiatric and psychological treatment in accordance with MHTM.

4.1.2. Hormonal treatment, as appropriate in accordance with the MHTM.

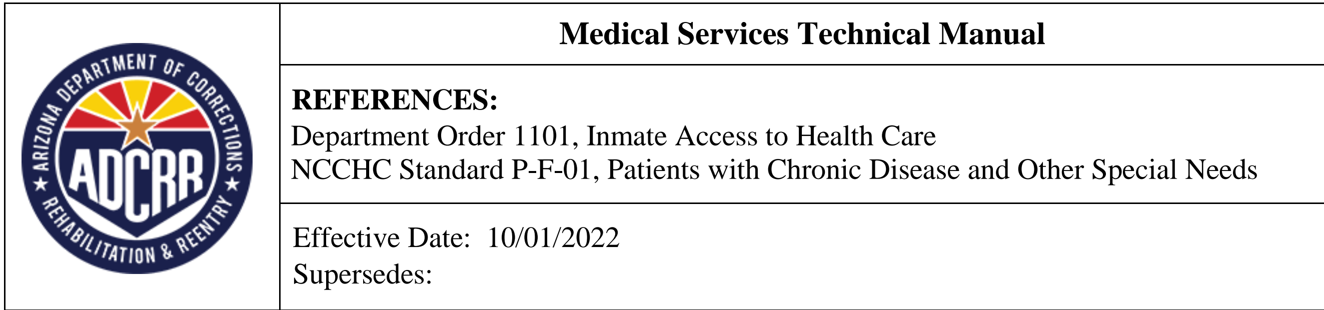
4.1.3. Other treatment and accommodations, determined to be clinically necessary.

4.2. Patients who have completed gender affirming surgery prior to incarceration shall be housed in a correctional facility determined appropriate by the Transgender Committee.

5.0. Apparel and Hygiene Accommodations

5.1. Patients may elect to have the institution provide state-issued undergarments of their gender identity.

5.2. Patients may order undergarments from the commissary that corresponds to their gender identity, in accordance with Department Order #810, Management of LGBTI Inmates.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs
	Effective Date: 10/01/2022 Supersedes:

P-F-01.04 Hunger Strike and Clinical Support

PURPOSE: To outline process and procedures to follow when an inmate refuses nutrition as a hunger strike.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) in conjunction with the Contract Healthcare Provider (CHP) to monitor the health and welfare of a patient engaged in hunger strike and ensure legal and medical procedures are pursued to preserve the patient's life.

PROCEDURES

1.0. Evaluation and Documentation:

- 1.1. According to Department Order #1101, Inmate Access to Healthcare, an patient is to be considered to be on a hunger strike when:
  - 1.1.1. Patient communicates to staff that he or she is on a hunger strike, and has been observed by staff to be refraining from caloric intake for a period in excess of 72 hours.
  - 1.1.2. Staff observes the patient to be refraining from eating for a period in excess of 72 hours.
  - 1.1.3. The patient on a hunger strike shall be referred to the CHP Facility Health Administrator (FHA) or designee, who shall schedule the patient for an evaluation in accordance with Department Order #1101, Inmate Access to Healthcare.
    - 1.1.3.1. Upon verification of a hunger strike, CHP FHA or designee shall notify CHP Regional Medical Director or designee, ADCRR Assistant Director for Medical Services, and ADCRR Medical Director or designee, and ADCRR Complex Compliance Monitor.
- 1.2. Upon referral to CHP staff, the following initial assessment procedures shall be completed:
  - 1.2.1. General physical exam by a CHP Practitioner within 24 hours for evaluation, including height, weight, and vital signs.
  - 1.2.2. Dipstick Urinalysis.
  - 1.2.3. Complete blood count and chemistry profile.
  - 1.2.4. Serum pregnancy test on female patients.
  - 1.2.5. Psychiatric or psychological assessment to determine patient's capacity to make decisions.
    - 1.2.5.1. For patient's found by mental health to be without the capacity to make decisions, legal proceedings shall be initiated to obtain a court order for forced care in accordance with Department Order #1101, Inmate Access to Healthcare.
- 1.3. CHP staff shall communicate findings of initial assessment procedures and outcome of Mental Health evaluation to Security staff who will facilitate patient housing relocation and property limitations as appropriate in accordance with Department Order #1101, Inmate Access to Healthcare.

2.0. Monitoring and Support Activity

2.1. A “Clinical Staffing” (to include Operational staff and CHP Mental Health staff) shall be convened within 24 hours of notification to discuss the patient’s purpose of the hunger strike.

2.1.1. Results of the Clinical Staffing shall be communicated in writing to CHP Regional Medical Director and ADCRR Assistant Director for Medical Services or designee on the same day the Clinical Staffing was completed.

2.2. CHP medical staff shall assess full vital signs, including weight at least once every 24 hours while a patient is on a hunger strike and documented in the patient’s health record.

2.3. Water intake is to be documented at least once every 24 hours.

2.3.1. Lab testing (e.g., urine specific gravity) may be utilized to access a patient’s hydration status.

2.4. Other medical procedures, including, Mental Health Assessments shall be repeated as medially indicated.

2.5. The CHP FHA or designee is to be updated on a daily basis of the patient’s general medical condition.

3.0. Refusal to Accept Treatment/Support

3.1. For patients on a declared hunger strike whose condition becomes life threatening, CHP Supervising Physician or designee shall ensure the patient is sent to an acute care facility for observation and/or treatment.

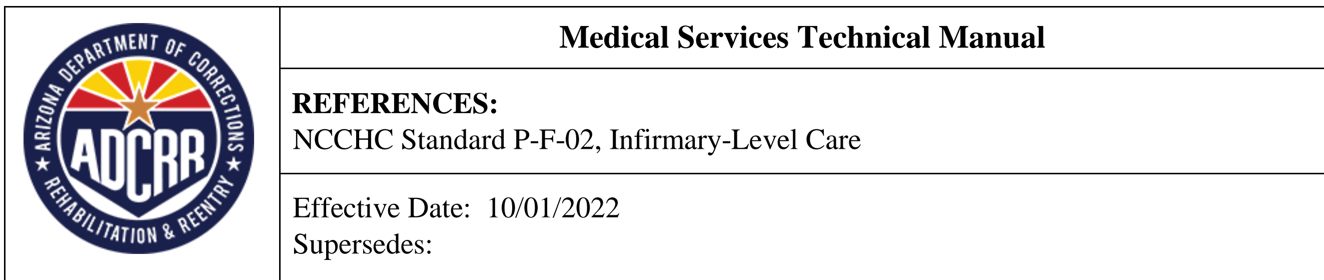
3.1.1. The CHP FHA shall notify their general counsel advising of the need for involuntary forced feeding prior to hospitalization, in accordance with Department Order #1101, Inmate Access to Healthcare.

4.0. Release from Hunger Strike Status

4.1. A declared hunger strike shall be documented as terminated upon the patient’s ingestion of food excluding water and medication for a sufficient period of time as determined by CHP Practitioner.

4.1.1. Only a CHP Medical Practitioner may order that a patient be released from a hunger strike evaluation and treatment.

4.1.2. The CHP Practitioner order must be documented in writing in the patient’s health record.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-F-02, Infirmary-Level Care
	Effective Date: 10/01/2022 Supersedes:

P-F-02.01 Infirmary Operations

PURPOSE: To define the scope of medical, psychiatric, and nursing care provided onsite to patients whose medical conditions warrants a higher level of nursing care than can be provided in the general housing areas.

RESPONSIBILITY: To provide continuity of care and ongoing clinical support for patients, CHP will provide subacute healthcare services within the designated facilities which matches ongoing needs of the patients at the appropriate level and type of clinical needs which include medical, nursing, and mental health, ranging from Infirmary level of care to lower levels of care which includes IPC levels 1, 2, 3, and Mental Health, Sheltered Housing, and Observation. This level of care will be assigned by a Provider and based on the acuity and complexity of the patient's condition and the type of needed services and resources.

PROCEDURES:

1.0. General Infirmary Information
- 1.1. The following housing options are available to patients who require infirmary care:
  - 1.1.1. Inpatient Component (IPC); also referred to as Infirmary
  - 1.1.2. Sheltered Housing; for patients who are Special Needs Unit status but located in an IPC
  - 1.1.3. Observation Beds
- 1.2. A manual of nursing care procedures is located at each unit and is consistent with the state's nurse practice act and licensing requirements.
- 1.3. Movement in and out of the IPCs is controlled and directed by the CHP medical personnel and is based upon a patient's medical condition. IPCs are NOT to be used for detention or other security purposes.
- 1.4. All medical visits in the IPC will be provided in at no charge.
- 1.5. Health Needs Request (HNR) forms are not completed by infirmary patients. Patients discuss health issue(s) during Provider or nursing rounds, via call light system, or ask Detention to contact healthcare staff.

2.0. Staffing Requirements: The number of qualified healthcare professionals providing infirmary-level care is based on the number of patients, the severity of their illness, and the level of care required for each.
- 2.1. <u>IPC Staffing:</u>
  - 2.1.1. A CHP Registered Nurse (RN) Supervisor will be responsible for the daily activities of the nursing staff on the unit.
  - 2.1.2. A CHP Licensed Practical Nurse (LPN) may be assigned to augment the activities of the RN.
    - 2.1.2.1. LPNs shall NOT be the supervising caregiver in an IPC.

2.1.3. CHP Certified Nursing Assistant (CNA) can be utilized to provide assistance with activities of daily living and routine care such as monitoring vital signs.

2.1.4. CHP Mid-level Practitioners may deliver care in the IPC under the supervision of a physician.

3.0. Admission/Discharge: An IPC admission note will be documented on every new admission to the IPC. The CHP Provider will complete a discharge summary when the patient is discharged from the IPC.

3.1. Admissions from another complex, intake, general population, or mental health unit:

3.1.1. Communication shall take place between the sending and receiving facilities.

3.1.2. The request for patient movement shall be forwarded by CHP personnel at the receiving facility to ADCRR Central Classification.

3.1.3. Clinic nurse tasks from referring facility:

3.1.3.1. Calls Infirmary to notify staff of pending admission and gives report to CHP IPC RN.

3.1.3.2. Notifies security to transport patient to Infirmary, if applicable.

3.1.3.3. Forwards patient-specific medication, by a corrections officer, to Infirmary in a secured bag.

3.1.3.4. Arranges for health records to be transferred to the receiving IPC by the sending facility, if applicable.

3.1.4. Receiving IPC CHP nurse:

3.1.4.1. Admits patient to Infirmary Level 1 and completes admission orders.

3.1.4.1.1. If there is no on-site CHP Provider, may obtain phone admission orders.

3.2. Admission from outside medical facility, hospital, or rehabilitation facility:

3.2.1. CHP health staff will obtain the patient's health records.

3.2.1.1. Sending hospital sends (through facsimile or electronic transmission) hospital provider discharge summary to the CHP Infirmary Provider or designee.

3.2.2. CHP Infirmary Provider or designee:

3.2.2.1. Reviews hospital discharge summary to determine if patient is appropriate for admission to Infirmary.

3.2.2.2. Admits patient to Infirmary Level 1 and enters admission orders.

3.2.3. Infirmary clinic CHP nurse:

3.2.3.1. Obtains verbal report from sending hospital nurse.

3.2.3.2. When there is no CHP Provider available, CHP nurse admits patient to Infirmary Level 1 and completes admission orders, through telephone or verbal order.

3.2.3.3. Notifies Security and ADCRR Central Classification that patient will be admitted to the Infirmary upon release from the hospital.

4.0. Clinical Responsibilities:

4.1. CHP Medical Provider:

4.1.1. **No more than 72 hours will lapse between visits to the IPC units.** In the absence of the assigned CHP Medical Provider**,** another CHP Provider will be assigned the responsibility of the visits.

4.1.2. On weekends/holidays after normal duty hours, the CHP Provider designated on the urgent notification roster will be called for orders when needed.

4.1.2.1. The CHP Provider will rewrite the orders on the next normal workday.

4.1.3. Patients admitted to the IPC will have a history and physical completed by the CHP Provider within 72 hours of arrival.

4.2. CHP Infirmary RN:

4.2.1. Admission assessment is documented within 1 hour of admission

4.2.2. Ensures infirmary CHP staff provides instruction to patient regarding call light, bed controls, side rails, ensures ID tag, and gives patient a Guide to the Infirmary.

4.2.3. At least daily, a supervising RN ensures that care is being provided according to CHP Provider order.

4.2.4. Verifies/Obtains orders that include diagnosis, allergies, medications, diet, activity/restriction, diagnostics required, special needs,

4.2.5. Collects any keep-on-person (KOP) medications that may have arrived with the patient upon admission.

4.2.6. Ensure all medications are administered by Direct Observation Therapy (DOT) or as ordered by Provider.

5.0. Level and Scope of Care in the IPC: The frequency of provider and nursing rounds for patients who need infirmary-level care is specified based on clinical acuity and the categories of care provided.

5.1. Infirmary-Level of Care is defined as care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention.

5.2. Patient who need infirmary-level care are always within sight or hearing of a facility staff member, and a CHP qualified healthcare professional that can respond in a timely manner.

5.3. All IPC patients shall have a properly working call light or buzzer.

5.3.1. If call lights or buzzers are not functional, CHP staff shall perform and document 30-minute patient welfare checks.

5.3.2. The use of nonmedical staff to alert CHP health staff in the event of need does not constitute compliance.

5.4. Level of care is ordered by the CHP IPC Provider. As clinical situation changes, the level of care is updated by the CHP IPC Provider:

5.4.1. Level 1: (IPC status)

5.4.1.1. New admissions to the infirmary are Level 1, until evaluated by a CHP Practitioner.

5.4.1.2. Medical provider rounds daily, Monday through Friday (excluding holidays).

5.4.1.3. Nursing assessments every - shift.

5.4.1.4. Vital Signs every - shift

5.4.2. Level 2: (IPC status)

5.4.2.1. Medical provider rounds three times per week (excluding holidays and weekends)

5.4.2.2. Nursing assessment three times per week

5.4.2.3. Vital signs three times per week

5.4.3. Level 3: (Sheltered Housing status)

5.4.3.1. Medical Provider rounds once per month or more often, as indicated

5.4.3.2. Nursing assessments once per week

5.4.3.3. Vital signs once per week

5.4.3.4. Access to non-emergent healthcare services via a Health Needs Request (HNR) shall be made available.

6.0. Observation Beds: Physical locations for infirmary-level care may also be used to provide observation beds. Observation beds are designated for medical or mental health observations for specific purposes.

6.1. Examples of situations that may warrant placements in an observation bed include:

6.1.1. Watching the patient's response to a change in a medication regimen

6.1.2. To prevent a patient from eating or drinking before a medical test

6.1.3. To allow patients to recover from day surgeries or medical procedures

6.1.4. To watch the general behavior of patients whose medical or mental stability appears questionable

6.2. Observation patients may be placed by a CHP qualified healthcare professional other than a CHP provider.

6.2.1. A Provider order is required for observation to continue beyond a 24 hour period when patient is placed in observation by a CHP qualified healthcare professional other than a CHP provider.

6.2.2. If a patient's observation status will exceed 48 hours than they need to be admitted to the IPC.

6.3. CHP staff members are available to assist patients on observation status 24 hours per day, seven days per week.

6.3.1. A CHP Provider is on-call 24 hours per day, seven days per week.

6.3.2. Patients are always within sight or hearing of a CHP qualified healthcare professional.

6.3.3. A supervising RN is onsite at least once every 24 hours.

6.4. When a patient is admitted to an observation bed for mental health reasons, the patient's mental healthcare is supervised by mental health clinicians.

6.5. A CHP Provider's order is required for release from observation.

7.0. Sheltered Housing: Physical locations for infirmary level care may also be used to provide sheltered housing for patient who are SNU status but located in an IPC.

7.1. Patients discharged from IPC, Infirmary Level of Care 1 or 2 but awaiting placement in a SNU shall receive care at IPC Level 3 (Sheltered Housing status):

7.1.1. Medical Provider rounds once per week or more often, as indicated

7.1.2. Nursing assessments once per week

7.1.3. Vital signs once per week

8.0. Mental Health (MH) Services for IPC patients

8.1. Patients continue to receive appropriate MH services for needs that have been previously identified or were identified at the time of admission.

8.2. CHP Infirmary RN reviews health record and/or hospital information and notifies Infirmary-assigned CHP MH staff that the transferring patient is in need of MH services.

8.3. If patient was on psychotropic medications at the time of admission to Infirmary, the CHP Practitioner reviews orders and health record to initiate new orders, as appropriate.

8.4. CHP MH staff assigned to the infirmary conducts a MH assessment, schedules psychiatric evaluation as needed, and initiates appropriate interventions if patients is a danger to self or others.

8.5. Patients shall not be admitted to an IPC bed for mental health watches.

9.0. Health records for patients who need infirmary-level care include:

9.1. Complete documentation of the care and treatment given that includes:

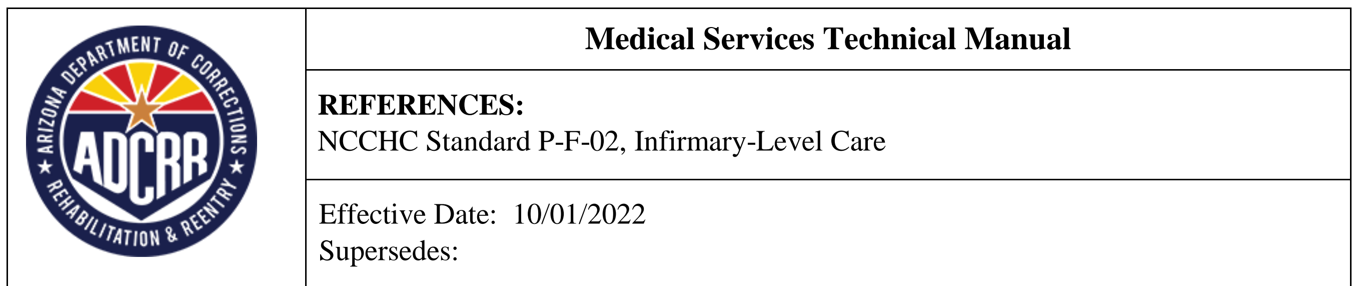
9.1.1. Initial clinical note that documents the patient's acute and chronic conditions and the reason for infirmary-level care.

9.1.2. Admitting order with diagnosis, reason for infirmary-level care, treatment goals and monitoring plan.

9.1.2.1. Admission orders shall include at a minimum level of care required, medication, diet, activity restrictions, diagnostic tests, and any necessary treatments.

9.1.3. Electronic Medication Administration Record.

9.1.4. Discharge plan and discharge notes.



	Medical Services Technical Manual
	REFERENCES: NCCHC Standard P-F-02, Infirmary-Level Care
	Effective Date: 10/01/2022 Supersedes:

P-F-02.02 Special Needs Unit (SNU)

PURPOSE: To define the scope of medical, psychiatric, and nursing care provided onsite to patients whose medical conditions warrants a higher level of nursing care than can be provided in the general housing areas but does not warrant infirmary-level care.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide SNU care for patients with health related issues that do not require infirmary-level care.

PROCEDURES:

1.0. The SNU provides care to patients with an illness or diagnosis that may require monitoring, medication and/or therapy less frequently than in an IPC setting, or may require assistance with activities of daily living (ADL).
  - 1.1. This unit allows for the provision of care to patients whose health needs require a protective environment than in the general population housing areas.
  - 1.2. The patients in this area require assistance with some of their care.
  - 1.3. Often they require cueing for some activities and medication administration.

2.0. Admissions to the SNU shall be coordinated through the CHP Site Medical Director or designee of the facility where the SNU is located.
  - 2.1. Admission and discharge of patients into and out of a SNU is done under the order of a CHP Medical Practitioner.
  - 2.2. CHP Practitioner rounds once per month or more often, as indicated
  - 2.3. CHP nursing staff shall visit the SNU at least every shift and more often, as indicated for the health and welfare of the assigned patient.
    - 2.3.1. A weekly documented nursing assessment shall be performed.
    - 2.3.2. All assessments shall include complete vital signs and weights with documentation.
    - 2.3.3. Access to non-emergent healthcare services via a Health Needs Request (HNR) shall be made available.

3.0. Staffing: The number of qualified healthcare professionals providing care in a SNU is based on the number of patients, the severity of their illnesses, and the level of care required for each.
  - 3.1. A CHP Registered Nurse (RN) shall be assigned to monitor the care provided in the unit.
  - 3.2. CHP Licensed Practical Nurse may be assigned to provide the nursing care in the unit with a CHP RN on-site for consultation when needed.
  - 3.3. CHP Certified Nursing Assistant may assist patient with personal care and ADLs as needed.

3.4. CHP Mid-level Practitioners may be assigned to provide the medical care.

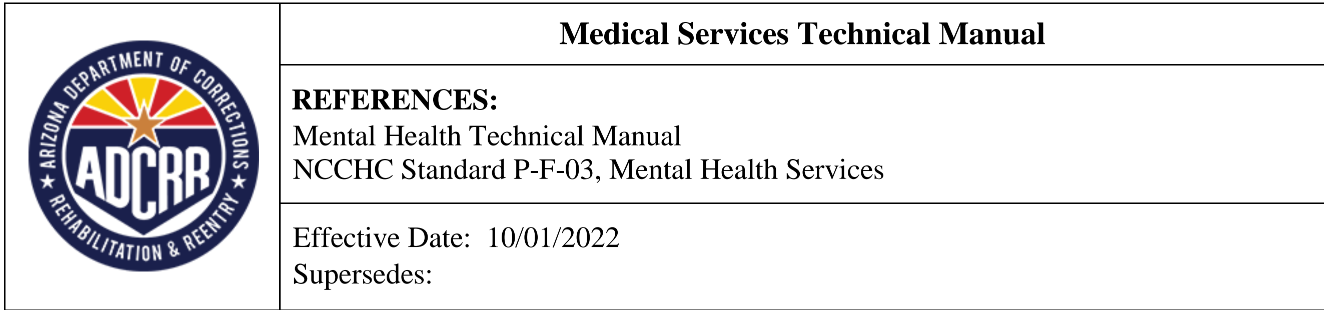
4.0. Mental Health (MH) Services for SNU patients

4.1. Patients continue to receive appropriate MH services for needs that have been previously identified or were identified at the time of admission.

4.2. CHP RN reviews health record and/or hospital information and notifies assigned CHP MH staff that the transferring patient is in need of MH services.

4.3. If patient was on psychotropic medications at the time of admission to the SNU, the CHP Practitioner reviews orders and health record to initiate new orders, as appropriate.

4.4. Assigned CHP MH staff conducts a MH assessment, schedules psychiatric evaluation as needed, and initiates appropriate interventions if patients is a danger to self or others.



	Medical Services Technical Manual
	REFERENCES: Mental Health Technical Manual NCCHC Standard P-F-03, Mental Health Services
	Effective Date: 10/01/2022 Supersedes:

P-F-03.01 Mental Health Services

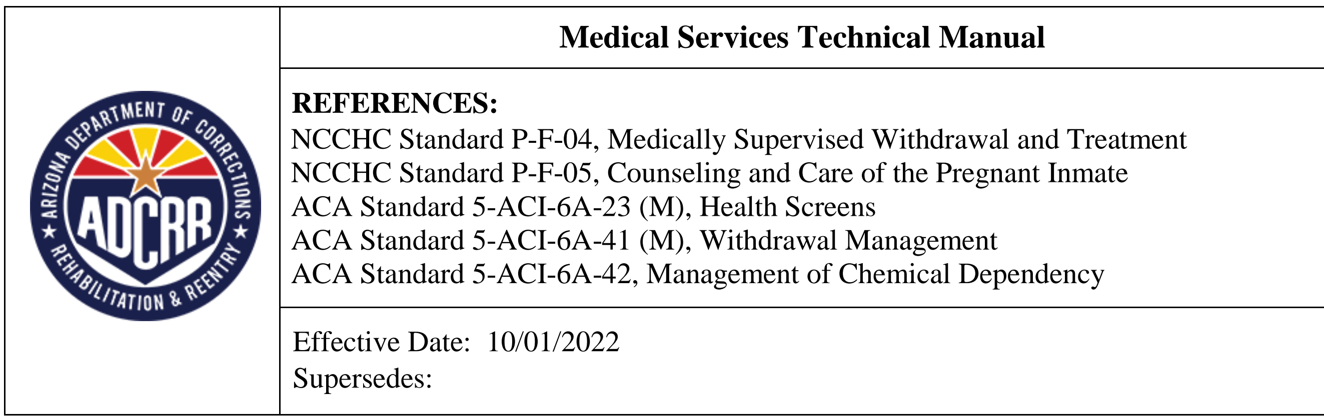
PURPOSE: To ensure mental health services are available for all patients who require them.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) To ensure patient's mental health needs are addressed on-site or by referral to appropriate alternative facilities.

PROCEDURE:

1.0. Outpatient mental health services are provided as outlined in the Mental Health Technical Manual (MHTM).

2.0. When commitment or transfer to an inpatient psychiatric setting is clinically indicated, procedures are followed in accordance with the MHTM.



Medical Services Technical Manual

REFERENCES:
NCCHC Standard P-F-04, Medically Supervised Withdrawal and Treatment
NCCHC Standard P-F-05, Counseling and Care of the Pregnant Inmate
ACA Standard 5-ACI-6A-23 (M), Health Screens
ACA Standard 5-ACI-6A-41 (M), Withdrawal Management
ACA Standard 5-ACI-6A-42, Management of Chemical Dependency

Effective Date: 10/01/2022
Supersedes:

P-F-04.01 Medically Supervised Withdrawal and Treatment

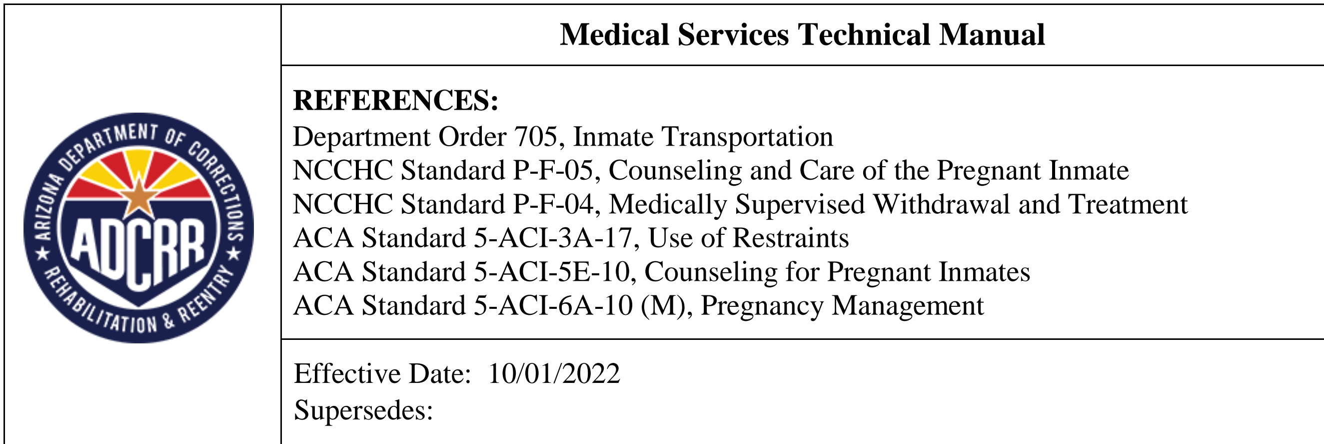
PURPOSE: To provide guidance to the Contract Healthcare Provider (CHP) staff in the appropriate management of patients who are intoxicated or withdrawing from alcohol or drugs and to provide guidance in educating and counseling the inmate population on drug and alcohol intoxication and abuse.

RESPONSIBILITY: It is the responsibility of CHP staff to evaluate and complete appropriate physical clinical assessments of intoxication and withdrawal of all patients and provide treatment for the physiological results of disorders associated with alcohol and other drugs as required.

PROCEDURE:

1.0. CHP staff shall obtain drug and alcohol use history of each new intake and evaluate for indication of drug or alcohol intoxication.
- 1.1. If clinically indicated, patient is referred to the CHP Practitioner for evaluation, or monitoring, or treatment in accordance with national guidelines.
  - 1.1.1. Any patient entering the facility on medication-assisted treatment (MAT) has their medication continued or a plan for medically supervised withdrawal is initiated.
- 1.2. For treatment of pregnant patients on MAT, refer to Medical Services Technical Manual P-F-05.01, Counseling and Care of the Pregnant Inmate.
- 1.3. Patients identified with disorders associated with alcohol and other drugs (e.g., HIV, liver disease) are recognized and treated in accordance with approved chronic care treatment guidelines.

2.0. CHP staff shall respond to any indication of alcohol intoxication or withdrawal symptoms:
- 2.1. Document observations in the health record.
- 2.2. Contact a CHP Practitioner immediately upon suspicion of active drug, alcohol intoxication, or withdrawal.
  - 2.2.1. Patients experiencing mild to moderate signs and symptoms shall be placed where staff can observe them and be monitored closely for increased severity of symptoms by qualified CHP staff using approved protocols as clinically indicated until symptoms have resolved.
    - 2.2.1.1. Protocols shall be reviewed annually by the ADCRR Medical Director or designee and are consistent with nationally accepted treatment guidelines.
  - 2.2.2. Patients experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to the hospital for treatment.



	Medical Services Technical Manual
	REFERENCES: Department Order 705, Inmate Transportation NCCHC Standard P-F-05, Counseling and Care of the Pregnant Inmate NCCHC Standard P-F-04, Medically Supervised Withdrawal and Treatment ACA Standard 5-ACI-3A-17, Use of Restraints ACA Standard 5-ACI-5E-10, Counseling for Pregnant Inmates ACA Standard 5-ACI-6A-10 (M), Pregnancy Management
	Effective Date: 10/01/2022 Supersedes:

P-F-05.01 Counseling and Care of the Pregnant Inmate

PURPOSE: To address the healthcare needs of patients throughout their pregnancy and postpartum stages in a manner that aligns with best practices, identifies risk and improves patient outcome.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) site Medical Director or designee and CHP complex Director of Nursing (DON), to assure that the CHP Obstetrician/Gynecologist (OB/GYN) or offsite OB/GYN and CHP nursing staff provide necessary counseling and care that align with best practices to pregnant patients throughout the intrapartum and postpartum timeframe.

PROCEDURES:

1.0. Intake Evaluation, Counseling, and Education for Pregnant Patients

- 1.1. Inmates new to Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) or parole violators returning to custody, with a verified pregnancy, shall be provided counseling on the day of arrival by the CHP intake nurse.
- 1.2. All counseling/education provided by the CHP medical staff related to pregnancy shall be documented within the patient health record.
- 1.3. Pregnant patients identified with active opioid use disorder at intake shall be evaluated by CHP Practitioner to determine need for medication-assisted treatment (MAT) with methadone or buprenorphine.
  - 1.3.1. If the patient is taking MAT during pregnancy due to opioid addiction, the CHP OB/GYN shall discuss ongoing use and issues, as well as prepare the patient for the cessation of the MAT following delivery.

2.0. Ongoing Pregnancy Care and Counseling

- 2.1. The CHP OB/GYN Practitioner will meet on a scheduled basis with all pregnant patients at a frequency determined by the progression of their pregnancy and special needs.
  - 2.1.1. Prenatal laboratory, diagnostic tests, and vaccine administration shall be completed in accordance with national guidelines.
  - 2.1.2. Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions.
  - 2.1.3. Counseling and education shall be provided in accordance with the pregnant patient expressed desires regarding her pregnancy and shall include keeping the child, the use of adoptive services, or abortion if allowed by state law.

2.1.4. The patient shall be provided an opportunity to ask questions about her pregnancy and questions are answered as comprehensively as possible.

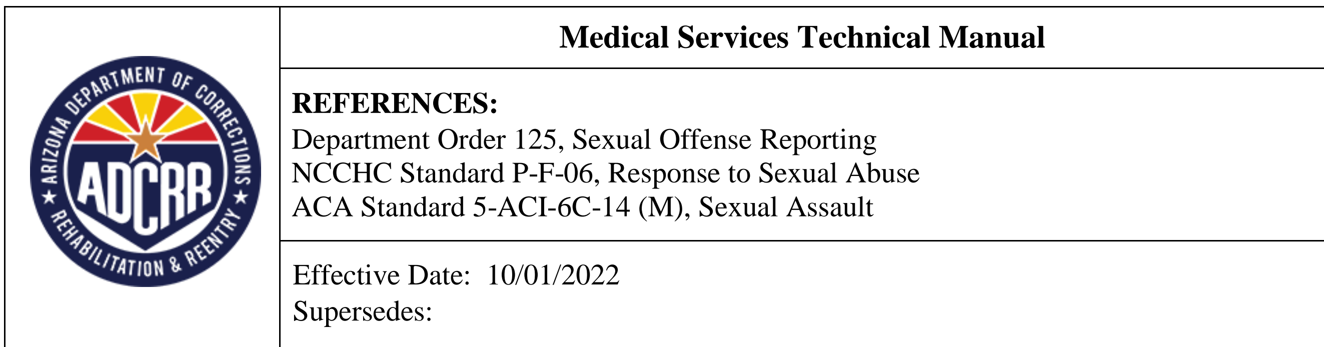
3.0. The mother and newborn baby may be transferred to an offsite facility for bonding purposes following hospital discharge prior to returning to the prison complex.

4.0. Routine offsite follow-up protocols shall be followed upon the patients return to complex.

5.0. Post-Partum Counseling: The CHP OB/GYN will schedule the patient for a follow-up appointment after delivery to evaluate medical needs related to post-pregnancy issues as well as any mental health needs that would warrant a referral to mental health services.

6.0. The CHP FHA of any ADCRR prison complex where pregnant patients are housed shall have Doppler fetal heart tone monitors available as well as emergency delivery kit(s) within the facility.

7.0. It is the responsibility of the Warden to ensure that pregnant patients are transported and restrained in accordance with Department Order #705, Inmate Transportation.



	Medical Services Technical Manual
	REFERENCES: Department Order 125, Sexual Offense Reporting NCCHC Standard P-F-06, Response to Sexual Abuse ACA Standard 5-ACI-6C-14 (M), Sexual Assault
	Effective Date: 10/01/2022 Supersedes:

P-F-06.01 Response to Sexual Abuse

PURPOSE: To ensure inmates who report or seek healthcare attention as a result of sexual assault during incarceration shall receive prompt attention for treatment and evidence gathering as required. The Arizona Department of Corrections Rehabilitation & Reentry (ADCRR) policy encourages victims of sexual assault to report the assault and the Department encourages cooperation in its investigation and prosecution. The identity and dignity of the victim will be protected to the fullest extent possible.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide access to PREA educations to all staff, report any findings or complaints of sexual assault or abuse from patients, provide supportive care to the individual and ensure that victims of sexual abuse receive appropriate intervention and treatment.

PROCEDURE:

1.0. Department Order #125, Sexual Offense Reporting outlines the guidelines and protocols regarding the detection, prevention, and reduction of sexual abuse.

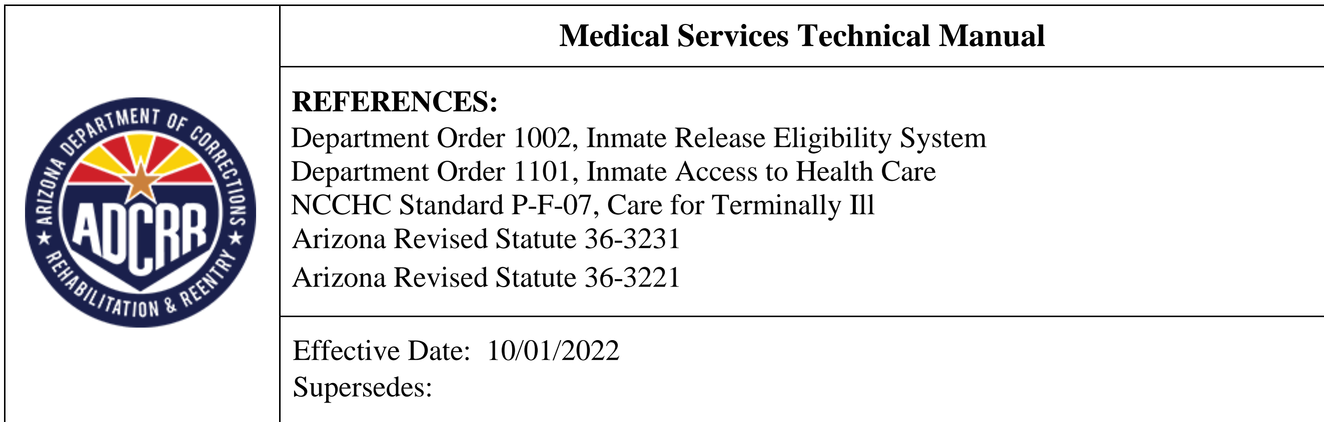
2.0. Suspected victim of sexual assault shall be escorted to the health unit for medical and mental health evaluation and assessment.
   2.1. At no time will staff leave the victim alone until evaluated by CHP Mental Health staff.

3.0. The victim shall be transported to the hospital emergency room for the collection of forensic evidence and medical treatment if determined appropriate by CHP Medical or Mental Health Provider.

4.0. CHP staff shall **not** conduct forensic examinations. If a forensic examination is appropriate the suspected victim shall be taken to a hospital emergency room for such an examination.

5.0. CHP staff will be trained in the *preservation* of physical evidence of sexual abuse.

6.0. Upon return from the hospital the following activities shall occur:
   6.1. Prophylactic treatment and follow-up care for sexually transmitted infections or other communicable diseases (e.g., HIV, hepatitis B) are offered to all victims, as appropriate.
      6.1.1. Emergency contraception is available to female victims of sexual assault, if allowed by the state law.
   6.2. Evaluation by CHP qualified mental health professional for crisis intervention counseling and follow-up as clinically indicated.



	Medical Services Technical Manual
	REFERENCES: Department Order 1002, Inmate Release Eligibility System Department Order 1101, Inmate Access to Health Care NCCHC Standard P-F-07, Care for Terminally Ill Arizona Revised Statute 36-3231 Arizona Revised Statute 36-3221
	Effective Date: 10/01/2022 Supersedes:

P-F-07.01 Care for Terminally Ill

PURPOSE: To establish guidelines that ensure consistent management practices in providing end of life care for Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) patients and to provide basic responsibilities and a foundational outline to guide in the development of a hospice/palliative care program.

RESPONSIBILITY: It is the responsibility of Contract Healthcare Provider (CHP) staff to inform inmates of their right to access to care, their right to limit life support measures and to provide care to terminally ill patients in a supportive environment that preserves the patient's dignity.

PROCEDURE:

1.0. Medical Directives: Inmate acknowledgement of rights including Durable Healthcare Power of Attorney and Living Will (End of Life Care) are discussed by the Correctional Officer III (COIII) with the inmate during intake/orientation or during the inmate's correctional plan review in accordance with Department Order #1101, Inmate Access to Healthcare.

- 1.1. Forms included are listed below and copies can be found Legal/Administrative section of the health record:
  - 1.1.1. Durable Healthcare Power of Attorney, Form 1101-97
  - 1.1.2. Living Will (End of Life Care), Form 1101-98
  - 1.1.3. Inmate Acknowledgement of Rights, Form 1101-99
- 1.2. Any request to change or modify Medical Directives by the patient is done by submission of an Inmate Letter, Form 916-1, to their complex COIII in accordance with Department Order #1101, Inmate Access to Healthcare.
- 1.3. Request to revoke Medical Care Directives by the patient is done by submission of Inmate Letter to their complex COIII in accordance with Department Order #1101, Inmate Access to Healthcare, and is completed upon receipt of Revocation of Medical Care Directives, Form 1101-90.

2.0. Do Not Resuscitate (DNR) Orders**:** Patient DNR request will be honored only by healthcare staff in accordance with Department Order #1101, Inmate Access to Healthcare.

- 2.1. DNR orders may be written by a CHP medical Provider in consultation with the patient.
  - 2.1.1. Upon patient's request to be DNR status CHP Practitioner shall complete Prehospital Medical Care Directive (Do Not Resuscitate or DNR) Form and tape this orange DNR form to a wall in a visible location in the nursing station of the IPC or SNU where the patient is housed.

2.1.1.1. Prehospital Medical Care Directive (Do Not Resuscitate or DNR) Form, must be printed on paper with an orange background and may be located at https://www.azag.gov/sites/default/files/docs/seniors/life-care/2020/2020_DNR_2pgs.pdf

2.1.2. Any DNR orders written by a hospital, hospice, or other medical Provider not directly employed by the CHP shall be honored.

2.1.3. A patient may revoke a DNR declaration at any time verbally or in writing stating his or her decision. All DNR identifying papers or other labeling method shall be removed from the patient's area. The paper work shall be placed in the legal section of the patient's health record and be duly annotated as withdrawn.

2.1.3.1. All medically indicated procedures shall be resumed as though the DNR had never been initiated.

2.1.3.2. Patient may reinstate the DNR directive by requesting a new declaration.

2.2. A DNR is for use only by outside healthcare providers, hospitals, and/or hospice facility, or for use by medical staff only while patient is housed in the Inpatient Component (IPC) or Special Need Unit (SNU).

2.2.1. As Private Prisons currently under contract with ADCRR do not maintain IPC or SNU, DNRs shall not be honored in ADCRR Private Prisons.

2.3. All correctional staff members are obligated to engage in life saving measures for any inmate in physical distress regardless of the cause. A patient's prehospital care directive or DNR request does not apply to security staff.

3.0. Surrogate

3.1. If a patient is determined to be unable to make or communicate healthcare treatment decisions, a reasonable effort will be made to contact a surrogate who has been identified by the patient. In the absences of a surrogate who has been identified by the patient, contact will be attempted in accordance with the guidance contained in Arizona Revised Statute; specifically A.R.S. 36-3231 which states in part:

3.1.1. If the patient has a heath care Power of Attorney that meets the requirements of A.R.S. 36-3221, the patients designated agent shall act as the patient's surrogate. However if the court appoints a guardian for the express purpose of making healthcare treatment decisions, that guardian shall act as the patients surrogate.

4.0. Hospice Services: Hospice care will be provided to ADCRR patients as appropriate.

4.1. Patient's become eligible for hospice care when they are diagnosed with a terminal illness and a prognosis of six months or less to live.

4.1.1. CHP Practitioner shall inform the patient of the prognosis and treatment options, which include palliative care upon admission to hospice.

4.1.1.1. The hospice care plan/program shall include pain management, mental healthcare needs, and the DNR process.

4.1.2. Upon placement of the patient in the hospice, care program the treating CHP Practitioner shall notify the CHP FHA who shall schedule interdisciplinary team meetings as necessary, coordinate with security special visits when appropriate, and remain responsible for ensuring all aspects of care are carried out.

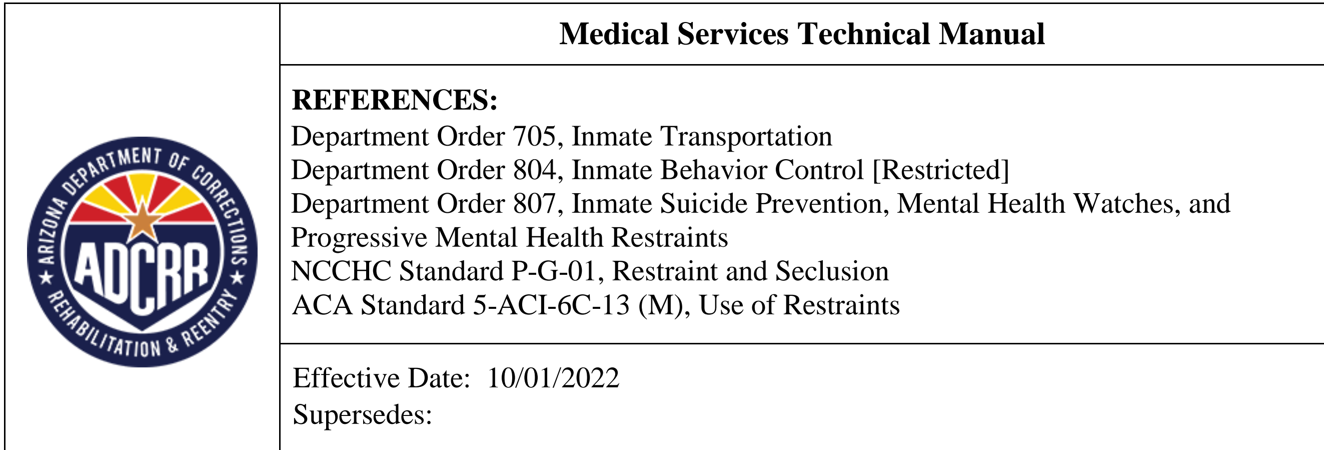
4.2. A multidisciplinary team shall be developed which may include direct care CHP health services staff, religious services, mental health personnel, offsite consulting Practitioners, and other members as deemed necessary by the CHP Facility Health Administrator (FHA) and security staff designated by the Warden.

4.3. CHP medical personnel trained in the delivery of palliative/hospice care will provide direct physical care and medication administration to patient's receiving hospice care.

4.3.1. Volunteers may be used for spiritual and emotional support.

4.3.1.1. Adequately trained, screened, and supervised inmates may be used as volunteers.

5.0. Clemency/Compassionate Release: The CHP FHA will facilitate the early release of terminally ill patients in a timely manner when appropriate consistent with state regulations and in accordance with Department Order #1002, Inmate Release Eligibility System.



Medical Services Technical Manual

REFERENCES:
Department Order 705, Inmate Transportation
Department Order 804, Inmate Behavior Control [Restricted]
Department Order 807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints
NCCHC Standard P-G-01, Restraint and Seclusion
ACA Standard 5-ACI-6C-13 (M), Use of Restraints

Effective Date: 10/01/2022
Supersedes:

P-G-01.01 Clinical Restraint

PURPOSE: To provide guidance in the use of clinically ordered restraints.

RESPONSIBILITY: All Contract Healthcare Provider (CHP) staff are responsible to ensure that when restraints or seclusion are used for clinical or custody reasons the patient is not harmed.

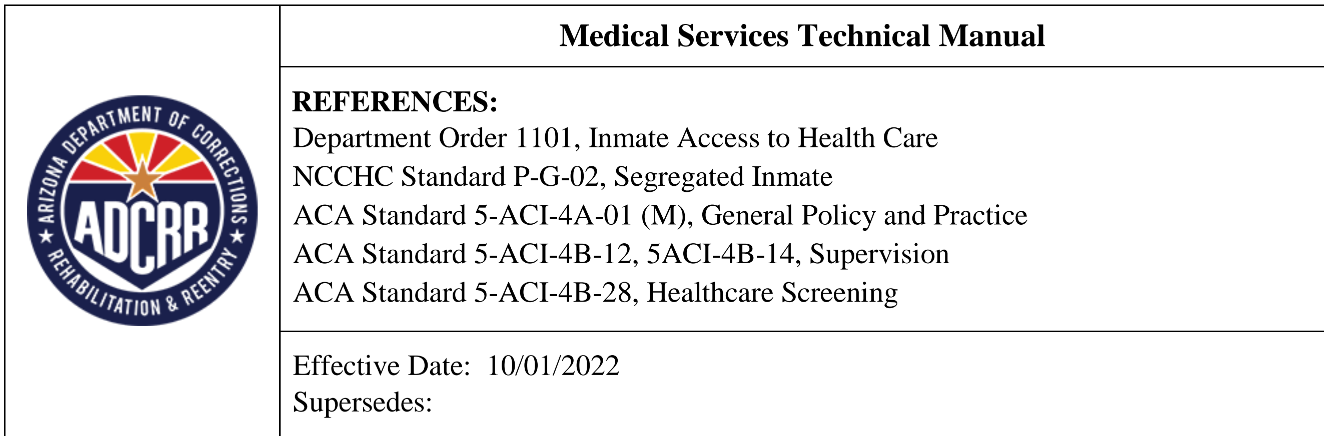
PROCEDURE:

1.0. Clinically ordered restraints:

- 1.1. Policies and procedures related to clinically ordered restraint are defined in Department Order #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints with additional information and guidance found in the Mental Health Technical Manual.

2.0. Custody ordered restraints and/or seclusion:

- 2.1. Policies and procedures related to custody ordered restraint and/or seclusion are defined in Department Order #804, Inmate Behavior Control and Department Order #705, Inmate Transportation.



Medical Services Technical Manual

REFERENCES:
Department Order 1101, Inmate Access to Health Care
NCCHC Standard P-G-02, Segregated Inmate
ACA Standard 5-ACI-4A-01 (M), General Policy and Practice
ACA Standard 5-ACI-4B-12, 5ACI-4B-14, Supervision
ACA Standard 5-ACI-4B-28, Healthcare Screening

Effective Date: 10/01/2022
Supersedes:

P-G-02.01 Segregated Inmate

PURPOSE: To provide continuity of care for all patients who may be transferred into a housing area that has been designated for isolation and/or segregation.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure that patient's medical needs are met, regardless of housing location.

PROCEDURE:

1.0. Security will notify CHP nursing staff of placement of a patient in segregation, including type of segregation/degree of isolation, within one hour after a patient is placed.
   - 1.1. Upon notification of a patient's transfer to segregation a CHP nursing staff member shall perform an immediate chart review to determine if any medical, dental, or mental health issues exist that would contraindicate the placement or require accommodation to the patient's lockdown status.
      - 1.1.1. When the notification includes information that the patient is injured or appears to be ill, CHP nursing staff shall conduct an immediate hands-on assessment.
      - 1.1.2. Documentation of chart review and/or any assessment findings shall be made in the patient's health record.
      - 1.1.3. Keep On Person (KOP) medications will be allowed to continue to be in the possession of the patient provided there is no indication of abuse.
   - 1.2. During the first segregation visit, CHP nursing staff shall complete an initial assessment to include vital signs and weight, any physical abnormalities, including bruises or abrasions.
      - 1.2.1. Any suicide/self-harm ideation shall be brought to the attention of the CHP mental health staff or the CHP Practitioner immediately.

2.0. Rounding Requirements:
   - 2.1. ADCRR does not utilize solitary confinement housing; however, any patient who may encounter staff or other inmates fewer than three times a day, are monitored daily by CHP medical staff and at least once a week by CHP mental health staff.
   - 2.2. CHP medical or mental health staff shall conduct segregation rounds a minimum of three times per week to observe the health status and coordinate any treatment required of segregated patients.
   - 2.3. All rounds shall be documented in the patients' health record and on ADCRR approved rosters or count sheets obtained for each scheduled date.

2.3.1. Documentation of segregation rounds shall include the date and time of contact as well as the signature or initials of the CHP staff member making the rounds.

2.4. Any patient found to be physically or psychologically deteriorating shall be promptly identified and reported to custody staff.

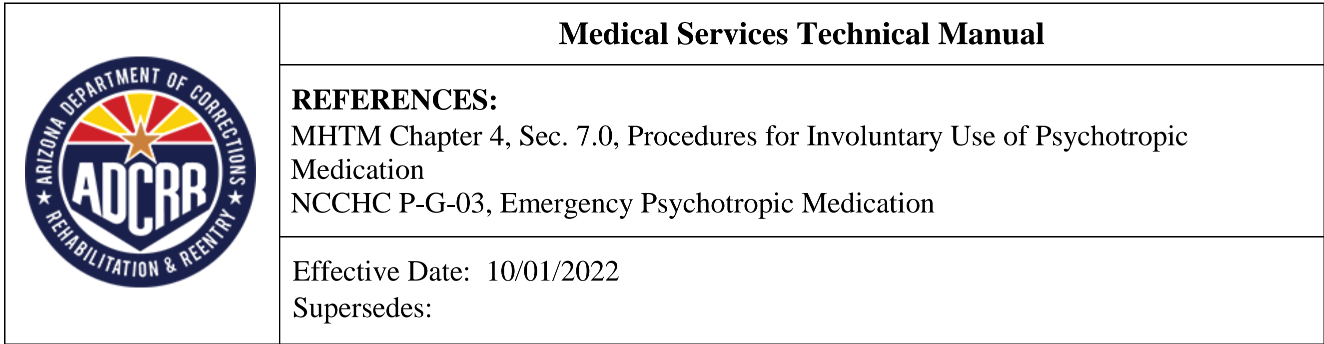
2.5. There will be no healthcare fee for the segregation rounds as the visit was initiated by the CHP staff.

3.0. Segregated patients shall have access to medical, dental, and mental health sick call seven days per week.

3.1. The access to healthcare shall be monitored by the CHP Facility Health Administrator (FHA) to ensure segregated patients have access to routine, urgent, and emergent care.

3.2. Necessary clinical encounters must occur in an appropriate clinical setting and not take place cell side. This requires coordination between the CHP FHA and Warden.

4.0. The CHP FHA is responsible to ensure that segregation rounds records are maintained in a complete form and are available for auditing.



	Medical Services Technical Manual
	REFERENCES: MHTM Chapter 4, Sec. 7.0, Procedures for Involuntary Use of Psychotropic Medication NCCHC P-G-03, Emergency Psychotropic Medication
	Effective Date: 10/01/2022 Supersedes:

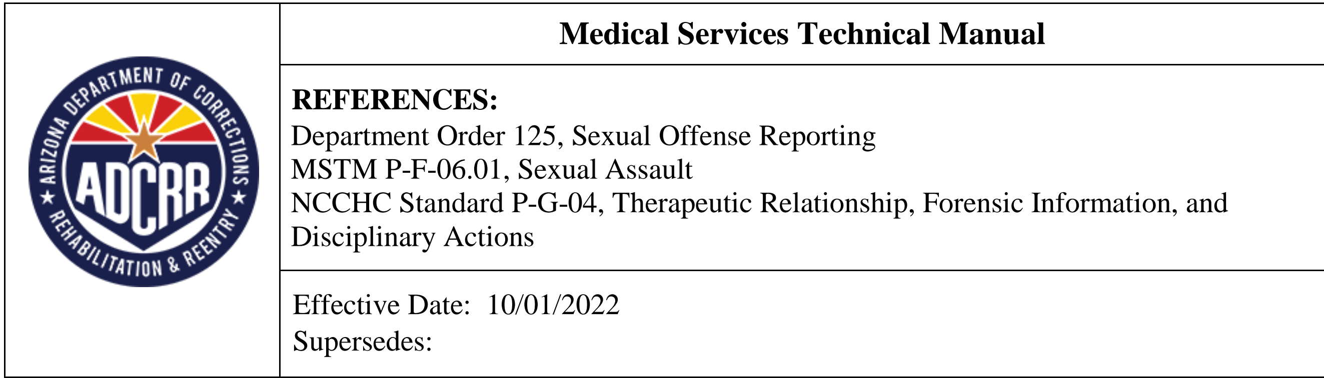
P-G-03.01 Emergency Psychotropic Medication

PURPOSE: To ensure Contract Healthcare Provider (CHP) staff follow policies developed for the emergency use of psychotropic medications as governed by the laws applicable in the jurisdiction and outlined in the Mental Health Technical Manual (MHTM).

RESPONSIBILITY: It is the responsibility of the CHP mental health staff and CHP nursing staff to deliver psychotropic medications to the inmate population and follow policies developed for the emergency use of psychotropic medications as governed by the laws applicable in the jurisdiction and outlined in the MHTM.

PROCEDURE:

1.0 The policies on emergency forced psychotropic medication can be found in the MHTM, Chapter 4, Sec. 7.0, Procedures for Involuntary Use of Psychotropic Medications.



Medical Services Technical Manual

REFERENCES:
Department Order 125, Sexual Offense Reporting
MSTM P-F-06.01, Sexual Assault
NCCHC Standard P-G-04, Therapeutic Relationship, Forensic Information, and Disciplinary Actions

Effective Date: 10/01/2022
Supersedes:

P-G-04.01 CHP Role in Collection of Evidence for Forensic Information related to Disciplinary and/or Legal Actions

PURPOSE: To ensure Contract Healthcare Provider (CHP) staff protect the integrity of the therapeutic partnership with their patients and to provide guidance regarding collection of or participation in collection of forensic information. Forensic information is physical data or items collected from a patient that may be used against him or her in disciplinary or legal proceedings.

RESPONSIBILITY: CHP Facility Health Administrators (FHA) are responsible to ensure that CHP staff assigned under their management does not participate in collection of forensic information for punitive purposes.

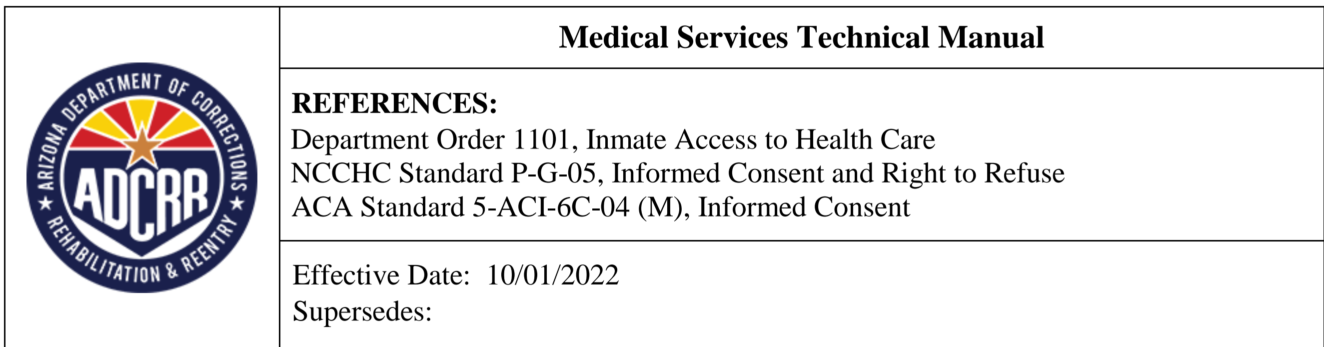
PROCEDURE:

1.0. CHP staff is prohibited to conduct forensic examinations except when:
- 1.1. Complying with State laws in collecting DNA samples for databases; or
- 1.2. Conducting body cavity searches or body fluid testing when done for medical purposes and under the orders of a physician; or
- 1.3. Conducting court ordered examinations with the consent of the patient.

2.0. As outlined in the Medical Services Technical Manual (MSTM) P-F-06.01, Sexual Assault, if a forensic examination is appropriate the suspected victim shall be taken to a hospital emergency room for such an examination in accordance with Department Order #125, Sexual Offense Reporting.

3.0. If a CHP Practitioner determines an patient requires removal of a foreign body (i.e., old bullet, shrapnel, pencil tip, etc.) for a medical indication and that item may be considered evidence, contact the Criminal Investigation Unit (CIU) supervisor and authorize CIU's attendance at the removal if the collection may be postponed without causing harm to the patient.
- 3.1. If the CIU supervisor determines the item to be of an evidentiary nature, they will witness the removal and advise in the preservation of the item.
- 3.2. If an item is removed as a result of an unplanned discovery, preserve the item and contact CIU for advice and direction.

4.0. CHP health staff do not participate in disciplinary action nor are compelled to provide clinical information solely for the purposes of discipline.
- 4.1. Treatments and medications are never withheld as a form of punishment.
- 4.2. Segregation and restraints are never clinically implemented as disciplinary action.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-G-05, Informed Consent and Right to Refuse ACA Standard 5-ACI-6C-04 (M), Informed Consent
	Effective Date: 10/01/2022 Supersedes:

P-G-05.01 Informed Consent

PURPOSE: To advise Contract Healthcare Provider (CHP) staff that all examinations, treatments, and procedures require the patient's informed consent.

RESPONSIBILITY: It is the responsibility of the CHP to obtain informed consent by providing the patients with information regarding recommended examinations, treatments, and procedures so that the patient can make informed decision regarding their healthcare.

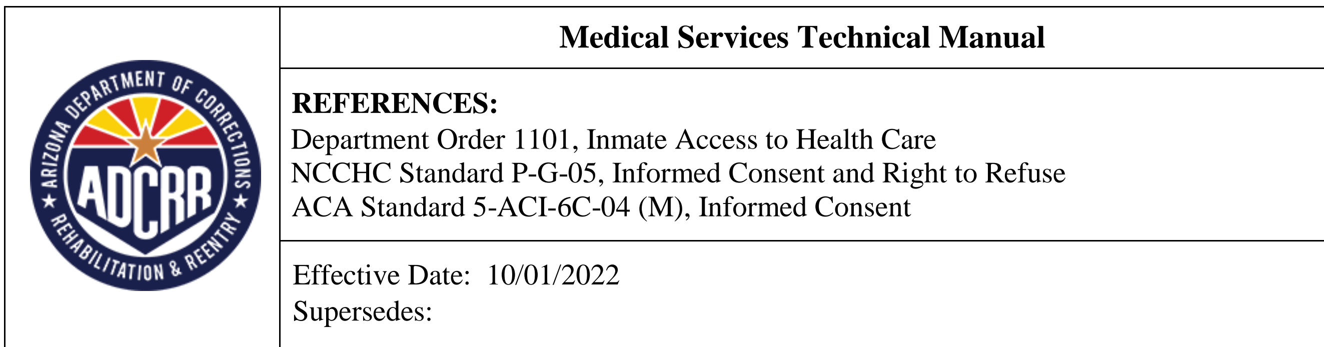
PROCEDURE:

1.0. The CHP Practitioner shall explain the recommended treatment plan in a language and terms the patient can understand.
  - 1.1. The explanation shall include what is being recommended and why.
  - 1.2. The CHP Practitioner shall explain the benefits, risks, and possible side effects of the recommended treatment.
  - 1.3. The CHP Practitioner shall explain any potential alternative treatment.

2.0. The CHP Provider shall document in the health record exactly what was explained to the patient regarding the recommended treatment.

3.0. Request the patient to sign a completed Consent to Treat Form when applicable and scan into the patients' health record.

4.0. The informed consent requirement **will be waived if**: an emergency requires immediate medical intervention for the safety of the patient; or if emergency care involves patients who do not have the capacity or ability to understand the information given or if a court order to treat has been obtained.



	Medical Services Technical Manual
	REFERENCES: Department Order 1101, Inmate Access to Health Care NCCHC Standard P-G-05, Informed Consent and Right to Refuse ACA Standard 5-ACI-6C-04 (M), Informed Consent
	Effective Date: 10/01/2022 Supersedes:

P-G-05.02 Appointment or Treatment Refusal

PURPOSE: To outline the process for documentation of a patient's refusal to attend an appointment or accept a recommended treatment for specific health issue. Patients have the right to make informed decisions regarding healthcare, including the right to refuse care.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible to inform the patient of any purposed or recommended treatment plan and obtain the patient's signed refusal should they choose not to accept the recommended treatment. The CHP licensed staff is responsible to educate the patient on potential consequences prior to obtaining signed refusal.

PROCEDURE:

1.0. A patient has the right to refuse any health evaluation and/or proposed treatment.
- 1.1. The CHP shall ensure a description of the service being refused is documented.
- 1.2. The CHP staff document evidence that the patient has been informed of any adverse health consequences that may occur because of the refusal.

2.0. Any request made by the patient to refuse medical services for the following conditions must be made in person by the patient coming to or being escorted to the health unit to sign the refusal:
- 2.1. For a serious or emergent medical condition
- 2.2. A follow-up with a CHP medical, mental health, or dental Provider
- 2.3. An on-site diagnostic test such as lab or x-ray
- 2.4. Any on-site specialty visit including telemedicine

3.0. Refusal of appointments for off-site medical care by specialists must be completed by the patient, in person, at the patient's treating health unit whenever possible based on availability of the CHP staff to take the refusal.

4.0. Documentation of Refusal: The patient must document their refusal by properly completing and signing the Refusal to Submit to Treatment, Form 1101-4, or electronic equivalent and submitting it to the CHP.
- 4.1. The patient's signature on the form or electronic signature, must be witnessed and signed by one CHP staff member.
- 4.2. CHP staff will document their efforts to explain the consequences and risk of this refusal.
- 4.3. The Refusal to Submit to Treatment, Form 1101-4, shall be scanned into the patients' health record, if not completed electronically within two business days.

5.0. If a patient refuses to sign a Refusal to Submit to Treatment, Form 1101-4, CHP nursing staff shall, in front of two witnesses:

5.1. Explain the consequences of the patient's refusal to accept the proposed procedure/treatment, in a language the patient can understand.

5.2. Document exactly what was told to the patient regarding the refusal of the procedure/treatment on the Refusal to Submit to Treatment form.

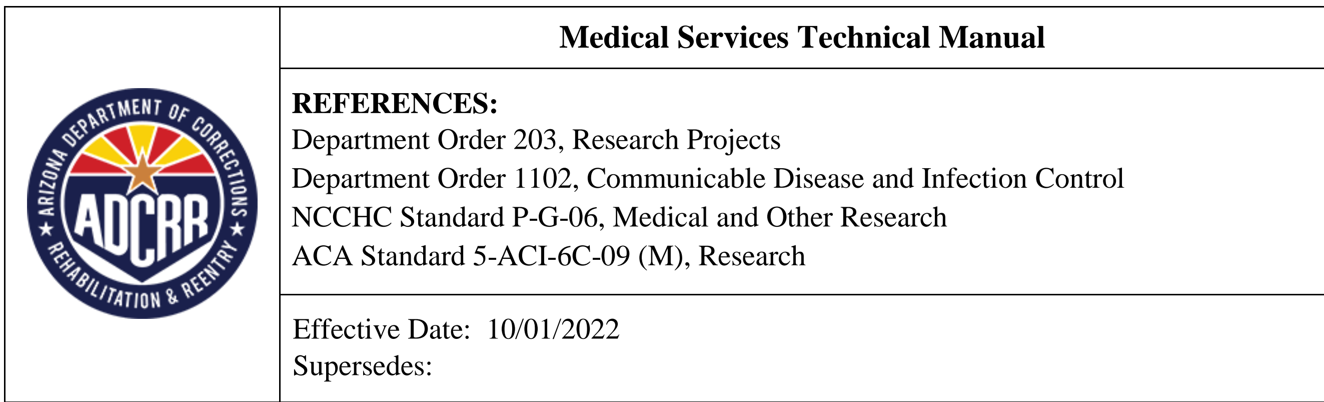
5.3. Have the Refusal to Submit to Treatment signed by the two witnesses.

5.3.1. One witness shall be CHP staff and the second witness may be a member of security staff if necessary.

5.3.2. CHP staff shall ensure the completed refusal is scanned/placed in the appropriate section of the patient's health record.

6.0. If a patient refuses the same treatment or service more than three consecutive times (e.g., a medication, fasting blood sugar, healthcare Practitioner ordered evaluation, etc.), the patient will be counseled by a CHP qualified healthcare professional with documented treatment plan change to reflect informed decision making by patient in the health record.

7.0. If the patient changes their mind, they may seek and be provided treatment if still clinically indicated.



	Medical Services Technical Manual
	REFERENCES: Department Order 203, Research Projects Department Order 1102, Communicable Disease and Infection Control NCCHC Standard P-G-06, Medical and Other Research ACA Standard 5-ACI-6C-09 (M), Research
	Effective Date: 10/01/2022 Supersedes:

P-G-06.01 Participation in Medical, Clinical, or Other Research

PURPOSE: To provide guidance in requesting, authorizing, and performance of biomedical research involving patients and to ensure compliance with all state and federal guidelines.

RESPONSIBILITY: It is the responsibility of the ADCRR Director, ADCRR Assistant Director of Medical Services and Contract Healthcare Provider (CHP) to ensure biomedical, behavioral and any other research using patients as subjects is consistent with established ethical, medical, legal, and regulatory standards for human research and to ensure that patient privacy and health is fully protected in the conduct of any approved research.

PROCEDURE:

1.0. Department Order #203, Research Projects, provides guidance in the process for obtaining approval to conduct research.

2.0. Confidential communicable disease information may be disclosed for epidemiological purposes in accordance with process outlined in Department Order #1102, Communicable Disease and Infection Control.

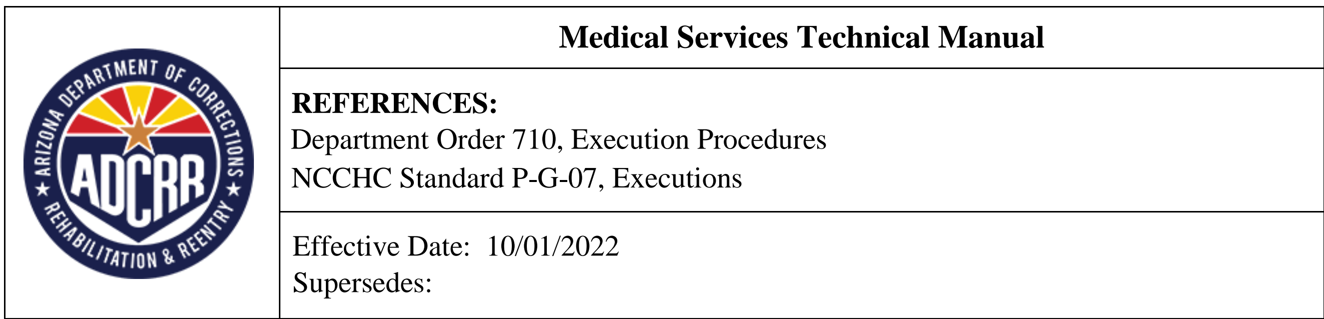
3.0. New arrivals to ADCRR who disclose at intake that they have been participating in a community-based research protocol prior to admission to ADCRR will be interviewed by a CHP Practitioner, and be asked for contact information of the research group.

3.1. The CHP Practitioner shall contact the research group to determine if an adverse reaction may result from the patient's removal from the protocol and notify the CHP Facility Health Administrator (FHA) of findings.

3.1.1. Written verification that the removal of the patient from the protocol will not cause harm to the patient must be received by CHP Practitioner or CHP FHA and documented in the patient's health record.

3.1.2. If an adverse reaction may result from the patient's removal from the protocol, the CHP Practitioner shall immediately contact the CHP Regional Medical Director or designee for approval and coordinate via electronic notification with ADCRR Assistant Director for Medical Services, to allow the patient to continue in the protocol.

3.2. All pertinent information, regarding any patient who refuses to cooperate in identifying the research group or for whom the research group does not provide an affirmative response to consequences of removing the patient from the protocol, is to be forwarded electronically to the CHP Regional Medical Director and to ADCRR Assistant Director of Medical Services or designee for consideration, action, and direction.



	Medical Services Technical Manual
	REFERENCES: Department Order 710, Execution Procedures NCCHC Standard P-G-07, Executions
	Effective Date: 10/01/2022 Supersedes:

P-G-07.01 Executions

PURPOSE: To provide guidance to Medical Services Contract Monitoring Bureau (MSCMB) and the Contract Healthcare Provider (CHP) staff regarding the conduct of inmate executions in the State of Arizona.

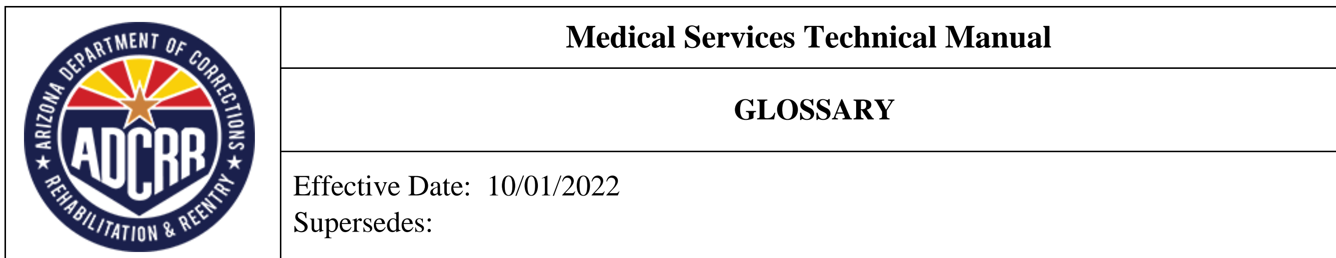
RESPONSIBILITY: Any real or perceived assistance in the execution of inmates is prohibited. It is the responsibility of the CHP to ensure that CHP staff are not assigned to perform services directly related to the execution of a condemned inmate.

PROCEDURE:

1.0. The MSCMB Assistant Director and the CHP shall ensure that healthcare continues throughout the lifespan of the incarcerated inmate.
- 1.1. CHP staff shall not assist in directly causing the death of an inmate.
- 1.2. CHP staff shall not supervise an activity that causes the death of an inmate or pronounce death in an execution.
- 1.3. CHP staff shall not contribute to another individual’s ability to cause the death of an inmate.

2.0. CHP Mental Health services will be provided as necessary. This will not include competency determination. Competency determinations will be provided by contracted professionals and not by the CHP.

3.0. In no event shall an execution be performed in an area designated as a health unit.



	Medical Services Technical Manual
	GLOSSARY
	Effective Date: 10/01/2022 Supersedes:

Glossary

PURPOSE: This document is the official listing and definitions of terms used in the Medical Services Technical Manual. The ADCRR MSCMB reviews and revises as needed this glossary on an annual basis. Suggestions for changes, additions, or deletions to this listing may be submitted for consideration to mscmbtechnicalmanuals@azadc.gov. Changes to the published list will be disseminated to the Contract Healthcare Provider staff for inclusion as they occur or annually as necessary.

- A -

ACCOUNTING: The act of recording, summarizing, analyzing, verifying, and reporting medication usage.

ACIS: (Arizona Correctional Information System) Online screen and batch report used to input data (e.g., inmate movement, medical status, medical holds, restrictions, etc.) to track inmate population.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS): An AIDS diagnosis is made when a person who is HIV positive, has a collapse in the body's natural immune system which allows an AIDS-related disease to occur.

ADMINISTERING: Medication is the act in which a single dose of an identified drug is given to a patient.

ADVERSE CLINICAL EVENT: An injury or death caused by medical management rather than by the patient's disease or condition.

AFB: Acid fast bacillus; M. tuberculosis is an example of an AFB positive organism.

ASSISTED LIVING: Care provided to patients whose health needs require a more protective environment than that in the general population housing areas.

- B -

BOARD OF EXECUTIVE CLEMENCY (BOEC): The BOEC considers and grants parole to inmates certified as eligible by the ADCRR and who meet the legal criteria for a grant of parole and it recommends to the Governor appropriate clemency actions.

- C -

CARRIER: An infected person who harbors an infectious agent in the absence of clinical disease and who serves as a potential source of infection.

CHARGE NURSE: The nursing staff member designated as the responsible nurse for a given shift.

CHRONIC CONDITIONS: Conditions or diseases requiring regular examinations as outlined in Department Order #1101, Inmate Access to Health Care.

CLINIC STOCK: A supply of essential medication and/or supplies not labeled for a specific patient, kept for the purpose of administration to a patient by an authorized ADCRR/CHP team member.

CLINICAL ENCOUNTERS: Are interactions between patients and health care providers that involve a treatment and/or exchange of health information.

COMMUNICABLE PERIOD: The time during which an infectious agent may be transferred directly or indirectly from one person to the other.

COMPLEX COMPLIANCE MONITOR: An ADCRR employee who reports to the Medical Services Contract Monitoring Bureau and is tasked with ensuring compliance with the health services contract. May also be referred to as Contract Monitor.

COMPLEX MORTALITY REVIEW COMMITTEE: A committee consisting of CHP Facility Health Administrator, CHP Site Medical Director, CHP Director of Nursing, CHP Mental Health staff (if appropriate), ADCRR Complex Compliance Monitor, ADCRR Warden or designee that conducts a mortality review at the prison complex where the mortality took place.

COMPLIANCE: The act of fulfilling official requirements, complying with federal, state, or local laws and regulations.

CONTACT: An individual (inmate or employee) who has shared the same air space as a person a contagious disease for a sufficient amount of time that there is a probability that transmission of the contagious disease may have occurred.

- *CLOSE CONTACT*: Someone who was less than six feet away from an infected person for a cumulative total of 15 minutes or more over a 24-hour period.
- *DIRECT CONTACT*: When a body fluid of one person comes into contact with the mucous membrane, body fluid, or broken skin of another person.

CONTACT INVESTIGATION: The process of identifying, screening, and evaluating individuals who are known to have a contagious disease to detect exposure to others and determine the need for subsequence screening.

CONTRACTED HEALTHCARE PROVIDER (CHP): The correctional medical services vendor with whom ADCRR contracts with to provide full service, medical, dental, and mental healthcare to the ADCRR inmate population.

CONTROLLED SUBSTANCE: A drug or a chemical substance whose possession or use is prohibited or regulated under the Federal Control Substances Act or similar state law.

CONVERTER: A patient who, within a two-year period, has had: An initial tuberculosis test without a "significant" reaction. A second test with a "significant" reaction, and a difference of six or more millimeters (mm) of induration between the two tests.

CORRECTIONAL OFFICER III/IV: A correctional officer with additional training who serves as a counselor and who meet regularly with inmates on their caseloads.

CORRIDOR FACILITY: This is an internal designation for larger complexes capable of supporting more complex health issues and most often found in close proximity to major highways with easier access to specialty care.

-D -

DEA-CONTROLLED SUBSTANCES: The medications that come under the jurisdiction of the federal Controlled Substances Act.

DECLARATION: A "Declaration of Intent to Limit Extraordinary Life-Support Procedures" form signed by a patient and two witnesses. A completed Declaration establishes the patient’s intent to limit extraordinary life-support procedures.

DECONTAMINATION: The use of physical or chemical means to remove, deactivate, or destroy biological pathogens on a surface or item, to the extent that the pathogens are no longer capable of transmitting infectious particles, and the surface or item is rendered safe for handling, use or disposal.

DENTAL CARE: (also referred to as oral care) Such intra-oral diagnostic and therapeutic procedures, operations, and services performed and which are provided by dentists and other professional dental care personnel operating under the supervision of a dentists, including but not limited to the practice of general dentistry, endodontics, periodontics, orthodontics, prosthodontics, and oral surgery, and includes instruction in oral hygiene.

DEVELOPMENTAL DISABILITY: A group of conditions caused by an impairment in physical learning, language, or behavior that usually begins during the developmental period that may impact day-to-day functioning.

DIRECT OBSERVED THERAPY (DOT): The act of licensed healthcare staff administering prescribed medications directly to the patient and observing the patient taking each dose. May also be called 'unit dose' or 'watch swallow'.

DIRECTOR'S INSTRUCTION: Instructional changes to current policy or procedure issued by the ADCRR Director prior to incorporation into the Department Order.

DISPENSING: Placing of one or more doses of a prescribed medication into containers that are correctly labeled to indicate the name of the patient, the contents of the container, and all other vital information.

DISPOSING: Destruction of medication after its expiration date or when retention is no longer necessary or suitable.

DISTRIBUTION: The system for delivering, storing, and accounting for medications from the source of supply to the nursing station or point where they are administered to the patient.

DSM-V: The Diagnostic and Statistical Manual of Mental Disorders, Edition, 5, Washington, D.C., 2013. The DSM-IV, which is the current taxonomy of mental disorders published by the American Psychiatric Association.

- E -

EPIDEMIOLOGY: The study and analysis of the distribution patterns and determinants of health and disease conditions in a defined population.

EXPOSURE INCIDENT: Any eye, mouth, mucous membrane, non-intact skin, or other parenteral contact with blood or other potentially infectious material.

- F -

FACILITY HEALTH ADMINISTRATOR (FHA): A person who by education, experience, or certification is capable of assuming responsibility for arranging all levels of healthcare and ensuring quality and accessible health services for inmates at their assigned prison complex. May also be called Health Services Administrator.

FOOD HANDLER: Any person who prepares or serves food or who has direct contact with food.

FORMULARY: A list of drugs approved for use within ADCRR.

- G -

- H -

HAZARDOUS MATERIALS: Substances and/or materials that are a potential threat to human health and well-being.

HEALTH NEEDS REQUEST (HNR) FORM: The form either electronic or paper the patient uses to request nonemergency health services.

HEALTHCARE PROFESSIONAL: Any person who is licensed in the state of Arizona to provide healthcare under a specific discipline.

HEALTHCARE PROVIDER (HCP): Persons with the authority to write prescriptions for patients.

HIPAA (Health Insurance Portability and Accountability Act): A federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patients consent or knowledge.

HUMAN IMMUNODEFICIENT VIRUS (HIV): A virus that attacks the body's immune system. If not treated it can lead to AIDS.

- I -

IGRAs (Interferon-gamma release assays): Whole-blood tests that can aid in diagnosing tuberculosis infection.

INCIDENT COMMAND SYSTEM (ICS): The combination of facilities, equipment, personnel, procedures, and communications operating with a common organizational structure, with responsibility for the management of assigned resources to accomplish incident objectives effectively and safely.

INCUBATION PERIOD: The time it takes for an infection to develop after a person has been exposed to a disease causing organism.

INFECTIOUS: Persons producing or capable of producing infection.

INFECTIOUS MATERIALS: Items that are contaminated with blood or body fluids that pose a potential health risk to people should they come in contact with them.

INFIRMARY: The infirmary (also referred to as Inpatient Component (IPC)) is an area in the facility accommodating patients for a period of 24 hours or more, set up and operated for the purpose of caring for patients who need skilled nursing care but do not need hospitalization or placement in a licensed nursing facility. It is not the area itself but the scope of care provided that makes the bed an infirmary bed.

INFORMED CONSENT: The agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination, or procedure; the alternatives to it; and the prognosis if the proposed action is not undertaken.

INPATIENT COMPONENT (IPC): See definition for Infirmary

INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION: Administering any psychotropic medication to a patient without the patient's agreement to take the medication.

- J -

JOINT MORTALITY REVIEW COMMITTEE (JMRC): A committee consisting of ADCRR and Contracted Healthcare Provider personnel deemed necessary to review the mortality of a patient.

- K -

KEEP ON PERSON MEDICATION (KOP): Medications that may be kept on person by the patient, for self-administration.

- L -

LATENT TUBERCULOSIS INFECTION (LTBI): When a person is infected with Mycobacterium tuberculosis but does not have active tuberculosis and has no clinical signs of tuberculosis other than the positive results from the approved test for tuberculosis, is not infectious to others.

LICENSED MENTAL HEALTH FACILITY: For adult male patients, the Alhambra Behavioral Health Treatment Facility (licensed as a Level 1 Behavioral Health Treatment Facility by the Arizona Department of Health Services) which includes Flamenco; for adult female patients, the Perryville Complex Ward (licensed as a Level 1 Behavioral Health Treatment Facility by the Arizona Department of Health Services).

LICENSURE: Documented confirmation that an individual is qualified and licensed by the appropriate Arizona Licensure Board.

LOCAL HEALTH AGENCY: State or County Health Department.

- M -

MEDICAL ADVISORY COMMITTEE (MAC): A committee consisting of the complex Warden, Deputy Warden, ADCRR Complex Compliance Monitor, and other parties as deemed necessary. The purpose of the committee is to review statistics and identify trends pertaining to the delivery of health services.

MEDICAL CARE: The ordinary and usual professional services rendered by a Physician or other licensed professional during a visit to improve health by prevention, diagnosis, or treatment of a disease, illness, or injury.

MEDICAL DIETS: Medical diets are special diets ordered for temporary or permanent health conditions that restrict the types, preparation, and/or amounts of food.

MEDICAL HOLD: A designation placed in a patient's file preventing transfer or moving between institutions while undergoing specialty medical care. A medical hold is temporary.

MEDICAL ISOLATION: Isolation of one or more individuals from the general population. The procedure of separating a person(s) who are already sick from others who are not in order to prevent the spread of disease.

MEDICAL ORDER: Instructions given or written by a healthcare provider treating a patient.

MEDICAL RESTRICTION: Is a permanent restriction to a unit, facility(ies) because of medical or psychiatric limitations or disorders.

MEDICATION LIAISON: (may also be referred to as Inventory Coordinator) The inventory coordinator's primary function is to process (intake/return) medication from the contracted pharmacy/healthcare vendor and transport medication to the assigned healthcare units as designated by the locator codes. They may also assist in some areas of inventory control.

MENTAL HEALTH CARE: (also referred to as mental health services) Defined broadly to include the sum of all actions taken for the mental well-being of the inmate population, including a range of diagnostic, treatment, and follow-up services. Mental health services include the use of a variety of psychosocial, psychoeducational, and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functioning, prevent relapse, and help patients to develop and pursue their personal recovery plans.

MENTAL HEALTH PROFESSIONAL: A staff member who is a licensed Psychologist, a Psychology Associate, a Psychiatrist, Clinical Social Worker or a Psychiatric Nurse Practitioner.

MENTAL HEALTH STAFF: Department/contract Psychiatrists, Psychologists, Psychology Associates and/or Psychiatric Registered Nurses.

MENTAL ILLNESS: A substantial disorder of a person's emotional processes, thought, cognition or memory. More specifically, for the purposes of the policies contained in this technical manual, a diagnosis by a licensed mental health professional that is consistent with one or more classes of mental disorders in the DSM-V (or the most current edition). Includes schizophrenic disorders; delusional disorders; psychotic disorders not elsewhere classified; mood disorder (bipolar disorder and/or depressive disorder); anxiety disorders (excluding social phobia or simple phobia); organic mental disorders or syndromes; and others disorders listed in the DSM-V, with the exception of psychosexual disorders. (Includes organic mood disorders; organic delusional disorders; organic anxiety disorders; organic personality disorders; organic hallucinations not caused by psychoactive substance use; and organic mental disorders not otherwise specified. Also includes maladaptive [self-destructive and/or suicidal] behaviors when caused by a mental illness as defined in the DSM-V.)

- N -

NEAR MISS CLINICAL EVENT: An error in clinical activity without consequential adverse patient outcome.

NURSE'S LINE: Patients being seen by a licensed nurse for routine services and non-emergent health care request.

NURSING ENCOUNTER TOOLS (NETS): A specific set of guidelines developed to be used by Contract Healthcare Provider nursing staff when treating specified illness/complaints.

- O -

OBSERVATION BEDS: Beds often found in an infirmary setting used to observe a patient for a short amount of time, not to exceed 48 hours, for specific purposes.

OBSERVATION RECORD: A documented record of all visual health and welfare checks conducted by staff during a suicide watch on a specific patient.

- P -

PAROLEE: An adult offender who has been granted a parole and is under community supervision.

PERSONAL PROTECTIVE EQUIPMENT (PPE): Any specialized clothing or equipment worn for protection against infectious materials.

PHARMACY AND THERAPEUTIC (P&T) COMMITTEE: A committee composed of MSCMB and Contracted Healthcare Provider Physicians, Pharmacist, and other members of the health staff as necessary, responsible for compiling, reviewing, and updating the medication formulary annually or more frequently if indicated.

POWER OF ATTORNEY: A legal document allowing another person to act in a specific written manner for the named individual.

PPD (PURIFIED PROTEIN DERIVATIVE) TEST: Mantoux tuberculin skin test consisting of an intradermal (within the skin) injection of five tuberculin units (0.1 cc) of PPD to determine if antibodies to mycobacterium tuberculosis are present.

PPD CONVERTER: A person who is now testing PPD positive after a previously negative PPD.

PRACTITIONER: May also be referred to as Provider, see Healthcare Provider definition.

PRESCRIPTION: A specific written, verbal, or faxed order for medication made by a licensed provider.

PROBLEM LIST: A chronological record of major health disabilities/problems as determined by the Health Care Provider.

PROCURING: The act of ordering medications for the facility.

PROTECTIVE CUSTODY: Separation from the general prison population of an inmate in order to safeguard from potential violence of others.

PROVIDER: May also be referred to as Practitioner, see Healthcare Provider definition.

PSYCHOTROPIC MEDICATIONS: Prescription medications ordered by a licensed provider for the treatment or mitigation of a psychiatric disorder or mental illness, as defined by the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV.

PSYCHOTROPIC MEDICATION REVIEW BOARD (PMRB): For the purposes of this order, a committee designated by the individual identified in Department Order as authorized to convene a committee composed of one Psychiatrist, one Psychologist, and one Deputy Warden or Associate Deputy Warden. The committee has the responsibility to consider and recommend or not recommend involuntary psychotropic medication.

- Q –

QUARANTINE: The procedure of separating and restricting the movement of persons who are not sick, but were exposed or are being investigated for possible exposure to a virus or infection.

- R –

RECEIVING FACILITY: The institution to which the patient is transferred, and which will take over responsibility for the patients' health care.

RELEASEE: An inmate who has been released.

REMOTE DRUG STORAGE AREA: Any area used for the storage of medication which lies outside the physical area of Contracted Healthcare Provider Pharmacy.

- S -

SEGREGATION: a location where an inmate can be separated from the general population and receive services and activities apart from other general population inmates.

SELF-DESTRUCTIVE BEHAVIOR: A pattern of deliberate behavior likely to result in self- inflicted bodily harm, but not in death.

SENDING FACILITY: The institution where an inmate is incarcerated immediately prior to a transfer.

SENTINEL EVENT: A patient safety event that results in death, permanent harm, or severe temporary harm.

SHARPS: Any instrument, implement or artifact, whether made of metal, glass or other substance, that could aid in the abuse of drugs or cause bodily injury.

SHELTERED HOUSING: Patients found in an infirmary setting designated as sheltered housing awaiting transfer to a special needs unit.

SICK CALL: The health care delivery system by which each inmate requests health care services of a non-emergency nature using a Health Needs Request Form.

S.O.A.P.E. FORMAT: For the purposes of the policies contained in this technical manual, the reporting format for documenting a health professional's encounter with patients. The format includes the following descriptive elements: Subjective; Objective; Assessment; Plan and Education.

SUICIDAL BEHAVIOR: Deliberate self-harming behavior with any intent to end one's life.

SUICIDE ASSESSMENT: An evaluation by mental health staff or, in their absence, health care staff, of a patient's behavior, statements and history for signs that would indicate a suicide risk. The assessment shall include face-to-face contact, a review of the patient's health record, and an evaluation of the patient's present life circumstance.

SUICIDE WATCH: Ordered for the immediate prevention of self-destructive or suicidal behavior by a patient who is considered to be at high risk. Suicide watch is not used as an alternative to ongoing mental health treatment.

- T -

TB CASE: A person who has been confirmed to have TB disease or someone infected with M. tuberculosis as confirmed by a sputum culture or through clinical evaluation.

TB SUSPECT: A person who presents symptoms and has physical or chest X-ray findings suggestive of tuberculosis, but confirmation by sputum culture has not been completed.

TELEMEDICINE: A healthcare encounter where patients are seen by a provider located offsite (or at another location) by means of video conferencing, audio transmission, high resolution photographs, radiological images, and review of health records (as necessary).

TUBERCULOSIS: An infectious disease caused by Mycobacterium tuberculosis and spread from person to person though air.

- U -

UNIT DOSE: A single oral dose of medication for administration and immediate consumption, see Direct Observed Therapy definition.

UNIVERSAL PRECAUTIONS: A standard set of guidelines to prevent a transmission of blood borne pathogens from exposure to blood and other potentially infectious materials.

- V –

- W –

- X –

- Y –

- Z –