Arizona Department of Corrections Rehabilitation and Reentry

Technical Manual

ACCESS

☐ **Contains Restricted Section(s)**

CHAPTER: 1100

Inmate Health Services

DEPARTMENT ORDER:

1101 – Inmate Access to Health Care

OFFICE OF PRIMARY RESPONSIBILITY:

HS

TECHNICAL MANUAL:

TM 1101 – State Prisons: Medical and Dental Services

Technical Manual

(MDSTM)

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Medical Services TM – October 1, 2022
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Ryan Thornell, Director

	Medical and Dental Services Technical Manual
	INTRODUCTION
	Effective Date: 10/01/2024 Supersedes only as it relates to State Prisons: 10/01/2022

INTRODUCTION

PURPOSE: This Healthcare Services Division (HSD) Medical and Dental Services Technical Manual (MDSTM) 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). The Mental Health Technical Manual (MHTM) is separate from the MDSTM and should be used as a reference for policies and procedures pertaining to mental health care. The standards, policies, and services outlined within this manual represent the minimum requirements for the delivery of health care and services to our patient population.

RESPONSIBILITY: Full service medical, dental, and mental health care is provided to the incarcerated population of ADCRR through contracts with correctional healthcare providers. It is the responsibility of the Contract Healthcare Provider (CHP), with oversight monitoring by HSD, to ensure that clinically appropriate, medical, dental, mental health, nursing, pharmaceutical, health records, laboratory, radiology, and specialty care services are available to the incarcerated population of ADCRR.

It is the shared mission of the HSD and our contracted healthcare partners to provide the highest quality healthcare to the incarcerated population in Arizona prisons. ADCRR provides resources to incarcerated individuals so they may live a healthy lifestyle and through its CHP provides access to medical, mental health, and dental services. ADCRR HSD provides oversight to ensure that all incarcerated individuals are provided access to scheduled and emergency (as needed) health care that is consistent with community standards and are not refused healthcare treatment due to inability to pay.

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.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care NCCHC Standard P-A-01, Access to Care NCCHC Standard O-A-01, Access to OTP Services
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-01.01 Access to Health Care

PURPOSE: To ensure all incarcerated individuals have access to high-quality health care for their medical, dental, and mental health needs from admission to discharge.

RESPONSIBILITY: The employees of the Contract Healthcare Provider (CHP) and affiliated subcontractors shall ensure that high-quality healthcare services are available to the incarcerated population and are delivered in a language the patient understands.

PROCEDURE:

1.0. All healthcare services shall be accomplished through cooperation and coordination between ADCRR security and support services, healthcare staff, and affiliated healthcare subcontractors.

2.0. Incarcerated individuals referred or self-referred for medication assisted treatment (MAT) program services are evaluated and, if assessed to be clinically appropriate for services, are enrolled in a timely fashion as dictated by the clinical need in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-F-04.02, Treatment of Substance Use Disorder.

3.0. CHP and ADCRR shall identify and eliminate any unreasonable barriers intentional and/or unintentional to patients receiving health care.

- 3.1. Health staff shall assess the English fluency of patients at the beginning of every clinical encounter and provide interpretation services via:
  - 3.1.1. In person by ADCRR approved healthcare staff proficient in the patient's preferred language,
  - 3.1.2. By video interpretation service (for sign language) or audio language interpretation service that is compliant with federal law and uses licensed interpreters, where required by state law; and provides for confidential communication in all circumstances (e.g., dual hand or headset device in locations where a speaker phone or computer can be seen or overheard by other incarcerated individuals or custody staff) or
  - 3.1.3. In an emergency and if the above is not feasible, by other available means, e.g., healthcare staff whose name is not on the ADCRR approved list, non-healthcare staff, or other incarcerated persons.
  - 3.1.4. The patient's preferred language should be updated in the electronic health record, as indicated.

4.0. At the time of admission all incarcerated individuals shall be informed about procedures to access health services in a language they understand.

- 4.1. Reasonable fees may be charged in accordance with Department Order #1101, Inmate Access to Health Care.
- 4.2. Care will not be refused or denied based on the inability to pay the fees.

5.0. All patients shall be assigned a medical primary care practitioner.

5.1. Assignment to a physician or advance practice provider (APP) shall be based on the complexity of the patient's health conditions.

P-A-02.01 Authority and Accountability

PURPOSE: To establish general authority for the provision of clinical services to the incarcerated population at each Arizona State Prison Complex (ASPC).

RESPONSIBILITY: The ADCRR Assistant Director for Healthcare Services provides guidance to the ADCRR Healthcare Services Division (HSD) staff in order to meet the mission of ADCRR and HSD, as well as ensure, through a joint effort with the Contract Healthcare Provider (CHP), the incarcerated individuals in the custody of ADCRR receive high quality healthcare.

ROLES:

1.0. HSD

1.1. The HSD under the direction of the ADCRR Assistant Director for Healthcare Services shall provide oversight to the provision of high-quality healthcare to the patient population in accordance with current contracts, through the implementation of a comprehensive quality assurance program.

2.0. CHP

2.1. The CHP is responsible for ensuring that all patients are provided access to health care and are not refused treatment due to financial reasons. The CHP shall ensure that health care is delivered through a joint effort of the CHP and security operations.

2.2. Complex CHP General Administration Responsibilities

2.2.1. The Facility Health Administrator (FHA)/Health Services Administrator (HSA) or designee in collaboration with the HSD staff, will ensure all healthcare staff adheres to ADCRR Department Orders, Healthcare Services Division Technical Manuals, and complex specific Health Services Post Orders.

2.2.2. It is the responsibility of the FHA/HSA or designee to ensure that adequate services are available to the incarcerated population in the following areas: medical, dental, mental health, nursing, pharmacy, health records, laboratory, x-ray, and other areas as applicable.

2.2.3. The FHA/HSA or designee 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.

2.3. Position Authority

2.3.1. The FHA/HSA at each complex is designated as the responsible health authority whose responsibilities are delineated by their job description, the Healthcare Services Division Technical Manuals, and the Contract.

2.3.1.1. The responsible health authority is responsible complex-wide for providing quality accessible health services at all levels to the patient population.

2.3.2. The Site Medical Director (SMD) 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 and Dental Services Technical Manual
	REFERENCES: Department Order #202, Public Access – Tours and Board Hearings NCCHC Standard P-A-02, Responsible Health Authority NCCHC Standard P-A-03, Medical Autonomy NCCHC Standard O-A-03, Medical Autonomy
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-03.01 Medical Autonomy

PURPOSE: To provide direction regarding communication between the Healthcare Services Division (HSD) staff and the Contract Healthcare Provider (CHP) staff ensuring healthcare decisions are made by qualified healthcare professionals for clinical purposes while promoting an atmosphere of shared information/ communication.

RESPONSIBILITY: It is the responsibility of 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. Clinical decisions and actions regarding healthcare services provided are the sole responsibility of qualified professionals and are not to be compromised for security reasons.

1.1.1. Within the medication assisted treatment (MAT) program, clinical decisions and their implementation are completed effectively and safely with the support of custody staff.

1.2. Final clinical judgments will rest with the Site Medical Director (SMD), Dental Director, or Director of Nursing (DON) for each complex.

1.3. Health care shall be delivered through a joint effort of healthcare staff and security operations. The healthcare staff and their subcontractors are subject to the same security regulations as ADCRR employees.

1.3.1. 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. The FHA or designee will discuss with the Warden or designee the implementation of any new or revised health services programs that have an impact on institution operations.

1.5. The FHA or designee shall ensure that all healthcare staff and their subcontractors are knowledgeable of their technical, professional, and operational responsibilities.

	Medical and Dental 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 MDSTM P-A-06.01, Quality Improvement of Health Services NCCHC Standard P-A-04, Administrative Meetings and Reports NCCHC Standard O-A-04, Administrative Meetings and Reports
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P-A-04.01 Communications, Meetings, and Reports

PURPOSE: To provide an outline of mechanisms for communication with different ADCRR individuals and groups both within and outside of the Healthcare Services Division (HSD) and other state agencies.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) and HSD to ensure that the communications regarding the delivery of healthcare services are accurate, complete, and timely with each being responsive to the other.

PROCEDURES:

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

1.1. Written communication, electronic or otherwise 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.

1.2.1. Significant verbal decisions and/or directions given or received by the initiator shall be followed up by a written memorandum to the other party.

2.0. Emergency Notifications:

2.1. To CHP Regional Leadership

2.1.1. The Facility Health Administrator (FHA) or designee shall notify their Regional Leadership or designee and the ADCRR Assistant Director for Healthcare Services or designee immediately when any of the following significant events occur:

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

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

2.1.1.3. Death of CHP's employee.

2.1.1.4. Inquiries from the Governor's Office, Congressional delegation, members of the State Legislature, other elected officials, and the news media.

2.1.1.5. Any significant communicable disease in accordance with Department Order #1102, Communicable Disease and Infection Control.

2.1.1.6. All violations or breaches of conduct, Code of Ethics, licensure or certification, and/or community standards of care.

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

2.2. To Warden

2.2.1. The FHA or designee shall notify the Warden, or designee, of anyone who is seriously ill, has sustained a serious injury, communicable disease outbreaks, or potential disease outbreaks when:

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

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

2.2.1.3. A patient is critically ill requiring notification of next of kin.

2.2.1.4. Any incident involving reported potential safety hazards.

2.2.1.5. Any suicidality or self-harm event.

2.2.1.6. There is a death of a patient.

2.3. Any notification to next of kin will be carried out by security operations and/or Faith Services according to established policy at the local prison complex and Department Order #711, Notification of Inmate Hospitalization or Death.

2.3.1. Any medically related questions shall be directed to the CHP. The FHA or designee shall make every effort to answer any related questions or inquiries by the family within the confines of confidentiality policies.

3.0. Meetings

3.1. The FHA shall attend a weekly meeting of their facility management team.

3.1.1. The facilities management team consists of the FHA, ADCRR Healthcare Coordinator or designee, Complex Warden, medication assisted treatment (MAT) program sponsor or their designees (if applicable), and other invited guests as deemed necessary.

3.2. At a minimum, the FHA shall convene a monthly Complex Continuous Quality Improvement (CQI) Committee meeting (more often as needed) in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-A-06.01, Quality Improvement of Health Services.

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

3.3.1. The review of emergency send outs shall be discussed at the monthly MAC meetings.

3.3.2. MAT program studies shall be discussed at the monthly MAC meetings, where applicable.

3.4. MAT program staff meetings occur at least monthly, where applicable.

3.5. The CHP and HSD staff members as applicable shall conduct quarterly Pharmacy and Therapeutics (P&T) Committee meetings.

3.6. Complex Mortality Review Committee (CMRC) meetings are conducted in accordance with the MDSTM P-A-09.01, Inmate Mortality.

3.7. Minutes of the meetings shall be made available to all members of the committee, clinical staff, and MAT program team members as appropriate.

4.0. Reports

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

4.2. 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 and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-A-05, Policies and Procedures NCCHC Standard O-A-05, Policies and Procedures
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-05.01 Policies and Procedures

PURPOSE: To outline the procedure for the establishment of guidelines for the provision of health care by the Contracted Healthcare Provider (CHP) to the incarcerated population.

RESPONSIBILITY: It is the responsibility of the ADCRR Healthcare Services Division (HSD) to provide current policy guidance in accordance with state and federal regulations and professional standards to the CHP. It is the responsibility of all CHP staff to ensure published standardized policies are adhered to.

PROCEDURES:

1.0. The HSD maintains the Healthcare Services Division Technical Manuals which include the Medical and Dental Services Technical Manual (MDSTM), MDSTM Attachments, Clinical Practice Guidelines (CPGs), and Mental Health Technical Manual (MHTM), which serve as an adjunct to the ADCRR Department Orders (DOs).

1.1. Each Healthcare Services Division Technical Manual and each Healthcare Services Post Order will be cross-referenced with the appropriate ADCRR Director's Instruction or Memorandums, ADCRR DOs, National Commission on Correctional Healthcare (NCCHC) Standard(s), and any other appropriate official document(s).

1.2. All Healthcare Services Division Technical Manuals shall contain only those policies that are approved by the ADCRR Assistant Director for Healthcare Services.

1.2.1. All Healthcare Services Division Technical Manuals bear the date of the most recent review or revision.

1.2.1.1. Site-specific policies and procedures pertaining to medication assisted treatment (MAT) program must contain the signature of the program sponsor and responsible physician.

1.3. The CHP is responsible for ensuring compliance with each policy.

1.4. The HSD in collaboration with the CHP will review annually and update as necessary the Healthcare Services Division Technical Manuals and Healthcare Services Post Orders.

1.5. The following departments will be notified of any HSD policy change or content update: HSD staff, ADCRR Executive Leadership, CHP Regional Leadership or designee, Private Prison Regional Leadership, Inspector General's Office, and others as applicable.

2.0. Each prison complex or site has a Facility Health Administrator (FHA) or designee who is responsible for regularly reviewing policies and procedures and advising subordinate staff of changes and/or modifications as related to their job duties.

2.1. The FHA or designee is responsible for disseminating the information within the Healthcare Services Division Technical Manuals as well as any new policy update to all health units and subordinates under their supervision.

2.1.1. The FHA or designee is responsible for maintaining a current up-to-date hard copy of all Healthcare Services Division Technical Manuals in the FHA's office.

2.1.2. The cover sheet of the FHA's master Healthcare Services Division Technical Manuals must indicate (by dated signature) an annual review by the complex Medical Director, Dental Director, Directors of Nursing, and the FHA.

3.0. Should a CHP staff member perceive a need for a change to policy or a waiver of policy, as it affects the delivery of health care at a specific complex or health facility, the CHP shall produce a letter to the HSD Technical Manuals Review Team.

3.1. The letter shall contain:

3.1.1. Identification of the particular policy element that presents a problem.

3.1.2. Identification of what is requested to be waived.

3.1.3. Description of any recommended changes to the policy.

3.1.4. Description of the expected outcome should the waiver not be granted.

3.1.5. A comment and endorsement by the appropriate CHP Regional Leadership or designee, prior to a decision by the ADCRR Assistant Director for Healthcare Services or designee.

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

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-B-08.01, Patient Safety NCCHC Standard P-A-06, Continuous Quality Improvement Program NCCHC Standard O-A-06, Continuous Quality Improvement Program
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P-A-06.01 Quality Improvement of Health Services

PURPOSE: To provide guidance and oversight 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 ADCRR Assistant Director for Healthcare 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 healthcare staff to implement and utilize quality improvement tools and concepts. The CHP 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, and Healthcare Services Division Technical Manuals.

PROCEDURES:

1.0. The ADCRR Healthcare Services Division (HSD) in conjunction with the CHP are responsible for the implementation of a robust CQI Program and the establishment of the CQI Committee.

2.0. At a minimum, the CQI Committee shall meet monthly, or more often if needed, and consist of representatives from all disciplines practicing at each complex including custody leadership.
- 2.1. The Site Medical Director (responsible physician) must be involved in the CQI process.

3.0. The CQI meeting minutes must be completed in an approved agenda format and include an update on any ongoing CQI process and/or outcome studies, peer reviews, review of grievances, infection control, medication errors, overview of chart reviews, environmental inspections, and any health care delivery concerns or improvements addressed by the committee. Action plans and any necessary remediation will be included in this report.
- 3.1. The CHP will forward a copy of each complex CQI monthly meeting minutes to the HSD as required by the contract.

4.0. CQI Committee Responsibilities:
- 4.1. Identifies healthcare aspects to monitor the quality of clinical care and areas for improvement as they relate to access, timeliness, completeness, and the quality of care delivered.
- 4.2. Designs quality improvement monitoring activities.
- 4.3. Track and discuss reported communicable diseases.
- 4.4. Analyzes the results of monitoring activities, for factors that present as barriers or are otherwise negatively impacting improvement.

4.5. Evaluate errors, system problems, and possible system problems identified through near miss and preventable adverse event reporting systems, mortality reviews, litigation filed by incarcerated individuals, grievances, the Court-appointed monitors, staff reports, monthly continuous quality improvement reporting, etc.

4.6. Where metrics or trends in metrics show room for improvement, the CHP shall make appropriate efforts to understand the underlying reason for the deviation, take reasonable steps to effectuate improvement, evaluate the effectiveness of these steps in a reasonable time, and make adjustments to its improvement efforts as needed.

4.7. Develop and implement improvement strategies to improve/correct the identified healthcare problem at a complex or statewide level as appropriate.

4.8. Re-monitors/re-audits the areas where improvement strategies were implemented to determine if change/improvement has occurred.

4.9. HSD shall provide oversight, education, and follow up, including but not limited to, attendance at complex level CQI meetings, identifying trends statewide, prioritizing study implementation, and reviewing the monthly minutes.

4.10. A master log will be maintained statewide by the CHP and communicated at the complex level during monthly CQI meetings, more often if needed, to help prioritize CQI studies based on the clinical needs of the patient population, as well as systemic improvement needs.

5.0. CQI committee minimum monthly monitoring requirements listed below will be assigned to specific complexes as determined by the ADCRR Quality Assurance team. This data should be evaluated on a monthly basis for trends and areas needing improvement and these issues should be added to the active log of problems that need to be addressed.

5.1. Percentage of individuals (regardless of whether diagnosed with hypertension) whose systolic blood pressure exceeds 140 mmHg or diastolic blood pressure exceeds 90 mmHg

5.2. Average hemoglobin A1C (regardless of whether diagnosed with diabetes)

5.3. Percentage of individuals taking ten or more prescribed medications

5.4. Percentage of women receiving timely breast screening

5.5. Percentage of women receiving timely cervical cancer screening

5.6. Percentage of pregnant women who have the results of routine prenatal laboratory tests results as recommended in current national guidelines (e.g., Guidelines for Prenatal Care, 8th Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologist, Table 6-2) documented within one month of diagnosis of pregnancy

5.7. Percentage of health care grievances which are appealed

5.8. Percentage of health care grievance appeal replies that are appropriate

5.9. Percentage of prisoners on antipsychotic medications receiving timely AIMS (abnormal involuntary movement scale) assessments

5.10. Percentage of prisoners on antipsychotic medications receiving appropriate and timely metabolic assessments

5.11. Percentage of prisoners receiving punishment for a rule violation, for whom a mental health intervention would have been more clinically appropriate than punishment; and

5.12. Percentage of prisoners arriving at ADCRR for whom intake screening by a Registered Nurse (RN) (or higher credentialed professional) is completed more than four hours after arrival.

5.13. Monitor the use of medications for substance use disorder treatment, including metrics like overdose trends in patients receiving MOUD, adherence to treatment, and numbers of patients waiting to start on MOUD:

5.13.1. Process data that tracks how well the program is being delivered

5.13.2. Outcome data that demonstrates the program's results

5.14. Other parameters as reasonably dictated by the other self-improvement activities as deemed necessary to address processes or clinical outcomes.

6.0. Process and/or Outcome Studies: When the committee is notified of or identifies a healthcare problem a CQI process and/or outcome quality improvement study shall be initiated to examine the effectiveness of the healthcare delivery process. The study which may require a multidisciplinary approach including custody staff is completed and reported to determine whether expected outcomes of patient care were achieved.

6.1. CQI study reporting includes:

6.1.1. How the topic was selected.

6.1.2. Methodology used to study the topic.

6.1.3. Review findings of the group.

6.1.4. Implement the plan for improvement based on evidence.

6.1.5. Implementation plan.

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

6.2. CQI study reports will be attached to the monthly CQI meeting minutes.

6.3. A minimum of one process study and one outcome study is required annually.

6.4. The CHP shall maintain active logs of all errors and problems to assist in deciding which issues to address and when to monitor progress in resolution. Based on this prioritization, at the complex and state level, root cause analysis shall be conducted as appropriate, from which an effective and sustainable remedial plan is implemented in a timely manner.

7.0. Peer Reviews: The CQI committee shall monitor the completion of peer reviews for licensed staff as required by the NCCHC and contract terms and the status to be reported in the monthly minutes.

8.0. CQI committee completes an annual review of the effectiveness of the CQI Program by reviewing findings from CQI meetings, studies and minutes, administrative and/or staff meetings, or other pertinent written materials.

9.0. The FHA and other pertinent clinical leadership shall participate in CQI Program training at least annually to enhance their skills and the program’s effectiveness.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-A-07, Privacy of Care NCCHC Standard O-A-09, Privacy of Care NCCHC Standard O-H-02, Confidentiality of OTP Records and Information Health Insurance Portability and Accountability Act § 164.512 (k) (5)
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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 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 including medication assisted treatment (MAT) program information, and all the information contained in the health records, are privileged and confidential. Healthcare staff may only disclose part or all of a patient's health records as authorized by Arizona State or federal law.

1.1. The CHP 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 of patients during "sensitive physical examinations".

3.1. Clinical encounters are conducted in private, without being observed or overheard by nonclinical staff or other incarcerated individuals. 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. Other than emergency responses, health encounters should not occur cell front.

3.1.1. Exception: Security personnel are to be present (in the same room) only if the patient poses a risk to the safety of the healthcare staff 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, no-contact room, restraints, or use of a white noise machine, will be utilized.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1104, Inmate Medical Records NCCHC Standard P-A-08, Health Records NCCHC Standard O-H-01, OTP Record Format and Contents NCCHC Standard O-H-03, Management of Health Records
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P-A-08.01 Establishment and Organization of the Health Record

PURPOSE: To provide a uniform document in which a record of a 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 or electronic version), is the responsibility of the Contract Healthcare Provider (CHP) staff and is available at all times. The CHP must have policies and procedures with a process for health information management, that 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 the Reception Centers, 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:

- 2.1. The patient's full name (last name, first name, middle initial) and ADCRR inmate number (which becomes the health record file number) are placed in the upper right-hand corner of the file jacket.
  - 2.1.1. 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.
- 2.4. 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.
- 2.5. Efforts should be undertaken to avoid the creation of paper records, including making electronic signatures the standard for most documents.

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 paper health records shall be done in accordance with Medical and Dental Services Technical Manual (MDSTM) Attachments 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 Healthcare Services Division (HSD) may be used in the health record.

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

5.0. Imported or scanned documents (including but not limited to diagnostic test results, consultation reports, and hospital discharge summaries) in the electronic health record (EHR) shall be filed in a clear, usable manner and chronological order.

5.1. Paper documents shall be imported or scanned right-side up into the EHR within two business days of receipt.

5.1.1. Following the document being scanned into the EHR, the paper copy shall be filed into the appropriate section of the patient's paper health record.

5.2. Scanned documents in the EHR shall be accurately labeled with meaningful titles/file names.

5.2.1. Avoid ambiguous names or titles beginning with "Miscellaneous" or "Other".

5.3. Scanned documents shall be dated and stored chronologically based on the clinically relevant date of the document.

5.3.1. Examples of clinically relevant dates are: discharge summary is the date of discharge; imaging study is the date of the study; lab test is the date the lab test result is reported by the lab; prior health record is the date it was received.

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 guidance on thinning a paper health record current volume, please refer to MDSTM Attachments P-A-08.01B, Thinning a Paper Health Record.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-A-08, Health Records NCCHC Standard O-H-01, OTP Record Format and Contents
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-08.02 Documenting in the Health Record

PURPOSE: To ensure documentation made in the health record is consistent, meets all necessary health record requirements, and is inclusive of all aspects of care.

RESPONSIBILITY: The accuracy of the information entered into the health record is the responsibility of all professionals authorized to document in the health record.

PROCEDURES:

1.0. The patient's electronic health record shall include an indication of the patient's language of choice on all screens commonly used during the provision of health care.

2.0. All entries must include complete patient identifying information and be stored or maintained in chronological and continuous order.

3.0. All entries shall identify the person entering the information and their credentials.

4.0. Encounters requiring an interpreter shall have the method of interpretation documented in the encounter, including a note if a certified interpreter is not available.
- 4.1. In the event a staff member is used to interpret, e.g., in an emergency, the chart documentation shall include the identity of the staff member.
  - 4.1.1. If the situation is urgent or emergent, and the patient requires an immediate higher level of care, then it may be justified to have a staff member interpret.

5.0. Documentation shall be made the same day as the encounter and completed at or as close to the actual time of the encounter as possible.
- 5.1. All entries are to be completed within 24 hours of seeing the patient.
- 5.2. Entries include the date (month/day/year) and time (24-hour, military time style).

6.0. Documentation of court-mandated treatment including medication orders, durable medical equipment, or specific accommodations must be included in the patient's health record.

7.0. Handwritten entries must be legible, and clear, 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.

8.0. Any abbreviations documented in the health record shall be done in accordance with Medical and Dental Services Technical Manual (MDSTM) Attachments P-A-08.02A, Approved Abbreviations for Documenting in the Health Record.

9.0. Late Entry:

9.1. 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.

9.2. Late entries are to be made as soon as possible after the encounter.

10.0. Progress Note Formatting:

10.1. All progress note entries will be made in accordance with the following format:

10.1.1. Subjective (S): Patient's complaint and answers to direct questions about the current illness, other systemic complaints, past medical history, family medical history, and social history.

10.1.2. Objective (O): Pertinent findings in the mental status exam and physical exam, including vital signs, radiological imaging studies, and laboratory data.

10.1.2.1. Complete vital signs are documented at each clinical encounter when applicable.

10.1.3. Assessment (A): Provider's diagnosis or a nursing assessment.

10.1.4. Plan (P): Treatment provided or diagnostic/treatment plan developed based upon the assessment. Specific directions were provided to the patient.

10.1.5. Education (E): The education provided to the patient.

10.2. Dental Charting and Documentation

10.2.1. A Tooth Chart is used to document conditions, pathology, previous treatment, treatment completed, and periodontal conditions.

10.2.2. An approved dental treatment plan form or approved electronic equivalent is used to document the treatment plan, periodontal treatment plan, PSR, types and number of radiographs taken, oral conditions, OHI given, reviewed and demonstrated brushing and flossing, head and neck exam, and Oral Cancer screening.

10.2.2.1. The treatment plan section of the treatment plan form is to be completed with the tooth number and treatment required for each tooth.

10.2.2.2. Ensure all areas of the dental treatment plan form are completed and no areas are left blank.

10.2.3. All other dental notes/entries and Comprehensive Periodontal Examinations including full mouth probings are to be documented in the dental record.

11.0. Paper Health Record

11.1. Formatting

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

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

11.1.3. Anything placed into the paper health record that is part of the medical record needs to also be scanned into the EHR.

11.1.4. Following a review by the provider, all diagnostic studies need to be signed and dated, whether through an electronic signature or a handwritten signature with a stamp or printed name and title.

11.2. Corrections

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

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

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

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

11.2.2. To make a correction to a lengthy entry:

11.2.2.1. The author must either draw a single thin line through the entire original entry or draw a large thin "X" over the original entry (the original entry must be visible and legible).
11.2.2.2. Write the word "Error" diagonally across the entry.
11.2.2.3. Make the correct entry.
11.2.2.4. Initial the corrected entry.

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

11.2.4. “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.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #704, Inmate Regulations Department Order #1104, Inmate Medical Records NCCHC Standard P-A-08, Health Records NCCHC Standard O-H-02, Confidentiality of OTP Records and Information Arizona Revised Statute § 31, Prisons and Prisoners – Section 224.01 (A), Prisoner medical records; release to immediate family or designated individual Arizona Revised Statute § 39, Public Records, Printing and Notices – Section 121.01 Definitions; maintenance of records; copies, printouts or photographs of public records; examination by mail; index
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-08.03 Access to Health Record Information

PURPOSE: To provide guidance in the protection of the patient's confidential health information and outlining processes related to the release of information and accessing health records.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) staff must adhere to the rules of release of patient's health information. The Facility Health Administrator (FHA) or designee shall control access to patient health information and respond to requests from family members/designees/attorneys for access to patient health information.

PROCEDURES:

1.0. Patients Access to Health Record Information/Record Review

1.1. Patients are authorized to review their entire health record once per month by submitting an Inmate Letter, Form 916-1, or approved equivalent to the health record staff.

1.2. The health records staff shall:

1.2.1. Identify the sections of the records that need to be printed.

1.2.2. Remove any documents from any section of the health record that may jeopardize facility safety or operations.

1.2.3. Schedule an appointment for the patient to review their records for a time period not to exceed 45 minutes.

1.2.3.1. If the patient requires additional health records review time (more than once per month), the healthcare staff shall advise the patient to submit an Inmate Letter to the FHA to justify the request.

1.2.4. Complete Form 1104-11, Guidelines for Inmate Medical Records Reviews and once signed by the patient file in Section IV, under the Legal/Administrative tab.

1.3. Any patient request to review mental health records shall be forwarded by health records staff to the Mental Health Lead, who will review the mental health records and remove any documentation that is reasonably likely to endanger the life or physical safety of the patient or another person, or cause substantial harm to the patient or another person, or jeopardize the physical health, mental health, safety, security, custody, or rehabilitation of the patient or any other person.

1.4. Patients may be permitted to maintain their medical records in their cell unless a practitioner documents in the patient's EHR how disclosure of such information would jeopardize the health, safety, security, custody or rehabilitation of the inmate or others or the safety of any officer, employee or other person at the correctional institution or of a person who is responsible for transporting the prisoner.
  1.4.1. Review and possession of medical records is not limited to active litigation.
  1.4.2. The process for requesting and obtaining medical records must be in accordance with Department Order #1104, Inmate Medical Records.
  1.4.3. Possession of medical records shall be subject to the quantity limitations in accordance with Department Order #909, Inmate Property. Refer to Department Order #704, Inmate Regulations and Department Order #909, Inmate Property for further information concerning storage boxes.
1.5. Patients may have a translator assigned and available to assist with record review in accordance with Department Order #704, Inmate Regulations and local procedure.
1.6. The health records are state property. Anyone caught tampering or destroying information contained in the health record will be referred for disciplinary action.
  1.6.1. If a patient is found guilty of tampering or destroying information, any future reviews of the health record must be approved by the ADCRR Assistant Director for Healthcare Services.
1.7. In accordance with state and federal law, patients are not allowed to possess nor view the records of other patients.
1.8. A patient may request a copy of recent lab, x-ray, and diagnostic test results by submitting a Health Needs Request, Form 1101-10ES, or approved electronic equivalent.
  1.8.1. Upon receiving a request for specific health record information, nursing staff shall conduct an in-person visit with the patient to deliver the requested information and document the encounter in the patient's health record.
1.9. Patients requesting copies of comprehensive health record information, more than an individual test or study result, may submit their request at any time by submitting an Inmate Letter, Form 916-1.
  1.9.1. Upon receipt of the patient's comprehensive health record request refer to Department Order #1104, Inmate Medical Records for further information.

2.0. Outside Parties Access to Health Record Information
2.1. Pursuant to Arizona Revised Statute § 31-224.01, the department or CHP shall, within 15 days of the receipt of the request, and with a valid release of information form, release their health record to a member of the patient's immediate family or designated individual.
2.2. The authorization must be in writing on a form prescribed by the department and include a release that complies with the health insurance portability and accountability act privacy standards (HIPAA; 45 Code of Federal Regulations part 164, subpart E). [1]
  2.2.1. Health record information may be released upon the written authorization of the patient that meets the following requirements:
    2.2.1.1. Authorization for Release of Protected Health Information, Form 1104-2, or approved equivalent must be signed by the patient.
      2.2.1.1.1. If the patient is active at an ADCRR facility, the form must be witnessed by ADCRR staff or CHP staff.
      2.2.1.1.2. If the patient is released a copy of their government-issued photo identification must accompany the signed request.

[1] Although ADCRR itself is not a HIPAA covered entity, the CHP is, and ADCRR follows many aspects of HIPAA either when cited in Arizona law (e.g., § 31-224.01) or when used to inform Department policy.

    2.2.1.2. The form must specify information to be provided with dates of service.
    2.2.1.3. The form must list the full name, address, contact number, and email address of the person to whom the records are to be released.

2.2.2. Patient authorization is not required to release in cases where a HIPAA exception exists (e.g., pursuant to the law or a court order, for continuity of care, etc.). In these cases, ADCRR or CHP staff shall consult with an attorney prior to making the disclosure to ensure that disclosures are consistent with HIPAA and that only the minimum amount of information necessary is disclosed.

2.3. Deceased Patient's Records Release. The ADCRR Medical Records Coordinator or designee is responsible for processing the copies of a deceased patient's health records and should consult with an attorney prior to release. ADCRR will follow HIPAA as guidance when determining what records can be released in this scenario.

2.3.1. Authorization to disclose copies of health records must be completed by the authorized person, witnessed by a notary, and the following will be required:

2.3.1.1. Verification of relationship

2.3.1.2. Death certificate.

2.3.1.3. A copy of government-issued photo identification.

2.3.2. Invoice will be sent to the requestor.

2.3.2.1. Payment is required before copies are released.

3.0. Release of Health Record Information, Legal Services

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

3.2. Health records may be released in response to a subpoena or court order, which has been validly served upon the custodian of health records.

3.2.1. For State ADCRR facilities, the Custodian is the CHP health record staff.

3.3. Subpoenas or Court Orders may be served in person in civil cases, or in person or via U.S. mail in criminal cases.

3.3.1. Out-of-state subpoenas will not be accepted.

3.4. 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:

3.4.1. Date and time of the receipt of the subpoena

3.4.2. Manner of services (e.g., in person or via mail)

3.4.3. Signature and title of custodian of health records

3.5. Processing legal request for copies:

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

3.5.1.1. Compute charges as appropriate and invoice requester.

3.5.1.2. Accept payment and complete a receipt.

3.5.1.3. Send a copy of the authorization and health record copies to the requestor.

3.5.2. Include a declaration statement with the following information: patient's name, patient's ADCRR inmate number, date range, number of pages, signature, and title of health records staff, and date completed.

3.6. 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 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 into the approved designated 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.

4.3.1. The "outside" records are filed or scanned into the appropriate section of the patient's health record.

4.4. Off-site medical practitioners responsible for the patient's care may receive health information from ADCRR and the CHP without the patient's authorization while the patient is in custody, as it pertains to the continuity of care of the patient.

4.5. The Industrial Commission, employers of incarcerated individuals (patients) filing industrial injury claims or the legal representatives of those employers, may receive a patient's health record to the extent they relate to the claim.

5.0. Charging for Health Record Copies

5.1. ADCRR may charge a reasonable per-page fee for non-indigent patients for the production of paper health record copies in accordance with Arizona Revised Statute §31-224.01, Arizona Revised Statute §39-121.01, and Department Order #1104, Inmate Medical Records.

5.1.1. Indigent patients will not be charged a fee.

5.1.2. Records requested in an electronic medium will be provided at no charge.

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

5.3 Payment must be made by cashier's check or money order, law firm check, or cash/debit payment made through the adcpay website.

5.1.3. No personal checks will be accepted.

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 advocacy, or for Discovery-ADCRR Legal Services/Attorney General's Office.

6.0. Processing Request for Copies of the Health Record

6.1. At ADCRR facilities: The CHP Health Records Supervisor or designee shall be responsible for compiling the records, invoicing the record requester, and sending the records once payment is received.

6.1.1. Records for continuity of care do not need to be invoiced and can be sent immediately upon receipt of the request.

6.1.2. Once the records are sent, the 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 a current or previous ADCRR health services staff member or Healthcare Services CHP employee is named in a lawsuit and served with a subpoena to answer interrogatory questions, the ADCRR Medical Records Coordinator shall be notified.

7.1.1. Staff are not permitted to review or copy any health records without the approval of the ADCRR Medical Records Coordinator and the FHA, in consultation with the Office of the General Counsel.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #901, Inmate Records Information and Court Action Department Order #1104, Inmate Medical Records Department Order #1105, Inmate Mortality Review MDSTM P-E-10.01, Discharge Planning/Transition To the Community NCCHC Standard P-A-08, Health Records NCCHC Standard O-H-02, Confidentiality of OTP Records and Information NCCHC Standard O-H-03, Management of Health Records
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 ensure 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 for ensuring 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 to aid in the delivery of healthcare to the patient.

2.0. Health records stored in the facility are maintained under secure conditions separate from correctional records.
- 2.1. Any health records transported by non-health staff are sealed.

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 Facility Health Administrator (FHA), Health Records Supervisor, Regional Leadership or designee, or ADCRR Medical Records Coordinator or designee.
- 3.2. Staff may not make copies or utilize any health 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, and Volume 3 of 3. Each previous volume should have been written on the front of the chart “Do not use see new volume”.

5.0. Health Records of Releasing or Released Patients

5.1. Prior to the patient's release each identified provider in the community shall be sent a summary of relevant care provided during incarceration and any necessary or follow-up care required. For additional information refer to Medical and Dental Services Technical Manual (MDSTM) P-E-10.01, Discharge Planning/Transition to the Community.

5.2. 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.

5.3. 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 ADCRR Healthcare Services Division (HSD).

5.3.1. Refer to the MDSTM Attachment P-A-08.04A, Health Record Inventory Entry into IHAS (Inmate Health Appointment System) for released record processing instructions.

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

5.5. 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).

5.6. The health records of patients who are transferred to another state for Interstate Compact are to be sent to the ADCRR Medical Records Coordinator 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. Radiographic Film/File Storage & Transfers

6.1. Active patients with historic radiograph files will have films stored at the complex and/or unit where the patient resides.

6.2. When a patient is transferred to another facility the radiographic films are packaged and given to the health records staff or designee to accompany the patient along with the health record as appropriate (if paper records are utilized).

6.3. If historic radiograph films are necessary for a consultation with a specialist, on or off-site, the clinical coordinator in cooperation with the CHP radiology technician will facilitate the delivery of the films for consultant review.

6.4. Request for duplication of x-ray films 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.

6.5. Radiographic films for released patients are retained at each prison complex for three months, then processed in IHAS or an equivalent electronic health record inventory system, and then forwarded to the CSF where they are retained for six years after which the films are destroyed.

7.0. Use of CSF

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

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

7.1.2. 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.

7.2. Storage boxes are prepared for transmittal:

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

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

7.2.3. Information to be included in the box is as follows:

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

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

7.2.3.3. The signature of the CHP health records staff and the date must be written on the inventory sheet.

7.2.4. 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.

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

8.1. If a patient 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 patient's health record.

8.2. 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.

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

9.0. Health Record of Deceased Patients

9.1. 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.

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

9.1.2. 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.

9.1.3. Immediately upon notification, the electronic health record shall be identified as "Record Locked."

9.1.4. 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 Records Coordinator.

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 for monitoring and maintaining 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.
  - 1.2.2. A medical hold shall be instituted when one of the following dental procedures is initiated:
    - 1.2.2.1. Endodontic Treatment
    - 1.2.2.2. Prosthetics
    - 1.2.2.3. Any other condition requiring continued observation or follow-ups by the dentist.
- 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
  - 1.5.1. Enter information regarding Medical and Mental Health scores, as determined by medical and mental health providers.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1105, Inmate Mortality Review MDSTM P-A-08.04, Health Record Security, Accountability, and Transfer MDSTM P-B-08.01 Patient Safety NCCHC Standard P-A-09, Procedure in the Event of an Inmate Death NCCHC Standard O-A-10, Procedure in the Event of an Inmate Death
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-09.01 Inmate Mortality

PURPOSE: To establish guidance for acknowledging, documenting, and reviewing mortalities of patients who die while in the custody of the ADCRR.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Regional Medical Director or designee is responsible for conducting a thorough review of all deaths of patients in custody. It is the responsibility of all CHP clinical staff to participate in the review process and to understand the results of the review in order to improve future healthcare delivery as indicated. This process shall be incorporated into the Continuous Quality Improvement (CQI) program.

PROCEDURES:

1.0. Pronouncement:
- 1.1. A Registered Nurse (RN), mid-level practitioner/provider, or physician may pronounce death.
- 1.2. As soon as possible after a patient is pronounced deceased, the Medical Examiner will be called by the ADCRR security staff.
  - 1.2.1. The patient's death will be certified by the Medical Examiner.
- 1.3. The Facility Health Administrator (FHA) or designee shall immediately upon the death of a patient, make notification of the mortality to ADCRR custody and clinical leadership in addition to CHP clinical leadership, on an HSD approved email distribution list.
  - 1.3.1. FHA shall, within 24 hours, report the facts surrounding the pronouncement of the patient's death to the CHP Regional Medical Director or designee.
- 1.4. All records, reports, databases, and meetings regarding the patient's death are protected by patient confidentiality, held in strict confidence, and shall not be subject to disclosure in accordance with Department Order #1105, Inmate Mortality Review.

2.0. Mortality Review:
- 2.1. All patient deaths, which include suicides, fetal deaths, or a fetal sentinel event beyond the first trimester, that occur while the inmate is in the care and custody of ADCRR, shall be reported for investigation in accordance with Department Order #1105, Inmate Mortality Review.
- 2.2. For the first review, within seven business days of a patient's death, fetal death, or a fetal sentinel event beyond the first trimester, the complex FHA or designee, shall:
  - 2.2.1. Complete the Contract Health Administrator Questionnaire, Form 1105-10, or approved equivalent 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) who shall:

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

2.2.2.2. Forward the completed Mortality Review Case Abstract and Cover Sheet form or approved equivalent 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. The CMRC shall include the Warden, Deputy Warden, and unit Chief of Security in the initial meeting.

2.2.2.4. The CMRC meeting shall include the identification of all significant health care and custody errors (i.e., near misses as well as preventable adverse events) with a root cause analysis conducted if clinically appropriate.

2.2.2.4.1. Root cause analysis will result in the development of an effective and sustainable plan which will be implemented and reviewed in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-B-08.01, Patient Safety Through Reporting of All Significant Health Care Events.

2.2.2.4.2. Errors should be prioritized for analysis and the complex level corrective action plan should be implemented within one month of the death.

2.3. Psychological Autopsy and Suicide Attempt Review

2.3.1. The Regional Mental Health Director shall ensure that a Psychological Autopsy is completed on all patients who commit suicide.

2.3.1.1. The Psychological Autopsy is completed utilizing the Psychological Autopsy, Form 1105-9 or approved equivalent and completed in accordance with procedures outlined in the Mental Health Technical Manual (MHTM).

2.3.2. The Regional Mental Health Director shall ensure that a Suicide Attempt Review is completed on all patients who attempt suicide.

2.3.2.1. The Suicide Attempt Review is completed utilizing the Suicide Attempt Review, Form 1105-11 or approved equivalent and completed in accordance with procedures outlined in the Mental Health Technical Manual (MHTM).

2.3.2.2. Identify all significant health care and custody errors (i.e., near misses as well as preventable adverse events). Based on prioritization of all errors identified, a root cause analysis shall be conducted if clinically appropriate, from which an effective and sustainable remedial plan shall be crafted. A sustainable plan is one which outlives staff memory from a single training after the review or staff turnover. Monitor the remedial plan for effectiveness and make appropriate and timely modifications to the plan based on the monitoring.

2.3.2.3. The sustainable plan shall be implemented within one month of the death or suicide attempt.

2.3.2.4. The Director of Medical Services or designee shall be notified of the completion of the custody mortality review or attempted suicide review.

2.3.2.5. A joint review shall be scheduled by the Medical Director or designee with the Security Operations Administrator to discuss the medical and custody review findings.

2.3.2.6. The Medical Director or designee shall document the review findings and any recommended changes or corrective action if warranted.

2.3.2.7. The Assistant Director for Prison Operations and/or the Medical Director or their designees shall implement sustainable operational changes for any lapses that have been identified during the review process.

2.4. Health records of deceased patients shall be processed in accordance with the MDSTM P-A-08.04, Health Records Security, Accountability and Transfer.

2.5. Joint Mortality Review Committee (JMRC)

2.5.1. The CMRC is a complex level review, whereas the JMRC is a statewide review that involves an independent review of the case, while taking into consideration the CMRC findings. The JMRC draws its own conclusions and develops a corrective action plan, when indicated.

2.5.2. Within 30 calendar days of the mortality, the ADCRR Medical Director or designee shall convene a monthly JMRC meeting consisting of ADCRR and CHP medical personnel for review of all inmate deaths which include suicides, fetal deaths, or fetal sentinel events beyond the first trimester.

2.5.2.1. Issues for review may include suicides, delayed diagnosis, incorrect diagnosis, delayed treatment causing or contributing to serious injury or death, avoidable deaths, and deviations from "community standards" for healthcare. In addition, the Autopsy and Toxicology reports (if available), the Psychological Autopsy report (if applicable), and the Mortality Review – Case Abstract and Cover Sheet form shall be reviewed.

2.5.2.2. Identify all significant health care and custody errors (i.e., near misses as well as preventable adverse events). Based on prioritization of all errors identified, a root cause analysis shall be conducted if clinically appropriate, from which an effective and sustainable remedial plan shall be crafted. A sustainable plan is one which outlives staff memory from a single training after the review or staff turnover. Monitor the remedial plan for effectiveness and make appropriate and timely modifications to the plan based on the monitoring.

2.5.2.3. The sustainable plan shall be implemented within one month of the death or suicide attempt.

2.5.2.4. 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 Healthcare Services, ADCRR Medical Director or designee, and CHP Regional Medical Director.

2.5.3. The CHP Regional Medical Director and the ADCRR Medical Director or designee shall review the ADCRR Assistant Director for Healthcare Services report and prioritize errors found for root cause analysis, and will result in the development of an effective and sustainable statewide plan which will be implemented within one month of the death.

2.5.3.1. The remedial plan shall be revisited and modified if necessary within one month of the Medical Examiner's report being received.

2.5.3.2. All CHP healthcare staff previously treating the deceased patient are informed of any pertinent findings discovered during all reviews.

2.6. If Autopsy and Toxicology reports were not available during JMRC review, the CMRC shall reconvene within three business days of the receipt of the reports from the County Medical Examiner's office.

2.6.1. The CHP FHA shall reconvene the CMRC, who shall:

2.6.1.1. Review the Autopsy and Toxicology reports.

2.6.1.2. Complete a secondary review utilizing the Mortality Review - Case Abstract and Cover Sheet form, updating the facts and conclusions as appropriate.

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

2.6.1.4. The site will review the Medical Examiner's report to determine if any CQI action or staff notice needs to take place.

2.6.1.4.1. The site should not wait for the autopsy report to implement a CQI action or staff notice.

2.7. Within 10 business days of receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office, the ADCRR Medical Director or designee shall communicate with the CHP Regional Medical Director and convene another JMRC, if the findings of the autopsy or toxicology report will change the previously implemented plan.

2.7.1. 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.

2.7.2. 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 were not available during the mortality review that took place within 30 calendar days of the inmate's death.

2.8. Internal Review and Quality Assurance: Mortality reviews shall identify and refer deficiencies to appropriate CHP managers and supervisors, including the 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.

2.8.1.1. 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.

2.8.1.2. Additional attendees will be assigned by the ADCRR Medical Director and CHP Regional Medical Director.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order 802, Inmate Grievance Procedure Department Order 1101, Inmate Access to Healthcare NCCHC Standard P-A-10, Grievance Process for Healthcare Complaints NCCHC Standard O-A-11, Grievance Mechanism for OTP Service Complaints
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-A-10.01 Grievance Process for Health Care 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 incarcerated individuals to resolve complaints and disputes at the lowest possible level within the organization and at the earliest opportunity.

PROCEDURE:

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

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

2.1. Filing the Grievance: The patient 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 patient's assigned Correctional Officer (CO) III has the authority to correspond or speak with the appropriate medical staff to develop a response.

2.2. In the event a patient is unable to resolve their complaint an Inmate Informal Complaint Resolution, Form 802-11, may be submitted to the 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 business days from the date of the action that caused the complaint. The patient shall attach copies of all documentation to support the complaint.

2.2.1. Within 15 business days of the CO IV upload to the site, the Assistant Director of Nursing or designee shall investigate the complaint and respond to the patient's informal complaint using ACIS, as outlined in Department Order #802, Inmate Grievance Procedure.

2.2.2. If the patient is dissatisfied with the informal complaint response or if the time frames for the response have been exceeded, they may file a formal grievance using an Inmate Grievance, Form 802-01, and Inmate Grievance GF Supplement, Form 802-07 (if applicable).

2.3. Formal Grievance Process (Medical)

2.3.1. A patient may file a formal grievance should they be unable to resolve their complaint informally. The patient has five business days from receipt of the response from the site Director of Nursing (DON) or designee to submit a formal grievance to the unit CO IV Grievance Coordinator, using the Inmate 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 business days of uploading the grievance, the site DON or designee shall:

2.3.2.1. Investigate the complaint.

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

2.3.2.2.1. A summarization of the patient'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 patient 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 their tracking log, print a completed formal grievance response, and forward the response to the patient.

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

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

3.1. Patients may elect to appeal the decision of the DON or designee to the CHP FHA or designee within five business days of receipt of the DON's or designee's decision by submitting an Inmate Grievance Appeal, Form 802-3, to the unit CO IV Grievance Coordinator. Patients may not file an appeal to the 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 FHA or designee and ADCRR Healthcare Services Division (HSD) via email. Each appeal will be logged using the date the email notification was sent to the 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 FHA shall:

3.3.1. Respond using Inmate Grievance Response, Form 802-2, and upload it into ACIS.

3.3.2. Notify the CO IV Grievance Coordinator and HSD via email that a written response was submitted.

3.4. The decision of the 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 it to the patient.

4.0. Reporting and record requirements: The unit CO IV Grievance Coordinator shall forward the previous month's Unit Coordinator Grievance Log to the HSD via email no later than the 25th of each month.

	Medical and Dental 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 NCCHC Standard O-F-02, Use of Tobacco
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-01.01 Health Education and Promotion

PURPOSE: The Contract Healthcare Provider (CHP) will provide information and services that promote a 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. All patients shall receive health education, suggested self-care strategies and information to promote a healthy lifestyle at each health services encounter and the education provided shall be documented in the patients' health record.

2.0. Patients with chronic diseases or those at risk for developing a chronic disease will be provided with information (in a language they understand) either on an individual or group basis that is designed to increase their ability to monitor and manage their health status.

3.0. Tobacco Use as outlined in Department Oder #109, Smoking and Tobacco Regulations

- 3.1. 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).
- 3.2. 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).

4.0. Patient Tobacco Use

- 4.1. Smoking cessation information shall be made available to patients in a language they understand. The healthcare staff will make information available to patients who request assistance with the cessation of use of tobacco products.
- 4.2. Smoking and the possession of tobacco and all smoking-related materials are prohibited by patients housed in reception centers, minor's units, all detention units, special management units, all medical units, and inpatient patient care (e.g., Inpatient Component (IPC)) areas.

5.0. Exercise

5.1. Exercise focusing on large muscle activities such as walking, jogging in place, basketball, and isometrics is encouraged.

5.2. Providers shall consider, if appropriate, exercise as an adjunct to any treatment plan.

6.0. Personal Hygiene

6.1. Incarcerated individuals are allowed to shower in accordance with Department Order #704, Inmate Regulations, Department Order #804, Inmate Behavior Control, Department Order #811, Individual Inmate Assessments and Reviews, and Department Order #812, Inmate Maximum Custody Management and Incentive System.

6.1.1. Providers shall write a Duty/Special Needs Order, Form 1101-60, or approved electronic equivalent for patients who need additional temporary shower accommodations due to medical needs.

6.2. Personal hygiene items are issued to incarcerated individuals in accordance with Department Order #909, Inmate Property. Additionally, a wide array of personal hygiene items are available for purchase from the Inmate Store.

6.2.1. Providers shall write a Duty/Special Needs Order, Form 1101-60, or approved electronic equivalent for patients who need additional or alternative personal hygiene products due to medical issues.

6.3. Patient shaving and grooming guidelines are outlined in Department Order #704 Inmate Regulations.

6.4. Nail clippers shall be available for use in the health unit through 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.

7.0. Sun Exposure Protection

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

7.2. Patients on medications that have photosensitivity reactions to the sun as a common adverse reaction may also qualify for an issuance of long-sleeved protection.

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

7.4. Patients who are not assigned to an outside work crew and who otherwise satisfy the requirements for sun exposure shall have a Special Needs Order (SNO) placed for the necessary items by the CHP.

	Medical and Dental 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 NCCHC Standard O-B-01, Infection Prevention and Control Program
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-02.01 Infectious Disease Prevention and Control

PURPOSE: To outline processes and procedures to prevent infectious disease and coordinate identification and response to infectious or potentially infectious diseases or ectoparasites.

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 ADCRR facility exposure control plan see Department Order #116, Employee Communicable Disease Exposure Control Plan.

2.0. The 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 diseases is effective.
  - 2.3.1. The provider evaluates the patient's medical condition, including any laboratory reports and any other diagnostic findings.
- 2.4. Immunizations to prevent diseases are provided when appropriate.
- 2.5. Patients with infectious diseases are identified and if indicated, medically isolated in a timely manner and shall remain isolated until they are no longer infectious.
- 2.6. Infectious patients receive medically indicated care.
- 2.7. Patients requiring respiratory isolation are housed in a functional negative pressure room.
- 2.8. Patients at increased risk for infection shall have additional precautions taken as clinically indicated.

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 of biohazardous materials and spills.

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

6.0. A screening for ectoparasites shall be completed by the nursing staff upon a patient's arrival and documented in the patient's health record.

6.1. If the individual is found with ectoparasites that are transmittable, such as lice or scabies, they are isolated from the rest of the population and immediately issued intervention. The nurse shall be 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 nurse shall make the necessary notifications to include the complex Director of Nursing, FHA, ADCRR Healthcare Coordinator, and Warden or designee.

6.2. Patients with close physical contact with the affected patient or those who share living quarters will be screened for ectoparasites by the nursing staff and treated accordingly. Asymptomatic close contacts (e.g., cellmates) may be offered treatment even if they are asymptomatic.

6.3. Hygienic maintenance of clothing, bedding, and personal hair items listed below need to be performed simultaneously.

6.3.1. Linens and clothes must be placed in a black bag with a label tag. Have the black bag sit in the sun for three days prior to washing.

6.3.2. The nurse will instruct security to have linens and clothes washed and dried at the prison laundry services. Remind laundry staff to use gloves and follow all required precautions.

6.3.3. Patient's personal items including mattress and linens will be laundered after cream/shampoo is applied.

6.3.3.1. Cloth mattresses or mattresses with holes must be bagged in a black bag for at least four days prior to washing.

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

6.4. Isolation of the patient:

6.4.1. <u>For head lice/pediculosis</u>: Once the shampoo treatment occurs, the bedding, clothing, and 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. <u>For scabies/body lice</u>: Once the cream has been left on for the recommended timeframe per provider order, the clothing, linen, and mattress must be washed and the patient's living area must be sanitized with disinfectant cleanser.

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 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 the provider's order.

6.4.2.1.2. If treatment is initiated with oral medication, the patient may be released from isolation only with a provider order.

6.4.3. <u>For Tinea Corporis or Tinea Capitas (ringworm of the scalp)</u>

6.4.3.1. These skin conditions are not ectoparasites; however, they can spread through skin contact from person to person.

6.4.3.2. Commonly referred to as "ringworm", they are not caused by a worm, but rather a fungus.

6.4.3.3. The patient does not have to be isolated from the other population.

6.4.3.4. The nurse will monitor the patient weekly on the nurses' line until resolved.

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

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

6.5.2. Follow-up appointments need to be scheduled at the time of the initial visit to avoid missing in case of a transfer.

6.5.3. A second treatment is recommended in most cases of lice and scabies one week after the initial treatment.

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

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

6.6.2. The receiving nurse who performs the chart review upon arrival confirms a scheduled follow-up appointment is on the nurse's line to screen the patient for ectoparasites.

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 the cleanliness and safety of all patient living areas; 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 FHA is responsible for ensuring that all manufacturer and state regulatory agency required inspections are completed on the health services equipment.

7.2. Inspection reports including documented corrective actions must be reviewed by the FHA or designee.

7.2.1. The original report on file may be retained by the appropriate supporting staff (e.g., Office of Safety and Environmental Services Liaison, Occupational Health Unit, etc.).

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1102, Communicable Disease and Infection Control MDSTM P-B-02.04, Communicable Disease Reporting and Management NCCHC Standard P-B-02, Infectious Disease Prevention and Control
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-02.02 Tuberculosis Screening & Management

PURPOSE: To provide standard guidelines for screening and management of active and latent tuberculosis (TB).

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

PROCEDURES:

1.0. Initial Screening at a Reception Center or Return to Custody

1.1. Symptom Screening: Nursing staff shall provide all newly arriving patients a symptom screening for pulmonary TB within 24 hours of admission.

1.1.1. Pulmonary symptoms include prolonged cough (longer than a three-week duration), chest pain and hemoptysis (bloody sputum); or at least three of the following systemic symptoms: fever, chills, night sweats, easily fatigued, 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, negative pressure room (if available), and placed on airborne precautions.

1.1.1.2. Patients with symptoms will be referred to the medical provider for further evaluation.

1.2. TB Skin Testing: 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 PPD skin test.

1.2.1. Patients vaccinated with Bacilli Calmette-Guerin (BCG) are not excluded from receiving a PPD test or an Interferon-Gamma Release Assay (IGRA).

1.3. Patients who receive 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 or until their test results are received and documented in the health record, prior to movement to another facility.

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

1.4.1. All return-to-custody patients 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.

1.5. Patients 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 less than one year has elapsed since their last tuberculin skin test (TST).

2.0. Annual Screening

2.1. Patients shall be screened annually for TB by PPD skin test and/or TB symptoms screening as stated in 3.0 below.

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

3.0. Reading PPD Skin Test and/or TB Symptoms Screening

3.1. Reading PPD Skin Test (for comprehensive guidance, refer to the CDC guidelines)

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

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

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

3.1.1.1.2. If the PPD skin test reaction is inconclusive, a repeat shall be administered in 7 to 12 days. If indicated, the patient may be transferred prior to the completion of the repeat PPD skin test and the Transfer Summary shall note that a repeat PPD skin test is required.

3.1.1.2. 10 or more (≥10) mm induration is considered a positive result in the majority of cases. These results are documented in the patient's health record and referred to the CHP practitioner for further evaluation and CXR.

3.1.1.3. 5 or more (≥5) mm induration is considered a positive result if the patient has any of the following conditions: human immunodeficiency virus (HIV), recent close contact with 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.

3.1.1.3.1. CHP nursing staff shall refer to the CHP medical provider to be seen within 72 hours of the result for CXR and evaluation for TB disease.

3.2. TB Symptoms Screening

3.2.1. For patients with a documented history of a positive PPD skin test, nursing staff shall verify treatment history as follows:

3.2.1.1. History of completed treatment: nursing staff shall perform TB symptom screening annually using Medical Work-Up, Form 1101-68, or approved electronic equivalent.

3.2.1.2. History of incomplete treatment: nursing staff shall refer patients to a medical provider for CXR & possible initiation of therapy. Nursing staff shall also perform symptom screening annually using Medical Work-Up, Form 1101-68, or an approved electronic equivalent.

4.0. The providers will provide evaluation and management of LTBI in accordance with approved Clinical Practice Guidelines and best practices.

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 based on clinical signs & symptoms, smear for Acid Fast Bacillus (AFB) or Nucleic Acid Amplification (NAA).

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

5.3. A medical provider or 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 as outlined in the Clinical Practice Guidelines (Latent Tuberculosis Infection) are negative for acid-fast bacilli (AFB).

5.4.2. Following two weeks of appropriate anti-tuberculosis treatment.

5.4.3. Clinical signs and symptoms of tuberculosis are improving.

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

5.6. Employee precautions while treating patients with suspected or confirmed active TB will be followed in accordance with Department Order #1102, Communicable Disease and Infection Control.

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

5.8. A patient on TB treatment shall receive thorough medical evaluation by a medical provider and be monitored by a nurse or medical provider for signs and symptoms of adverse reaction.

5.9. 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 Facility Health Administrator (FHA) 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.

5.10. In the event the patient is noncompliant with TB treatment, counseling with the 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.

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

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

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

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

6.0. Contact investigation procedures for patients diagnosed with active or suspected TB.

6.1. The FHA shall immediately notify the CHP Regional Medical Director or designee and continue reporting requirements as outlined in the Medical and Dental Services Technical Manual (MDSTM) P-B-02.04, Communicable Disease Reporting and Management.

6.2. CHP staff shall conduct contact investigations as recommended by ADHS directives provided during a teleconference in accordance with MDSTM P-B-02.04, Communicable Disease Reporting and Management.

6.2.1. Any additional patient evaluation or contact investigation shall be completed within three business days after being identified as a contact to a TB case.

6.3. Patients determined to be in close contact with a person diagnosed with active or suspected TB, shall have a PPD skin test unless they have had a known positive PPD.

6.4. Patients determined to be at close contact with a person diagnosed with active or suspected TB, who have had a positive PPD in the past shall undergo a chest x-ray.

6.4.1. Patient management and follow up shall be guided by the CHP Infection Control Coordinator or designee.

6.5. Close contacts receiving a PPD skin test with < 5 mm shall be retested at 12 weeks.

7.0. Refusal Process

7.1. If a patient refuses the administration of a PPD skin test, chest x-ray, or blood test, the nurse shall provide counseling regarding the intent and purpose of the test and document all counseling in the patient's health record.

7.2. If a patient does not cooperate after receiving counseling, the Director of Nursing shall notify the FHA, who shall notify the site Medical Director to discuss the case with the patient and decide if the patient is a clinical risk that requires isolation.

7.2.1. When a patient requires isolation, the CHP shall notify the Warden or designee, about the need to transfer the patient to a negative pressure room.

8.0. Documentation

8.1. Documentation of a completed PPD skin test or TB symptomology shall be noted in the appropriate area of the patient's health record.

P-B-02.03 Influenza Like Illnesses

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

RESPONSIBILITY: The ADCRR Medical Director or designee develops the program for surveillance, prevention, diagnosis, and treatment of suspected or confirmed communicable diseases. The Contract Healthcare Provider (CHP) is responsible for providing care to patients with suspected or confirmed communicable diseases and promulgating a screening program for communicable diseases.

PROCEDURES:

1.0. Immediately upon arrival to any facility, all patients shall be screened by CHP staff for recent exposure to and/or current symptoms of influenza-like illnesses.

1.1. Symptoms of influenza-like illnesses may include:

1.1.1. Fever (≥38°C, 100.4°F)

1.1.2. Chills

1.1.3. Headache

1.1.4. Sore Throat

1.1.5. Congestion or runny nose

1.1.6. Muscle pain

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

2.0. Patients with symptoms or possible exposure will be tested and isolated as clinically indicated (e.g., COVID-19, influenza, RSV, or other respiratory viruses).

3.0. Patients at high risk of complications from exposure to influenza-like illness, including elderly patients and those with chronic conditions, should be treated and closely monitored as clinically indicated.

4.0. Isolation, quarantine, or cohorting of patients shall take place as stated in the Medical and Dental Services Technical Manual (MDSTM) P-B-02.04, Communicable Disease Reporting and Management.

5.0. Infection prevention, education, and protocols for staff and patients will be in accordance with CDC guidelines.

6.0. Testing shall be available, completed, and results reported as directed by the in accordance with CDC and Arizona Department of Health Services (ADHS) recommendations.

7.0. For information regarding vaccinations, refer to the MDSTM P-B-03.01, Clinical Preventive Services.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1102, Communicable Disease and Infection Control NCCHC Standard P-B-02, Communicable Disease Prevention and Control NCCHC Standard O-B-01, Infection Prevention and Control Program Arizona Department of Health Services (ADHS)
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-02.04 Communicable Disease Reporting and Management

PURPOSE: Communicable disease notification and reporting shall occur to ensure that the incarcerated population and staff are protected and reporting is completed in accordance with local, state, and federal laws and regulation requirements as part of the infectious disease program/protocols.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for ensuring that all CHP staff comply with proper communication and notifications are made regarding communicable diseases in accordance with these guidelines as well as those outlined by the Arizona Department of Health Services (ADHS).

PROCEDURE:

1.0. The Facility Health Administrator (FHA) or designee shall submit a communicable disease report to the State Health Department within the required time frame of a case or a suspected 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 patient is a food handler.

1.1.2. Report outbreaks only.

1.1.3. Report directly to the State Health Department.

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

1.2.1. CHP reporting staff shall ensure each section of the communicable disease report is accurately completed for each suspected or confirmed communicable disease.

1.3. Any communicable disease that requires a consultative teleconference with ADHS shall have the teleconference be convened and attended by CHP staff and ADCRR staff as deemed appropriate.

1.3.1. CHP shall provide a written summary of the teleconference for distribution electronically to the participants to include recommendations and follow-up meetings as necessary.

2.0. The 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 procedures and timelines outlined by ADHS.

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

3.1.1. Notifications to custody staff shall be made in accordance with Department Order #1102, Communicable Disease and Infection Control.

3.1.2. 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.

3.2. FHA shall ensure appropriate follow up care is received by patients determined to require contact investigation by ADHS.

4.0. Within 30 calendar days of the completion of any outbreak investigation CHP staff shall submit to the local health department a written summary of the outbreak investigation which shall include all components required according to ADHS.

5.0. Reported communicable diseases shall be tracked and discussed at the monthly Continuous Quality Improvement (CQI) Committee Meeting.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-B-03, Clinical Preventive Services NCCHC Standard O-E-02, Health Assessments
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 months 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 as clinically indicated.

4.0. Dental Services

4.1. Patients are qualified for dental prophylaxis and Periodic Oral Exams (POE/recalls) yearly.
4.2. Patients who require routine prophylaxis, full mouth debridement, or periodontal maintenance shall have those services completed during their Complete Oral Exam (COE) or Periodic Oral Exams (POE/recalls) visits as clinically indicated.
4.3. Patients who require SRP (scaling and root planing) shall be scheduled for a follow up appointment to complete treatment as indicated.
4.4. Patients with periodontal disease shall have periodontal maintenance every six months. One may occur during yearly Periodic Oral Exams (POE/Recalls).
4.5. Patients are qualified for fluoride treatments on a yearly basis.

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 the intake process.

6.0. Immunizations:
6.1. Immunizations should be offered as clinically indicated to patients in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations.
6.1.1. Patient consent for immunization, administration, and education, including the providing of vaccination information statements (VIS's) shall be properly documented by CHP nursing staff in the patient's electronic health record to allow for the transfer of information to the Arizona State Immunization Information System (ASIIS).
6.2. Adverse Events
6.2.1. Healthcare staff should follow existing emergency protocols to assess and treat individuals with an adverse reaction following a vaccine.
6.2.2. Utilization of the Vaccine Adverse Event Reporting System (VAERS) shall be done to report adverse effects from a vaccine.
6.3. Refer to the Clinical Practice Guidelines, Clinical Preventive Services for additional information.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #903, Inmate Work Activities Department Order #912, Food Service Department Order #918, Fire Crew / Disaster Aid NCCHC Standard P-B-04 Medical Surveillance of Inmate Workers
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-04.01 Inmate Workers Clearance and Medical Surveillance

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 General Inmate Worker Screening/Clearance

1.1. An institutional committee or equivalent body exists that identifies and oversees inmate occupational associated risks through a medical surveillance program as referenced in Department Order #903, Inmate Work Activities.

1.2. All arriving inmates at the Reception Center shall receive an initial medical screening/physical exam at intake to evaluate for contraindications prior to enrollment into a work program.

1.2.1. Initial medical screening/physical exam shall be documented on Physical Examination, Form 1101-77 or approved electronic equivalent and documented in the patient's health record.

1.3. Inmate's medical and mental capacity will be taken into consideration when work is assigned based on skills and abilities required to successfully and safely perform the work assignment. All questions regarding eligibility of inmate workers shall be referred to the CHP who shall make the final clearance determination based on job risk factors and patient condition.

2.0 Food Service Inmate Workers

2.1. Inmates who have been identified as potential 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. Inmate workers with an acute infectious illness that may be transmissible to others (e.g., diarrheal illness), shall be excluded from work until medically cleared by CHP health staff.

3.0 Special Assignment Worker Clearance

3.1. Inmate Fire Crew

3.1.1. As stated in Department Order #918, Fire Crews / Disaster Aid, within ten business days of receipt of an inmate fire crew application, Inmate Fire Crew Application, Form 918-5, from the ADCRR Inmate Work Incentive Pay Plan (WIPP) Coordinator the CHP shall medically clear the inmate for work and complete the medical assessment portion of the application.

3.1.2. Fire Crew membership is voluntary. To be eligible the following pre-screening criteria/disqualifications apply:
3.1.2.1. Medical score of M-1, or chronic care classification stable condition of M-2.
3.1.2.2. Have a mental health score of MH-3 or lower; all MH 3 shall be assessed by a complex mental health lead.
3.1.2.3. No insulin-dependent diabetic.
3.1.2.4. No uncontrolled chronic illnesses.
3.1.2.5. No proven asthma diagnosis or significant pollen allergies.
3.1.2.6. No anaphylactic reactions to bug bites, ant bites, bee stings, or other insect bites.
3.1.2.7. No recent or active history of feet, ankle, knee, hip, and back/neck problems; no active or recurrent joint pain/treatments.
3.1.2.8. Must be able to ambulate (walk/run) without mechanical assistance.
3.1.2.9. No chronic headaches, dizziness, or balance problems.
3.1.2.10. No patients with a current diagnosis or history of epilepsy.
3.1.2.11. No mechanical hearing assistive devices; average hearing.
3.1.2.12. Have an average vision. If vision correction is necessary patient must be able to walk or run on rough terrain without glasses necessary.
3.1.2.13. No weekly or re-occurring medication requirements, no direct observed therapy (DOT) medications.
3.1.2.14. Monthly keep-on-person (KOP) medications may be authorized on a case-by-case basis.
3.1.2.15. If not disqualified in the pre-screening chart review, the inmate(s) shall be scheduled for:
3.1.2.15.1. Dipstick urinalysis
3.1.2.15.2. Completion of History and Physical (H&P) Form that meets Department of Transportation requirements.

3.2. Inmate on-complex drivers
3.2.1. Medical score of M-1.
3.2.2. Chronic care classification of stable M-2 may be authorized.
3.2.3. No MH-4 or MH-5. MH-3 shall be assessed by the complex mental health lead.
3.2.4. No insulin-dependent diabetics.
3.2.5. No uncontrolled chronic illnesses.
3.2.6. Must be able to ambulate without mechanical assistance.
3.2.7. No chronic headache issues, dizziness, or balance problems. No seizures in the past five years; no epilepsy.
3.2.8. Average visual acuity if glasses are worn. Not legally blind.
3.2.9. If an inmate is NOT disqualified based on the above criteria, they should be scheduled for:
3.2.9.1. Dipstick urinalysis.
3.2.9.2. Completion of a history and physical that meets Department of Transportation requirements.

3.3. Arizona Correctional Industries (ACI)
3.3.1. Must have a current physical exam to ensure the patient can safely perform duties required for an assigned position in accordance with Department Order #903, Inmate Work Activities.

4.0 Medical Surveillance of Inmate Workers
4.1. 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.
4.2. 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.
4.3. The responsible physician reviews and approves the health aspects of the medical surveillance program.
4.4. Inmate illnesses or injuries potentially related to occupational exposure or with occupational implications are identified and the information is provided to the quality improvement committee for review during the monthly Continuous Quality Improvement (CQI) meeting.

4.4.1. Any inmate worker who experiences an illness or injury while on the job or potentially related to their occupation shall be re-evaluated by the CHP for appropriateness of assignment prior to returning to work.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints 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 NCCHC Standard O-G-01, Suicide Prevention Program
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-05.01 Suicide Prevention and Intervention

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

RESPONSIBILITY: It is the responsibility of any staff member who becomes aware of a patient at risk of a suicidal gesture or experiencing an acute mental health issue to notify the shift commander or the healthcare staff so appropriate measures to protect the patient can be initiated.

PROCEDURES:

1.0. Staff shall follow the mental health watch policies outlined in MHTM Chapter 5, Section 1 and Department Order #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints.

2.0. The facility has an approved suicide prevention program which shall include the following:
- 2.1. Identification of a suicidal patient and immediately initiate precautions, including one-on-one constant observation of the patient until a QMHP can evaluate.
- 2.2. A prompt evaluation by a qualified mental health professional (QMHP), in collaboration with the MH Duty Officer after hours, who directs the intervention and ensures follow up as needed.
- 2.3. Acutely suicidal patients are monitored in-person, not over video camera, by facility staff via constant face-to-face observation.
- 2.4. Non-acutely suicidal patients are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.

3.0. Any patient who presents as a suicide risk shall have a formal in-person suicide risk assessment completed by a QMHP, in collaboration with the MH Duty Officer after hours, and placed on a mental health watch if clinically indicated in accordance with the Mental Health Technical Manual (MHTM) and Department Order #807, Inmate Suicide Prevention, Mental Health Watches, and Progressive Mental Health Restraints.
- 3.1. The use of other incarcerated people in any way (e.g., companions, suicide prevention aids) is not a substitute for staff supervision.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-B-06, Contraception
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 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.
   2.1. Examples include, but are not limited to, patients with polycystic ovary syndrome, abnormal uterine bleeding, or dysmenorrhea.

3.0. Upon request, contraception may be prescribed and dispensed to women one month prior to release with an additional month's supply given at the time of release.
   3.1. Information about contraceptive methods and community resources is available.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care NCCHC Standard P-B-07, Communication of Patients Health Needs NCCHC Standard OA-08, Communication of Patients Health Needs
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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

PURPOSE: To share information between the facility security, administration, and treating clinicians regarding the patient's significant health needs that must be considered to preserve the health and safety of the incarcerated individuals 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 incarcerated population.

PROCEDURES:

1.0. Healthcare needs are to be considered in decisions regarding the patient's housing assignment, work assignment, and available 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 the 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 the 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, when a new health condition is identified, or the patient has a change in condition.

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 and Dental Services Technical Manual
	REFERENCES: Department Order #108, American with Disabilities Act (ADA) Compliance MDSTM P-E-04.01, Initial Health Assessment NCCHC Standard P-B-07, Communication on Patients' Health Needs NCCHC Standard, O-A-08, Communication on Patients' Health Needs
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-07.02 Americans with Disabilities Act (ADA) Accommodations

PURPOSE: To ensure patients with a disability have equal access to programs and services and are not excluded from participation in programs, services or activities, or subject to discrimination. This policy is focused only on the ADA as it relates to patient healthcare.

RESPONSIBILITY: Each complex has a Facility ADA Coordinator who is responsible for coordinating the facility's efforts to comply with the ADA. In cooperation with the Facility ADA Coordinator, the Contract Healthcare Provider (CHP) is responsible for the identification of ADA-eligible patients and their needs and communicating those needs.

PROCEDURES:

1.0. Background

1.1. In accordance with Title II of the Americans with Disabilities Act of 1990 (ADA), the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) will not discriminate against individuals with disabilities based on their disability in access to services, programs, or activities.

1.2. ADCRR must provide appropriate auxiliary aids and services to allow for effective communication for qualified individuals with disabilities.

1.3. ADCRR must also provide reasonable accommodations and make reasonable modifications to policies, practices, and procedures to ensure that individuals with disabilities have an equal opportunity to participate in all of its programs, services, and activities.

1.4. Patients shall not be housed at a higher security level due to a lack of appropriate accessible placements at their security level.

2.0. Facility ADA Coordinator is responsible for coordinating the implementation of all ADA-related issues at the complex.

3.0. Procedures during intake and 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 Disabilities Act (ADA) Compliance.

3.1. During an assessment, if a medical provider or Registered Nurse (RN) identifies a patient who meets the designated criteria for transfer/placement of disabled patients, they shall perform a functional assessment examination and document the findings on the Functional Assessment, Form 108-1, or approved electronic equivalent. The Functional Assessment shall be saved to the patient's health record.

3.2. The medical provider shall assign a medical and health care needs (M) score, identify the related disability needs (appliances, aids, services, accommodations, special housing requirements), 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.

3.2.1. If not transferred electronically, the M score and related disability needs information shall also be entered into the Arizona Correctional Information System (ACIS) system to communicate the special needs of the patient.

4.0. Functional assessments shall be completed by a medical provider periodically as clinically indicated.

5.0. Auxiliary Aids and Services

5.1. As described in Department Order #926, Management of Inmates With Disabilities, and consistent with security requirements, ADCRR and CHP shall provide and 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.

5.2. If a request cannot be accommodated, the Facility ADA Coordinator shall be contacted for guidance.

5.3. 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.

5.4. The CHP shall communicate what auxiliary aids and services are necessary for effective communication with the patient when scheduling outside appointments, or when the patient requires off-site emergency treatment.

5.5. Patients who require assistive devices for their disabilities shall not be charged for these items.

5.6. Vision Disabilities

5.6.1. CHP shall conduct screening for low vision or blindness during the intake process as outlined in the Medical and Dental Services Technical Manual (MDSTM) P-E-04.01, Initial Health Assessment.

5.6.2. A patient with a vision disability is considered either blind or low vision based on the below parameters:

5.6.2.1. Blind – Corrected visual acuity of 20/200 or worse in the best eye.

5.6.2.2. Low Vision – Corrected visual acuity of 20/70 or worse in the best eye.

5.6.2.3. Patients with a corrected visual acuity of better than 20/70 in the best eye (monocular vision) are not considered to be low vision or blind.

5.6.3. When clinically indicated, CHP shall order assistive technologies and auxiliary aids and services. Primary consideration shall be given to the auxiliary aids requested by the patient for effective communication.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-A-04.01, Communications, Meeting, and Reports MHTM, Chapter 2, Section 3.0, Suicide Attempt or Completed Suicide Review NCCHC Standard P-B-08, Patient Safety NCCHC Standard O-B-02, Patient Safety
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-B-08.01 Patient Safety Through Reporting of All Significant Health Care Events

PURPOSE: To promote patient safety by prevention of adverse or near-miss clinical events and to provide guidance in the reporting requirement of all significant errors.

RESPONSIBILITY: The Contracted Healthcare Provider (CHP) is responsible for implementing systems to reduce risk and prevent harm to patients and reporting any error(s) that cause more than minimal harm to a patient.

PROCEDURES:

1.0. Preventable Adverse and Near-Miss Events: The CHP implements a reporting system for health staff to report preventable adverse and near-miss events that affect patient safety.

1.1. The CHP shall maintain an active log of all preventable adverse events and near miss events reported to prioritize analysis and remediation of errors and other system problems.

1.1.1. The CHP shall submit an event report log monthly with CQI minutes to the HSD who will assist in deciding which issues to address and when, and to monitor progress in resolution.

1.2. Reporters of preventable adverse events and near misses shall receive feedback about submitted reports and their impact.

1.2.1. In addition to individual feedback, all healthcare staff shall also receive feedback as it relates to specific patient safety changes that resulted from reporting.

1.3. Preventable adverse event reporting is mandatory for all staff.

1.3.1. Reporting of preventable adverse events shall be completed using an Information Report, Form 105-2, or a Significant Incident Report, Form 105-3, in accordance with Medical and Dental Services Technical Manual (MDSTM) P-A-04.01, Communications, Meetings, and Reports.

1.3.2. Preventable adverse events include errors that cause more than minimal harm to a patient (it includes more than medication-related errors).

1.4. Near-miss event reporting is voluntary and may be completed by anyone, including patients, into a developed system that allows for tracking and accountability.

1.4.1. Near-miss events are errors that cause no or minimal harm to a patient.

1.4.2. These reporting requirements are inclusive of only near miss events:

1.4.2.1.1. The reporter is immune from discipline, punishment, or retaliation related to the error unless the following are all true: the reporter is a staff member, the error is one they made themselves, and the error is one for which they have a current disciplinary or other performance improvement plan that addresses such errors.

1.4.2.1.2. Near miss reporting will be incorporated into the master log of all quality issues, not limited to near misses.

1.4.2.1.2.1. Reporting can be verbal (via telephone or face-to-face) or in writing (paper or electronic).

1.4.2.1.3. A minimal amount of information is required of the reporter initially so that the reporting process itself is not a barrier to reporting.

1.4.2.1.3.1. Because minimal information is required initially, reports are confidential but not anonymous, so that the reporter can be contacted to obtain more and complete details later if needed.

1.4.2.1.3.2. More complete details will be obtained for a root cause analysis and corrective action, when indicated, by the CHP Quality Assurance Director or designee. The timeline will be prioritized by the CHP Quality Assurance Director or designee with oversight by the ADCRR Healthcare Services Division Quality Assurance Director.

1.5. Following the report of any patient death, suicide attempt, significant health care error, preventable adverse event, or near-miss event, the CHP staff shall conduct further analysis of all these events, then conduct a root cause analysis, based on priority, and develop an effective and sustainable plan.

1.5.1. The Suicide Attempt Review Committee shall be convened in accordance with the Mental Health Technical Manual (MHTM) Chapter 2, Section 3.0 Suicide Attempt or Completed Suicide Review. This will include implementation of corrective action plans when indicated in the context of CQI program.

1.5.2. CHP shall provide the ADCRR Healthcare Services Division (HSD) with a sustainable remedial plan for review and approval. Prioritization of corrective action plans will be determined by the CHP Quality Assurance Director or designee with oversight by the ADCRR Healthcare Services Division Quality Assurance Director.

1.5.3. Approved remedial plan shall be implemented within one month of the event.

2.0. Medication Error Reporting (categorized as "near miss" reporting or a preventable adverse event, as clinically appropriate)

2.1. A Medication Incident Report will be completed and submitted whenever there is an administration error or pharmacy error discovered.

2.1.1. The Medication Incident Report shall be submitted to the Facility Health Administrator (FHA) who will provide a copy to the appropriate CHP Regional and site level leadership and the ADCRR Healthcare Coordinator.

2.1.2. The Medication Incident Report will include:

2.1.2.1. Patient's name

2.1.2.2. Patient's ADCRR inmate number

2.1.2.3. Date

2.1.2.4. Prescriber's name

2.1.2.5. Persons involved

2.1.2.6. Description of error

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

2.1.2.8. Other relevant information to the incident

2.2. When a patient has taken a medication in error, the patient will be evaluated and provided appropriate clinical management.

2.3. The error must be documented in the patient's health record.

2.4. The FHA is responsible for tracking, reviewing, and including medication errors in the monthly Continuous Quality Improvement (CQI) meeting.

3.0. Adverse Drug Reaction

3.1. Adverse drug 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 identified, the CHP nurse or provider staff shall add the medication to the patient's allergy list.

3.1.2. When an adverse drug reaction is suspected, the CHP Nurse or CHP Pharmacy Director or designee will notify the attending CHP practitioner/provider for their review.

3.1.3. The reaction will be recorded by the CHP staff on Form-FDA 1639a or FDA Form 3500 (6/93) and sent to the ADCRR Medical Director or designee.

3.1.4. The CHP Pharmacist will evaluate and forward appropriate reports to the FDA at:

3.1.4.1. 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

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

3.1.5. HSD shall monitor the remedial plan for effectiveness and make appropriate and timely modifications to the plan based on the monitoring.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #712, Tool Control NCCHC Standard P-B-09, Staff Safety NCCHC Standard O-B-03, Staff Safety
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 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 any time there are patients in a clinical area while maintaining auditory and visual confidentiality.
- 2.2. Security personnel are present to accompany contracted healthcare staff when entering housing locations.

3.0. For patients attending a healthcare appointment with restraints applied by an escorting correctional officer, the provider may request an alternate method of restraint to permit the physical examination or testing of the patient whenever it is safe to do so.

4.0. 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.

P-B-09.02 Management and Control of Hazardous or Infectious Materials

PURPOSE: To provide guidance to the Contracted Healthcare Provider (CHP) in the management and control of hazardous materials found in the workplace and proper procedures in the handling of infectious materials encountered during the provision of healthcare.

RESPONSIBILITY: It is the responsibility of the CHP to have a Hazard Communication Plan with specific information regarding chemical hazards employees may encounter in the workplace. The CHP shall also ensure that hazardous materials are properly labeled, and stored and an up-to-date Safety Data Sheet (SDS) is on file when applicable. The CHP is responsible for the proper handling and disposal of infectious material.

PROCEDURES:

1.0. Hazardous Materials

1.1. Levels of Responsibility

1.1.1. Employers:

1.1.1.1. Monitors/reviews program progress.

1.1.1.2. Assures compliance with SDS and label requirements.

1.1.1.3. Assures mandatory education and training.

1.1.1.4. Shall immediately refer CHP staff with chemical accidents to appropriate medical personnel.

1.1.1.5. Shall inform outside contractors about potential exposures when those employees perform work in the office and provide them with access to the SDS file.

1.1.1.6. Assures compliance with hazardous waste removal.

1.1.1.7. Handles concerns of employees.

1.1.2. Hazard Communication Plan Coordinator:

1.1.2.1. Maintains current CHP staff list.

1.1.2.2. Maintains training records.

1.1.2.3. Maintains hazardous chemical list.

1.1.2.4. Can demonstrate safe handling of hazardous chemicals.

1.1.2.5. Be knowledgeable about the SDSs and their use.

1.1.2.6. Maintain the SDS file and keep it current.

1.1.2.7. Be knowledgeable about label requirements and monitor labels.

1.1.2.8. Ensures compliance with safety procedures.

1.1.2.9. Assures training when new chemicals arrive.

1.1.3. Employees:

1.1.3.1. Responsible for practicing job safety.

1.1.3.2. Attend training and education sessions and apply this information on the job.

1.1.3.3. Read and become familiar with the SDS file.

1.1.3.4. Become familiar with labeling protocols and keep them current.

1.2. Identification of Hazardous Materials:

1.2.1. Primary responsibility for hazard determination lies with the product supplier.

1.2.2. Once the hazard determination is made, the supplier must develop an SDS for each Material that contains hazardous ingredients.

1.2.3. It is the responsibility of the dental clinic to keep a current inventory list of hazardous materials used, along with the products SDS.

1.3. SDS
    1.3.1. All CHP staff shall have access to SDSs.
    1.3.2. The clinic has designated an employee as the hazard communication plan coordinator and this person is responsible for SDS collection, updating, and availability. If this person leaves, a new person will be appointed as soon as possible.
    1.3.3. The hazard communication plan coordinator will ensure that as new products are received, the inventory and SDS file are updated and the rest of the CHP staff is aware of the new hazardous material.
        1.3.3.1. If no SDS is received with the product, the dental supplier or manufacturer will be contacted, and a copy of the request placed in the SDS file.
    1.3.4. All employees will periodically review the Hazard Communication Plan and SDS file.
    1.3.5. At least yearly, the SDS file shall be checked to see if any SDSs are no longer used or current.

2.0. Labeling:
    2.1. The hazard communication plan coordinator shall ensure the hazardous materials label has the identity of the chemical, the type of hazard posed by the material, and the supplier's name and address.
    2.2. If materials are placed in a secondary container, this unmarked container needs to have a label posted on it that indicates the chemical name and appropriate warning.
        2.2.1. This label may be a copy of the label from the original container, label may not be handwritten.
    2.3. If the secondary container is stationary, labeling may be done by posting a placard on or near the stationary container.
    2.4. All staff will ensure that the labels are legible, not defaced, nor removed. If they are, make additional labels when needed.

3.0. Information and Training
    3.1. At the time of initial employment, CHP staff will be provided with information and training on hazardous chemicals.
    3.2. CHP staff shall provide the Hazard Communication Plan and SDS file and staff are expected to be familiar with their contents, including the requirements of the OSHA Hazard Communication Standard, the list of hazardous chemicals in the office, the location of the SDS file, and the labeling protocol, etc.
        3.2.1. This information will be reviewed on an annual basis and documented.
    3.3. As new products are introduced to the work area, the hazard communication plan coordinator will plan training in identifying the physical and health hazards of the new chemical and present measures staff can take to protect themselves.

4.0. Dental Infectious and Hazardous Material Control
    4.1. CHP dental staff shall wear personal protective equipment (PPE) for any surgical procedure when decontaminating and disinfecting environmental surfaces and at all times when splashes, spray, spatter, aerosols, or droplets of blood, or other potentially infectious materials may be generated.
    4.2. CHP dental personnel who clean instruments or other soiled items shall wear puncture and chemical-resistant/heavy-duty utility gloves to minimize health risks.
    4.3. Critical and semi-critical items shall be packaged prior to sterilization in a self or manual sealing pouch or sterilization wrap.
    4.4. All metal or heat-stable, reusable, critical, and semi-critical items including instruments attached to, but removable from, the dental unit air and water lines, such as ultrasonic scaler tips and components or parts of air/water syringes, etc., shall be cleaned and sterilized after each use.

5.0. Hazardous Medical Waste (applies to all health services)
    5.1. The CHP Facility Health Administrator (FHA) shall ensure that all CHP staff are using standard precautions and utilizing appropriate PPE to minimize the risk of exposure to hazardous or infectious material.

5.2. The CHP FHA shall ensure that all CHP staff are properly trained on protocol and procedures to properly dispose of biohazardous waste including infectious waste, radioactive waste, and/or sharps in appropriately labeled containers (i.e., red bags, barrels, biohazard containers, etc.) for the safe and efficient removal and destruction of such material.

5.2.1. Infectious medical waste is any sort of waste that is capable of producing or spreading infection. This type of waste should be handled with caution and by those specifically trained to handle the material. Examples of infectious waste include:

5.2.1.1. Personal protective equipment (PPE)

5.2.1.2. IV tubing

5.2.1.3. Wound dressings

5.2.1.4. Sharps

5.2.1.5. Body tissue or organs

5.2.2. Radioactive medical waste is one of the most dangerous types of medical waste if handled improperly. Exposure to it can lead to many severe long-term ailments. Much of the radioactive medical waste produced in the healthcare field comes from radiation therapy. Examples of radioactive medical waste include:

5.2.2.1. Sharps used for radiation

5.2.2.2. Clothing and utensils used for radiation

5.2.2.3. Any disposable material that comes into contact with radioactive rays

5.2.3. Sharps are defined as any medical utensil that can puncture human skin. CHP staff shall dispose of sharps in containers specially made for safe sharp disposal. Examples of sharps include:

5.2.3.1. Needles

5.2.3.2. Syringes

5.2.3.3. Scalpels

5.2.3.4. Lancets

5.2.3.5. Autoinjectors

5.3. CHP FHA shall ensure that incarcerated workers with assigned duties in the health unit are trained in the appropriate handling and disposal of biohazardous materials or spills.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care NCCHC Standard P-C-01, Credentials NCCHC Standard O-C-01, Credentials NCCHC Standard O-D-05, Hospital and Specialty Care
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-01.01 Credentialing Responsibilities

PURPOSE: To ensure that all professional healthcare staff providing care to patients within ADCRR are in good standing with their respective licensure/certification board to practice their profession, provide services only within their scope of practice, and to validate the legal and performance qualifications of the practitioners/providers employed by the Contract Healthcare Provider (CHP).

RESPONSIBILITY: The CHP is responsible for ensuring that healthcare staff provides care within their expertise/training in accordance with their scope of practice and that the care provided is high quality. It is the 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 or certification to practice their profession obtain and maintain current credentials within the State of Arizona and are in compliance with the standards of the code of conduct for their profession.

- 1.1. The CHP shall ensure all health staff practice within their license and/or credentialing scope of practice set forth in the Arizona Administrative Code.
- 1.2. The CHP shall ensure that appropriate health staff submits copies of documentation that verifies licensure/certification.
  - 1.2.1. The documentation to verify current credentials for all qualified healthcare professionals will be maintained locally by the FHA or designee.
- 1.3. 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 regulations.
- 1.4. If a CHP professional comes under investigation for any reason or has their license/certification revoked/suspended or restricted by their respective Board, the CHP healthcare professional shall immediately notify their supervisor.
- 1.5. The CHP shall notify ADCRR Healthcare Services Division (HSD) of any information received regarding revoked/suspended and/or restricted license/certification, license under investigation, or an expired license without documentation supporting the requested renewal.
  - 1.5.1. The CHP shall ensure any CHP professional whose licensure expires is taken off the schedule and addressed appropriately.
  - 1.5.2. Staff who hold a professional license may not provide care with a restricted license if the restriction is related to clinical competency or restricted to practice in a correctional facility.

2.0. Medical Directors and all other clinical supervisory positions must have at least two years clinical experience at time of hire.

3.0. Physician Specific Credentialing Requirements: All medical physicians at hiring and during employment shall be board certified in Internal Medicine or Family Practice, or board eligible if within seven years of their completion of an Accreditation Council for Graduate Medical Education (ACGME) approved residency in one of these two specialties with the following exceptions:

3.1. Medical directors, shall be board certified at hiring and during employment;

3.2. Physicians providing obstetric and gynecologic services shall be board certified or board eligible if within seven years of their completion of an ACGME approved residency in obstetrics and gynecology.

4.0. On-Site Specialty Services

4.1. CHP shall ensure providers seeing patients for on-site medical and mental health specialty services have the appropriate licenses and certifications prior to providing care.

	Medical and Dental Services Technical Manual
	REFERENCES: MHTM Chapter 1, Section 2.0, Psychiatric and Mental Health Peer Review NCCHC Standard P-C-02, Clinical Performance Enhancement NCCHC Standard O-C-08, Professional Development
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-02.01 Peer Reviews of Professional Activities

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

RESPONSIBILITY: The Contract Healthcare Provider (CHP) discipline directors shall ensure that processes are in place to conduct peer reviews in a timely manner to maintain the provision of high quality healthcare.

PROCEDURE:

1.0. The clinical performance of the facility's direct care clinicians, OTP licensed providers, Registered Nurses (RNs), and Licensed Practical Nurses (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 healthcare provider
  - 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 review is to be made available to the ADCRR Healthcare Services Division (HSD). 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 provider's competence.
  - 1.3.1. The FHA implements procedures to improve an individual's competence when such action is necessary and reports to HSD as needed.
  - 1.3.2. Privileges for existing clinical staff may be denied, modified, or removed based on assessments of clinical competence or fitness for duty.

2.0. Site level reviews shall be conducted according to the following peer review procedures:

- 2.1. The records of the Site Medical Director (SMD), Dental Director, and Director of Nursing (DON) shall be reviewed by the Regional Director or designee of that discipline.
- 2.2. The SMD or designee shall review the health record activity entries of all healthcare providers at the complex.
- 2.3. The Site Dental Director or designee shall be responsible for the requirements of the Contract, policies, and procedures related to the dental program, and shall review the dental activity records of all dental care Providers at the complex accordingly.

2.4. For the mental health staff professional/peer review process, please refer to the Mental Health Technical Manual (MHTM) Chapter 1, Section 2.0 Psychiatric and Mental Health Peer Review.
2.4.1. Psychiatric provider and Mental Health Clinician peer review shall be conducted in accordance with Chapter 1, Section 2.0 of the MHTM.
2.5. The complex DON or designee shall review the health record activity entries of all nursing staff (RNs and LPNs) at the complex.
2.6. 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 SMD and Site Dental Director in conjunction with the FHA shall retain all copies of review reports for one year following the review.
2.6.1. Hard copies of the health record sections are not necessary for local review.
2.7. At a minimum, 10 charts are reviewed per healthcare professional twice yearly.
2.7.1. If corrective action is needed, then a repeat review of 10 charts will take place within 90 days.
2.7.2. For a medical provider, the charts are reviewed to answer the following questions:
2.7.2.1. Is provider documentation sufficient to support provider's assessment and plan?
2.7.2.2. Are prescribed medications consistent with ADCRR Clinical Practice Guidelines?
2.7.2.3. Were labs/studies ordered as recommended by ADCRR and/or nationally recommended guidelines?
2.7.2.4. Was follow-up frequency in accordance with ADCRR and/or nationally recommended guidelines?
2.7.2.5. Are appropriate patient education, discharge planning, and counseling documented?
2.7.3. For a registered nurse, the charts are reviewed to answer the following questions:
2.7.3.1. Was patient encounter due to health care complaint (i.e., sick call, emergency, staff referral) evaluated using appropriate nursing protocol form or is documented in SOAP format?
2.7.3.2. Did the documentation of patient health assessment include vital signs?
2.7.3.3. Was the appropriate history of complaint(s) obtained?
2.7.3.4. Was the physical assessment appropriate to the nature of complaint(s)?
2.7.3.5. Is there evidence that components of plan were carried out (follow up appointment scheduled, blood pressure checks scheduled, etc.)?
2.7.3.6. Was education is provided to patient?
2.7.3.7. Was there an appropriate referral to higher level of care when indicated?
2.7.4. For a licensed practical nurse, the charts are reviewed to answer the following questions:
2.7.4.1. Were the narcotic/sharp counts completed at the beginning and the end of each shift?
2.7.4.2. Were on-coming shift and off-going shift signatures are present on narcotic/sharp sheets?
2.7.4.3. Were medications are administered in a timely manner and documented appropriately?
2.7.4.4. If a medication was not administered, was there appropriate documentation in place with an explanation?
2.7.4.5. Were blood sugars completed with results documented on EMAR?
2.7.4.6. Were blood pressure checks completed and documented on EMAR?
2.7.4.7. Were medication carts neat and orderly for oncoming shift?
2.7.4.8. Was wound care completed per physician's orders and the documentation present?

3.0. Formal peer review (if deemed necessary):
3.1. A formal peer review or case review may be requested relative to patient health care by the ADCRR Assistant Director for Healthcare Services, ADCRR Medical Director, an ADCRR Director of Nursing, or CHP.

3.2. Within ten business 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): FHA; medical provider(s); dental provider(s), mental health provider(s); 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 Healthcare Coordinator or designee to an ADCRR Director of Nursing within ten business 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 Director of Nursing or designee within ten business days to conduct a comprehensive review of all relevant materials, documents, and initial peer review findings.

3.6. The committee may include, as appropriate, the following: ADCRR Medical Director, ADCRR Directors of Nursing, and other members as required or directed by ADCRR Assistant Director for Healthcare Services.

3.6.1. The committee may seek input from other subject matter experts as appropriate and necessary.

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 ADCRR Assistant Director for Healthcare Services within ten business days.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #509, Employee Training and Education NCCHC Standard P-C-03, Professional Development NCCHC Standard O-C-02, Staffing NCCHC Standard O-C-03, Professional Development
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-03.01 Professional Development

PURPOSE: To ensure qualified healthcare professionals providing patient care 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. Continuing clinical and professional education is required annually for all staff in accordance with Department Order #509, Employee Training and Education and National Commission on Correctional Health Care (NCCHC) standards.
- 1.1. Continuing medical education shall be in accordance with a health professional's licensing board.

2.0. All Contract Healthcare Provider (CHP) qualified healthcare professionals working for the CHP in Arizona will show proof of at least 12 hours of continuing education on average per year.
- 2.1. Yearly continuing medical education shall include classes on opioid substance use disorder (SUD) and withdrawal.
  - 2.1.1. All medication assisted treatment (MAT) health staff participate in continuing education that focuses on topics related to OTP.
- 2.2. Full-time qualified healthcare professionals must obtain and maintain continuing education requirements in accordance with current Drug Enforcement Administration (DEA) regulations.
  - 2.2.1. All full-time qualified healthcare professionals shall obtain a minimum of four hours per year related to opioid treatment.
- 2.3. A list of completed courses, dates, and number of hours per course is on file.

3.0. The FHA maintains a list of Arizona's continuing education (CEU) requirements for each category of licensure of all qualified healthcare professionals and documentation to indicate compliance with CEU requirements.

4.0. All staff members assigned to work in the MAT program have a detailed job description for their assigned position kept in their personnel files.
- 4.1. Each health staff member working in the MAT program has a professional development plan that is reviewed at least annually.

5.0. All CHP qualified healthcare professionals who have patient contact have an active, unexpired BLS certificate.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #509, Employee Training and Education NCCHC Standard P-C-04, Health Training for Correctional Officers NCCHC Standard O-A-09, Privacy of Care NCCHC Standard O-C-03, Professional Development
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 the healthcare needs of incarcerated individuals, provide care in life-threatening situations, and refer incarcerated persons to a healthcare professional when necessary.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) 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.

PROCEDURES:

1.0. Correctional Officers are to receive health-related training at least annually.
- 1.1. The training will include at a minimum the following:
  - 1.1.1. Administration of first aid
  - 1.1.2. Recognizing the need for emergency care and carrying out intervention in life-threatening situations (i.e., heart attack, suicide attempt)
  - 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, decompensation patterns, and procedures for suicide risk detection and prevention
  - 1.1.7. Knowledge regarding individualized Behavior Management plans and de-escalation techniques with additional training for staff assigned to living units that house patients in isolation and those in Crisis Stabilization/Suicide Watch regarding therapeutic intervention strategies specifically suited to this population
  - 1.1.8. Knowledge of procedures for appropriate referral of inmates with health complaints to health staff
  - 1.1.9. Knowledge of procedures and precautions concerning infectious and communicable diseases
  - 1.1.10. BLS certification
  - 1.1.11. Knowledge regarding medication assisted treatment (MAT) program relevant security and health services policies and procedures, response to emergency situations, and appropriate use of naloxone for overdose.
  - 1.1.12. Dental emergencies
  - 1.1.13. Maintaining confidentiality

2.0. The appropriate nature of the health-related training is verified by an outline of the course content and length of the course.
- 2.1. Each complex has a training officer who maintains original training records and associated rosters.

2.1.1. 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 with the established ADCRR standards requires at least 75% of the staff present on each shift are current in their health-related training.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-B-08.01, Patient Safety Through Reporting of All Significant Health Care Events NCCHC Standard P-C-05, Medication Administration Training NCCHC Standard O-C-04, Medication Administration Training
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-05.01 Medication Administration Training

PURPOSE: To establish a program to ensure healthcare staff assigned to administer or deliver medications to patients are appropriately trained.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) and Nursing Supervisors to ensure that healthcare staff are appropriately trained to administer or deliver prescription medication.

PROCEDURES:

1.0. CHP must provide an approved medication administration training program to clinical staff assigned to administer or deliver prescriptions that complies with the state of Arizona's scope of practice and licensure requirements.
- 1.1. The training is approved by the responsible physician or designee and the FHA or designee.
- 1.2. Retraining on medication administration should be given annually and periodically as needed to all licensed nursing staff and include a post-training evaluation.

2.0. All new licensed nursing staff (CHP or subcontractor) assigned to administer and/or deliver medication to patients must complete the medication administration training within 30 days of hire.
- 2.1. The CHP Nursing Supervisor, Preceptor or designee shall:
  - 2.1.1. Review medication procedures with each staff member including training related to:
    - 2.1.1.1. Security
    - 2.1.1.2. Accountability
    - 2.1.1.3. Common side effects
    - 2.1.1.4. Documentation of the administration of medications
  - 2.1.2. Meet with the staff member upon completion of the training and complete an assessment of learning to evaluate the staff member's understanding of medication administration, including the administration of insulin.
    - 2.1.2.1. Documentation of assessment of learning shall be kept on file for each staff member assigned to administer and/or deliver medication.
  - 2.1.3. Ensure the staff member receives instructions on security issues (e.g., accountability of medication/sharps, timing of medication administration related to the correctional clock, etc.) related to medication administration or delivery.
  - 2.1.4. Ensure that the staff member is oriented to the Medication Incident Report policy in accordance with Medical and Dental Services Technical Manual (MDSTM) P-B-08.01, Patient Safety Through Reporting of All Significant Health Care Events.

3.0. Nursing staff assigned to administer or deliver medication for opioid use disorder (MOUD) under the authority of the medication assisted treatment (MAT) program, as well as other controlled substances, are appropriately trained.

3.1. Staff who administer or deliver medication for MOUD are trained in the needed matters of security, accountability, common side effects, and documentation.

3.2. The training is approved by a clinician designated by the program sponsor and FHA or designee.

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

5.0. The FHA or designee shall ensure that all completed training, assessments of learning, and a copy of the training checklist is maintained in each employee training file.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #903, Inmate Work Activities NCCHC Standard P-C-06, Inmate Workers NCCHC Standard O-C-05, Inmate Workers
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-06.01 Incarcerated Workers

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

RESPONSIBILITY: It is the responsibility of the Warden and the Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) or designee to ensure that people who are incarcerated 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 workers who are incarcerated.

PROCEDURE:

1.0. Workers who are incarcerated do not make treatment decisions or provide patient care.

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

3.0. Workers who are incarcerated and are employed to clean health unit(s), including infirmaries, SNUs, and suicide watch, will be appropriately trained and supervised regarding their work assignment.

4.0. Incarcerated workers are not permitted to:
- 4.1. Distribute or collect sick-call slips.
- 4.2. Schedule appointments.
- 4.3. Transport or view health records.
- 4.4. Handle or administer medications.
- 4.5. Handle surgical instruments and sharps.

5.0. Inmates in peer-health-related programs are permitted to:
- 5.1. Assist patients with various activities in order to provide assistance (e.g., mobility – pushing a wheelchair; recreation – reading a book).
- 5.2. Participate in a buddy system for suicidal patients without current suicidal ideation after documented training.
- 5.3. Participate in hospice programs after documented training.

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 incarcerated 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 incarcerated population.

PROCEDURES:

1.0. Staffing Plans:

1.1. The CHP will develop and monitor a staffing plan, under the direction of any court mandates and under guidance of the ADCRR Healthcare Services Division. The staffing plan will ensure that a sufficient number of qualified health personnel assigned to each discipline are available to provide timely evaluation and treatment consistent with the standard of care within the community.

1.1.1. Staffing plan shall include sufficient personnel so that healthcare staff responsible for direct patient care will not be mandated to work greater than 12 hours in any 24 hour period, have less than 8 hours off between any two shifts, or work more than 60 hours in a calendar week.

1.1.2. Limits on overtime may be extended during emergency situations (e.g., a prison riot or natural disaster). Chronic understaffing does not constitute an emergency situation.

1.2. The staffing plan will be monitored in accordance with the ability to meet all patients' healthcare needs within a reasonable time frame, as determined by the ADCRR Healthcare Services Division (HSD) and the Inmate Healthcare Contract.

1.3. Staffing will be determined by the size of the complex, the types and scope of services delivered, and the needs of the inmate population.

1.3.1. A staffing plan will be reviewed by the HSD to address its adequacy for 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.

1.4.1. Time spent on call is not included in the above-referenced time limits.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-C-08, Healthcare Liaison
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 and Dental Services Technical Manual
	REFERENCES: Department Order #509, Employee Training and Education NCCHC Standard P-C-09, Orientation for Health Staff NCCHC Standard O-C-03, Professional Development
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-09.01 Orientation and Education for Health Staff

PURPOSE: Health staff are properly trained 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 complete an orientation to the correctional setting and the health services delivery system.

PROCEDURES:

1.0. The orientation program is approved by the ADCRR Healthcare Services Division (HSD) 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 receive 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 the staff member's functional position description, a map of the facility, and a 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 Department Orders (DO):

3.1.1.1. DO #1101, Inmate Access to Health Care
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.

3.1.3. The CHP shall provide a copy of the Health Services Emergency Response Plan and the employee shall sign acknowledging receipt.

4.0. Each new CHP employee shall be provided training on infectious control procedures prior to assignments involving direct or indirect patient care duties.

4.1. Documentation of training provided to dental staff on infection control procedures shall be submitted to the ADCRR Dental Director and include the following information:

4.1.1. Date(s) of training
4.1.2. Duration of training
4.1.3. Content of training
4.1.4. Name(s) and signature(s) of person(s) conducting the training
4.1.5. Name(s) and signature(s) of all employees attending the training

4.2. Documentation of completed training shall be maintained by the FHA in the employee's personnel file at the complex for which they are assigned.

5.0. Within 30 days of employment the new employee shall complete a discipline-specific orientation which upon completion is documented and maintained in the employee's personnel file.

6.0. Within 90 days of employment, all health staff complete an in-depth orientation to the overall correctional health delivery system including all policies and procedures located in health services technical manuals that may not have been addressed in the Basic Orientation.

7.0. Annual Training

7.1. Dental staff shall be provided with training on infectious control procedures annually.

7.2. All CHP health staff are required to complete annual training as assigned to each individual in accordance with Department Order #509, Employee Training and Education.

8.0. It is the responsibility of the CHP to ensure completion of the orientation program, all educational activities, and training documents are kept on file for each of their employees.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #121, Arizona Criminal Justice and Non-Criminal Justice Information And Identification System Department Order #509, Recruitment and Hiring NCCHC Standard P-C-09, Orientation for Health Staff
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-C-09.02 Student and Extern Clinical Rotation Programs

PURPOSE: To establish a procedure for orientation and participation of students serving a clinical rotation with the Contracted Healthcare Provider (CHP) and ADCRR. Specifics regarding each type of clinical rotation requirements are addressed in the applicable Affiliation Agreement between the university and the CHP.

RESPONSIBILITY: It is the responsibility of the CHP to ensure that all actions by students are in accordance with ADCRR Department Orders (DO), Technical Manuals, Personnel Rules, and the applicable Affiliation Agreement.

PROCEDURES:

1.0. Prior to the starting date, the university or college sponsoring the student's clinical rotation will provide the information necessary to obtain a security clearance in accordance with DO 121 Arizona Criminal Justice and Non-Criminal Justice Information And Identification System and DO 504 Recruitment and Hiring.

1.1. Upon completion of security clearance, the student shall be issued a temporary contractor identification (ID) badge.

2.0. The CHP and ADCRR in conjunction with a representative from the university will determine an appropriate rotation schedule for the students requesting a clinical experience.

2.1. The clinical rotation list shall be provided to the appropriate Site Medical Director, the appropriate complex Director of Nursing, and the appropriate Facility Health Administrator (FHA).

3.0. The receiving FHA shall designate an appropriate preceptor who shall ensure each student receives a proper orientation to the correctional environment and scope of health care provided to patients at the student's assigned complex and unit.

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

3.1.1. How health services are provided to meet the needs of the incarcerated population;

3.1.2. The philosophy of ADCRR with regard to the delivery of health services;

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

3.1.4. ADCRR Department Orders, Technical Manuals, and Post Orders relevant to the student's clinical experience.

3.2. CHP practitioners/providers and professionals assigned as preceptors are to be familiar with the course objectives for the student and are to be responsive to the student 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 or the CHP.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #702, Key Control Department Order #1101, Inmate Access to Healthcare MDSTM-P-E-10.01, Discharge Planning/Transition To The Community NCCHC Standard P-D-01, Pharmaceutical Operations Arizona Revised Statute 32-1964, Record of Prescription Orders; confidentiality
	Effective Date: 10/01/2024 Supersedes only as it relates to State Prisons: N/A

P-D-01.01 Pharmaceutical Operations

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. Inventory of Pharmaceuticals

1.1. Security

1.1.1. Only authorized persons shall have access to areas where medications are stored.

1.1.2. A key control system shall be instituted by the Warden to control access and accountability in accordance with Department Order #702, Key Control.

1.1.2.1. CHP employees shall be responsible for the control of keys issued to them until the keys are returned to the control area at the end of the shift or when transferring to another work site.

1.1.2.2. Key control violations constitute a major breach of security. CHP employee negligence in key control may result in disciplinary action.

1.1.2.3. All missing keys shall be reported to security staff immediately.

1.1.3. At the discretion of the Warden, emergency keys to areas where pharmaceuticals are stored may be authorized and held in a secure area.

1.1.4. Facility security personnel may enter the medication storage area, without a licensed CHP staff member, if a non-medical emergency threatens the storage area or adjacent buildings.

1.1.5. Agents of recognized law enforcement and regulatory agencies shall be allowed access to the medication storage 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).

1.1.6. At all times when authorized non-licensed personnel are present in the medication storage areas, all controlled substances shall remain under lock and key.

1.2. Storage of Pharmaceuticals

1.2.1. General Storage Guidelines

1.2.1.1. 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.

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

1.2.1.1.1.1. Room temperature must be between 65º to 85ºF or 18º to 29ºC.

1.2.1.1.1.2. Refrigerator temperature must be between 36º to 44ºF or 2º to 7ºC.

1.2.1.1.2. If any temperature is found to be outside of the range recommended by the manufacturer, appropriate action shall be taken and documented.

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

1.2.1.2. Medication storage areas are monitored to ensure there are no outdated, discontinued, or recalled medications, except in a designated area for disposal.

1.2.1.2.1. Medication for patients who are out to court or in the hospital shall be stored and maintained at the unit pending the patient's return to the facility unless the order has expired.

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

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

1.2.1.5. CHP staff shall ensure the poison control telephone number is posted in any area where overdoses or toxicological emergencies are likely.

1.2.2. Multi-Dose Vial Storage

1.2.2.1. Multi-dose vials shall be dated when opened and initialed by the user and will be good for use for 30 days unless otherwise stated by the manufacturer or the expiration date is less than 30 days.

1.2.2.1.1. Exception: All insulin shall expire 28 days once opened and properly disposed of unless stated otherwise by the manufacturer.

1.2.2.2. Noncompliance with this procedure shall be reported to the FHA or designee.

1.2.3. Release Medication Storage

1.2.3.1. All release medications, including controlled substances shall be inventoried as outlined in the Medical and Dental Services Technical Manual (MDSTM) P-E-10.01 Discharge Planning/Transition to the Community.

1.2.3.2. Maintenance of temperature logs is required for release medication storage areas according to above guidelines.

1.2.3.3. Storage of controlled substance release medications shall be in accordance with the double-lock requirement as outlined in the MDSTM and comply with existing CHP policy and procedure.

1.2.4. Clinic Stock Storage

1.2.4.1. Clinic stock storage areas shall be established in areas determined to be appropriate by the CHP Pharmacist, approved by the Unit Deputy Warden or Warden, the facility's CHP supervising Physician/Dentist, and the FHA.

1.2.4.2. Medications in the clinic stock storage area are the responsibility of the CHP Regional Pharmacy Director and FHA or designee and shall be handled in accordance with all applicable laws and the rules and regulations of the Arizona State Board of Pharmacy.

1.2.5. Controlled Substance Storage

1.2.5.1. All controlled substances including clinic stock and individual patient prescription medications shall be stored separately from all other medications.

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

1.2.5.3. Nurses responsible for controlled substance medication administration shall be assigned and held accountable for keys allowing access to narcotic storage areas.

1.3. Accountability

1.3.1. All clinic stock, 340B medication, controlled substances, and stat medications are to be inventoried daily except when the storage area is sealed by a safety seal.

1.3.1.1. An inventory of any sealed storage area shall be conducted each time the safety seal is broken or a minimum of once per week.

1.3.2. Clinic Stock

1.3.2.1. Availability

1.3.2.1.1. Medications available in clinic stock shall be determined by the CHP Pharmacist with input from the practitioner/providers, and limited to those authorized by the Pharmacy and Therapeutics (P&T) Committee, with a periodic automatic replenishment (PAR) level set and governed by patient population and anticipated usage.

1.3.2.2. Manifest

1.3.2.2.1. One CHP licensed staff shall sign the manifest at the time of medication delivery that acknowledges receipt of clinical stock.

1.3.2.2.2. Manifests acknowledging receipt of controlled substances shall be signed by two licensed CHP staff.

1.3.2.3. Perpetual Inventory

1.3.2.3.1. All medications kept as clinic stock shall be accompanied by a perpetual inventory for accountability.

1.3.2.3.1.1. Each prescription shall include a beginning total count and a record of each dose administered.

1.3.2.3.2. The maintenance of an accurate perpetual inventory in date sequence is the responsibility of CHP licensed staff.

1.3.2.3.3. The Perpetual Inventory Log shall be shall include the following information:

1.3.2.3.3.1. Name of medication,
1.3.2.3.3.2. Strength,
1.3.2.3.3.3. Sub-unit of issue (i.e., tablet, capsule, vial, etc.),
1.3.2.3.3.4. Date and time of removal or addition,
1.3.2.3.3.5. Prescription number,
1.3.2.3.3.6. Quantity added/removed,
1.3.2.3.3.7. Patient name and ADCRR number,
1.3.2.3.3.8. Ordering CHP provider,
1.3.2.3.3.9. Name and signature of CHP licensed staff, and
1.3.2.3.3.10. An accurate total ending balance

1.3.2.3.4. The addition of medication to clinic stock shall be accurately noted on the perpetual inventory, as well as wasted or returned medications.

1.3.3. Controlled Substances

1.3.3.1. The CHP licensed staff shall maintain accountability of use for Drug Enforcement Agency (DEA) controlled substances in accordance with all state and federal regulations.

1.3.3.2. CHP licensed staff shall document the receipt of controlled substance medication received from the pharmacy on the perpetual inventory receiving log where it will be accounted for until assigned to a specific medication room or cart.

1.3.3.3. Controlled substance medications received for a specific med room or cart shall be entered into the Controlled Substance Record Book specific to that med room or cart.

1.3.3.3.1. Each Controlled Substance Record Book shall be legible, maintained in chronological order, and include an individual page for each medication prescription.

1.3.3.3.1.1. CHP shall carry a medication balance from a full page onto a new page noted as a balance carried forward and include the new page number.

1.3.3.4. Removal of controlled substances from clinic stock or a patient-specific prescription for administration shall be documented and acknowledged by CHP licensed staff signature.

1.3.3.4.1. Documentation of removal shall include the patient's name, ADCRR inmate number, current date and time, and an accurate count of the remaining balance.

1.3.3.5. Two nurses shall count controlled substances on their assigned unit at the beginning and end of every shift or upon arrival and departure from their assigned duty post.

1.3.3.5.1. Health units that do not remain open for 24 hours shall have a controlled substance count prior to closing the unit for the evening.

1.3.3.5.2. When only one licensed CHP nurse is available on the unit, an unlicensed or a member of security personnel may witness, verify, and sign the Controlled substance count with the licensed CHP Nurse.

1.3.3.5.2.1. Nurse shall maintain actual physical control of medications whenever a count is conducted with an unlicensed staff.

1.3.4. Audits and Inspections

1.3.4.1. All 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, or other law enforcement or regulatory agency.

1.3.4.2. All medication storage area audit results are reported at the next on-site Continuous Quality Improvement (CQI) Meeting for discussion and follow-up.

1.3.4.3. Daily Audits

1.3.4.3.1. CHP shall complete daily audits of all controlled substances, all 340B medications, stat medications, and perpetual inventory medications.

1.3.4.3.2. Daily audits shall be conducted by using the Electronic Health Record (EHR) to substantiate appropriate administration, quantity administered, appropriate source of medication, discrepancies in medication receipt, duplicate/excessive active prescriptions, and irregular start/stop of prescription medications.

1.3.4.3.2.1. Refusals must be substantiated by an appropriately utilized refusal form documented in the EHR

1.3.4.4. Weekly Audits

1.3.4.4.1. CHP shall conduct weekly audits of at least 10% of each unit's population.

1.3.4.4.2. Weekly audits shall be conducted by using the EHR and the criteria in the above paragraph from a randomized source document obtained from the electronic health record.

1.3.4.4.3. The required weekly audit is in addition to the daily audits listed above.

1.3.4.5. Monthly Audits

1.3.4.5.1. DON or designee shall complete an inspection and audit of all medication storage areas at least monthly to ensure all medications are properly packaged, stored, and not expired, and that proper documentation and accountability is being maintained for each area.

1.3.4.5.2. The results of each monthly audit will be reported to the FHA, who will report findings to the CHP Pharmacy Director, Nursing Supervisor, and/or Lead Dentist for follow-up.

1.3.4.5.2.1. Results shall also be made available to the ADCRR Healthcare Services Division (HSD).

1.3.4.5.3. Two nursing staff shall conduct monthly inventory audits for all controlled substances in each unit.

1.3.4.5.3.1. This is in addition to the daily shift change count audits completed by the nursing staff.

1.3.4.5.4. The completed monthly inspections and inventory audits shall be kept on file by the complex DON.

1.3.4.6. Quarterly Audits

1.3.4.6.1. An Arizona licensed CHP Pharmacist shall conduct an audit of each health unit medication storage area quarterly.

1.3.4.6.1.1. CHP Pharmacist shall review and document the stock levels of medication inventories during this audit.

1.3.4.6.1.2. Results of this audit shall be maintained on-site by the FHA or designee with a copy sent to HSD.

1.3.4.6.1.3. Quarterly audit results shall be reported to the P&T Committee for discussion and follow-up by the identified discipline.

1.3.5. Discrepancies

1.3.5.1. Nursing staff shall report any discrepancy found during an audit or count to their DON or designee and document the finding on a Medication Incident Report, Form 1101-53P.

1.3.5.1.1. Attempts to account for the medication discrepancy shall be made and the outcome documented on the Medication Incident Report.

1.3.5.2. Any counting or recording error made in the paper perpetual inventory or controlled substance log shall be lined through using one horizontal line, annotated with "error", and initialed by the person who made the error. The accurate entry shall be recorded below the error entry.

1.3.5.2.1. Errors shall not be "blacked out" or written over.

1.3.5.2.2. All count discrepancies (including corrected count, or otherwise) must be accompanied by an Information Report (IR), Form 105-2 number located directly on the perpetual inventory where noted.

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

1.3.5.4. Any medication that remains unaccounted for will be reported to the FHA via a completed IR, Form 105-2 for further investigation and action.

1.3.5.4.1. Upon receipt of an IR regarding a medication discrepancy, the FHA shall conduct a thorough investigation and report the outcome to ADCRR security staff and HSD.

1.3.5.5. CHP shall report any discrepancy involving controlled substances, regardless of quantity or circumstances, to the Arizona State Board of Pharmacy through the use of a Report of Theft or Loss of Controlled Substances, Drug Enforcement Administration (DEA) Form 106.

2.0. Management of Pharmaceuticals

2.1. Procuring and Distribution

2.1.1. The CHP shall ensure a system is in place to acquire and distribute urgent, necessary medications ordered practitioners and ensure the continuation of chronic medications without interruption.

2.1.2. The CHP shall purchase, inventory, and ensure accountability of medications including prescribed and over-the-counter medications.

2.1.3. The FHA shall monitor the daily delivery of medications and notify the CHP Regional Pharmacy Director of any delays in shipments.

2.1.3.1. If a delayed delivery includes a prescribed medication that is needed urgently/emergently or to ensure continued care, a backup pharmacy shall be used.

2.1.3.2. Each delivery shall include a packing slip noting the medications in the shipment, patient information, medical unit location, and date of dispensing.

2.1.3.3. Any discrepancies in the contents of the delivery shall be reported to the CHP sending pharmacy within one hour of receipt.

2.1.4. A member of the CHP staff shall be responsible for the receipt of the medication being delivered, verification of accuracy based on a review of the packing slip, and distribution to the appropriate health units.

2.1.5. The FHA will designate an Inventory Coordinator (IC) and backup staff as necessary who will be trained in the following areas:

2.1.5.1. Preparation of medication for delivery to health staff.
2.1.5.2. Ordering and distribution of over-the-counter medication to providers and nursing staff.
2.1.5.3. The IC shall not be permitted in areas that store controlled substances unless they are licensed nurses or supervised by a licensed nurse

2.2. Dispensing
2.2.1. CHP Pharmacy shall ensure medications are dispensed in plastic containers or ADCRR approved packaging that meets all state and federal guidelines.
2.2.1.1. Medications not packaged in ADCRR approved packaging shall be considered DOT.
2.2.2. Keep-on-person (KOP) maximum quantities delivered to a patient may not exceed the maximum quantity of a 30-day supply or 120 dosage units per fill.
2.2.2.1. CHP Pharmacy shall not fill prescriptions beyond the stop date and must ensure the stop date is printed on each medication label at the time of dispensing.
2.2.2.2. 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.
2.2.2.3. All prescriptions received by the CHP Pharmacy shall be reviewed for completeness and accuracy, potential interactions, therapeutics relevance, and other pertinent or necessary information to ensure compliance with all State and Federal regulations.
2.2.2.4. 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.
2.2.2.5. Product information is required to be provided to patients each time a new prescription is provided for the following medications:
2.2.2.5.1. Birth Control Pills
2.2.2.5.2. Oral Estrogen Products
2.2.2.5.3. Vaginal Estrogen Products
2.2.2.5.4. Oral Progesterone Products

2.3. Disposal
2.3.1. CHP nursing staff shall ensure medication storage areas have a designated space for medications that are expired, contaminated, or partial drug stocks awaiting disposal to ensure the items are kept separate from current stock until they are returned to the pharmacy.
2.3.1.1. A log of medication disposals shall be kept on file.
2.3.1.2. Notation of any wasted non-controlled substance medication shall be noted by a nurse's signature.
2.3.2. 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.
2.3.2.1. Any necessary adjusting entries in the controlled substances logbook shall be made in accordance with State and Federal laws.
2.3.2.2. Any notations of wasted controlled substances must be accompanied by two nurse signatures.
2.3.2.3. The sheet listing the controlled substances to be destroyed shall be signed and dated and the record maintained with the annual inventory.
2.3.2.4. Any controlled substance received from an outside source at an intake facility shall be sent to the CHP Pharmacy for destruction or as per policy and mandated by state and federal law.
2.3.3. All prefilled syringes (except controlled substances) shall be disposed of in an approved sharps container without emptying their contents.
2.3.4. 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.
2.3.5. KOP items found in a patient's possession are considered contraband after the stop date printed on the medication label. These items are to be disposed of in accordance with Federal, State, and local regulations.

2.3.6. All medication prescribed to a patient that is sent for disposal, wasted, or returned shall be documented by the nursing staff in the patient's EHR.

2.4. Drug Recall

2.4.1. 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.

2.4.2. For all Class I recalls identify and contact all patients that have received or may have received the drug product.

2.4.3. Patients should be notified of Class II or Class III recalls if the medication may cause an adverse reaction or a change in their treatment is required as a result of the recall.

2.4.4. Patients shall be instructed to stop taking the medication and return it immediately to the pharmacy.

2.4.5. All practitioners/providers shall be notified and advised of the recall.

2.4.6. Comply with instructions in the Recall Notice.

2.4.7. Annotate on the Recall Notice the actions taken, date, and initials of the responsible person.

2.4.8. File Recall Notice and retain for two years on file in the CHP Pharmacy.

3.0. Administration and Oversight

3.1. Drug Enforcement Agency (DEA) Requirements

3.1.1. Each complex 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.

3.1.2. The FHA shall ensure at least one authorized provider on each complex has a DEA number specific to the physical address of the assigned work location and the DEA number is kept on file.

3.1.2.1. When a DEA registration is issued, an initial actual physical count of all controlled substances in inventory must be taken including:

3.1.2.1.1. The date and the time of the inventory

3.1.2.1.2. The drug name, strength, and form (e.g., tablet, capsule, etc.)

3.1.2.1.3. The number of units/volume; and the total quantity

3.1.2.1.4. The name, address, and DEA registration number of the registrant and the signature of the person or persons responsible for taking the inventory

3.1.2.2. A copy of this inventory must be maintained at the registered location for a minimum of two years.

3.1.3. Following the initial inventory, the registrant is required to take a biennial inventory (every two years), conducted in the same manner as the initial inventory, and include all clinic stock storage areas with controlled substances on hand.

3.1.3.1. The biennial inventory may be taken on any date that is within two years of the previous inventory date.

3.1.3.2. There is no requirement to submit a copy of the inventory to the DEA.

3.1.3.3. When taking the inventory of Schedule II controlled substances, an actual physical count must be made.

3.1.3.4. For the inventory of Schedules III, IV and V controlled substances, an estimated count may be made.

3.2. General Regulations and Management

3.2.1. CHP Pharmacy Director or designee shall ensure all pharmaceutical operations are conducted in accordance with applicable local, state, federal, and Board of Pharmacy laws, rules, regulations, and quality standards and medication services are provided according to ADCRR Department Orders, the Medical and Dental Services Technical Manual (MDSTM), and accepted standards for the practice of pharmacy.

3.2.2. CHP Pharmacy staff shall maintain records of compliance for licensure, Pharmacists' continuing education, inspections, and reporting.

3.2.3. CHP Pharmacy staff shall maintain a "signature file" of all staff authorized to prescribe medications and/or record on any required pharmacy form or record.

3.2.4. The CHP Pharmacy Director or designee shall ensure that all prescriptions are dispensed in a timely manner.

3.2.5. The CHP Pharmacy Director or designee shall ensure authorized medication storage areas are sufficient in size to meet State Board of Pharmacy regulations.

3.2.6. CHP FHA or designee shall ensure all perpetual inventories, invoices, manifests, as well as any other documentation of receipt, distribution, administration, destruction, return, and waste is maintained on the respective unit for a minimum of seven years.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Healthcare MDSTM P-D-01.01, Pharmaceutical Operations NCCHC Standard P-D-02, Medication Services NCCHC standard O-D-02, Medication Services
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-D-02.01 Medication Services

PURPOSE: To provide guidance in prescribing, ordering, administration, and delivery of all prescription medications and to define the 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. Ordering/Prescribing

- 1.1. Prescription medications are given only upon the order of a medical practitioner, dentist, psychiatric provider, or other legally authorized individual and prescribed only when clinically indicated, therapeutically correct, and as determined by their license privilege or restrictions.
- 1.2. Nursing staff may issue prescription medications under approved and active nursing Emergency Response Orders (EROs) and Nursing Assessment Protocols (NAPs). The CHP shall ensure properly labeled, prepackaged medications are available and limited to those authorized for use by nursing staff.
- 1.3. Psychotropic medication ordering requirements shall be followed as stated in Chapter 4, Section 1.0 of the MHTM.
- 1.4. All prescriptions shall be written and presented to the CHP Pharmacy with all necessary information provided, in a clear, concise format, and comply with all State and Federal regulations.
  - 1.4.1. Prescription information shall include the duration determined by the prescribing provider and must include:
    - 1.4.1.1. Start date or effective date for the medication order.
    - 1.4.1.2. A stop date for the medication order.
    - 1.4.1.3. Prescriptions not submitted in accordance with these requirements shall be returned to the provider to correct or complete.
- 1.5. Prescribing practitioners shall ensure all patients receive laboratory monitoring when placed on high-risk medications, as clinically appropriate.
- 1.6. The practitioner writing the prescription or ordering the medication shall indicate the type of medication administration or delivery required, direct observed therapy (DOT) or keep-on-person (KOP).
- 1.7. Any request to change medication from KOP to DOT or DOT to KOP must be made via a new order from the prescribing provider to the CHP Pharmacy.
  - 1.7.1. Drug Utilization Review (DUR)/ Drug Utilization Evaluation (DUE) will be reviewed and the results reported to the P&T Committee for evaluation and action if necessary.
    - 1.7.1.1. A file of DUR/DUEs will be maintained by CHP Pharmacy.
    - 1.7.1.2. Facilities may conduct additional DUR/DUEs to meet their needs.
- 1.8. DOT Medication Orders
  - 1.8.1. Medications on the approved DOT medication list shall be administered as DOT only.

1.8.1.1. The list can be found in the Medical and Dental Services Technical Manual (MDSTM) Attachments P-D-02.01A, Direct Observed Therapy (DOT) Medication Listing, maintained by the ADCRR with input from the P&T committee.
1.8.1.2. DOT medications shall be prescribed at their least frequent dosing interval, when clinically appropriate (e.g., BID instead of TID or QID).
1.8.1.3. All other medications are DOT at the discretion of the prescriber, but the default should be KOP whenever possible.
1.8.2. All controlled substances as well as those medications determined by the ADCRR, CHP policy, or the P&T Committee that may necessitate DOT shall be prescribed as such.
1.8.3. Medical and psychiatric providers can restrict the administration of any medication to DOT as necessary for specific individual patients.
1.8.3.1. All information supporting the need to have a medication administered by DOT shall be documented in the patient's health record.
1.8.4. All patients housed in Inpatient Component (IPC) and Special Needs Unit (SNU) beds shall have all medications ordered and administered as DOT by nursing staff.
1.8.4.1. KOP medication is not authorized in the IPC or SNU setting.
1.8.5. Patients housed under mental health watch or suicide watch shall have all their medication ordered and administered as DOT, unless approved by the facility Medical Director or higher.

2.0. Refills and Renewals
2.1. Prescription refill requests made by the patient for non-chronic medications, including 'prn', shall be delivered to the patient before the medication runs out, based on the date of the previous fill, provided the patient submitted the request within the required timeframe.
2.1.1. The prescription refill request shall be reviewed for compliance, expiration date, and refill status.
2.1.2. CHP staff with concerns regarding a patient's refill request shall contact the prescribing provider for further advisement.
2.1.3. Inability to fulfill a patient's refill request must be communicated with the patient and documented in the patient's health record.
2.2. Refills for chronic medications (not prn) shall be on auto refill and not require a Health Needs Requests, Form 1101-10ES.
2.3. Medications may be administered from stock on a dose-by-dose basis to bridge the gap until the patient's KOP supply is delivered if necessary.
2.3.1. If a refill medication is needed immediately and not available in clinic stock, continuity of care must be maintained by utilizing an off-site pharmacy to ensure continuity of care.
2.4. For expiring medication orders, the CHP prescriber shall be notified of the impending expiration date of an order so that the prescriber can determine whether the drug is to be continued or altered.
2.4.1. CHP staff shall review a medication expiration reports weekly to provide continuity of care and prevent the expiration of a prescription.
2.4.2. Once the prescription has expired, it is necessary to provide emergency coverage through clinic stock or off-site pharmacy to ensure continuity of care as clinically indicated.

3.0. Prescription Limits
3.1. Controlled substance prescription authorization shall not exceed State and Federal limitations upon each class and may not exceed 30 days to facilitate inventory tracking and control.
3.2. Prescriptions written for chronic conditions may be prescribed for up to a one-year time period if clinically appropriate.
3.2.1. Prescriptions for prenatal vitamins and iron can be valid for the duration of pregnancy plus two months.
3.3. Prescriptions for unit dose medications may be filled for up to a 30-day supply.

4.0. Formulary/Non-Formulary
4.1. Formulary Medications

4.1.1. All newly prescribed formulary medications are delivered in a timely manner not to exceed three days.
4.1.1.1. Newly prescribed antibiotics and/or pain medications shall be provided to the patient within the timeframe ordered or if no timeframe is specified within 12 hours of order.
4.1.1.2. For any medication not available in a timely manner CHP shall utilize a backup pharmacy to ensure timely treatment when clinically indicated.

4.2. Non-Formulary Medication
4.2.1. Ordering providers may prescribe a medication not on the P&T Committee approved formulary list as clinically indicated.
4.2.1.1. Procedures for prescribing non-formulary medications shall be outlined in detail within CHP policy and procedure.
4.2.2. CHP Pharmacy shall respond to non-formulary requests made by the ordering provider within two business days of the order and include recommended substitutions if applicable.
4.2.2.1. Upon approval, the non-formulary medication must be delivered in a clinically appropriate timely manner.
4.2.2.2. If a non-formulary medication is an urgent request the process must be expedited and obtained by off-site backup pharmacy until the non-formulary is approved or denied.
4.2.3. Practitioner will provide formulary medication for continuity of care if needed, while the non-formulary drug request (NFDR) is being processed.
4.2.3.1. Continuity of care must be maintained at all times.
4.2.4. Non-formulary medications recommended by outside consultants may be substituted with a therapeutically equivalent medication available from the Formulary.
4.2.5. Patients admitted to ADCRR on a psychotropic which is not on ADCRR's formulary, the medication shall be continued if, based on the patient's history, there is significant risk of worsening of the condition if a different medication is prescribed. If no such risk exists, the medication shall be continued long enough to allow a safe transition to a different medication or medications.

5.0. Administration/Delivery
5.1. Medications shall be administered as ordered daily at a consistent, reasonable 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.
5.1.1. For medications ordered at an hourly frequency of every eight hours or more frequently, or for immediate-acting insulin, medication must be administered within one hour of the specific time set in policy, procedure, or orders for administration.

5.2. Administering DOT medications
5.2.1. All medications ordered as DOT shall be administered directly to the patients by licensed CHP nursing staff.
5.2.2. Patients on units with open movement shall receive DOT medications administered at regularly scheduled times by nurses in the health unit or at an alternate, clinically appropriate location in accordance with site-specific policy.

5.2.3. Patients housed in Lock-down Units shall have all medications, KOP and DOT delivered and administered at regularly scheduled times by the CHP health staff.
5.2.3.1. All DOT medications shall be administered directly to the patients by nursing staff.
5.2.4. The Medication Administration Record (MAR) must accompany the nursing staff member during the administration of DOT medication to the patient.
5.2.4.1. Prior to administration, the nursing staff member must verify the medication with the MAR to ensure the appropriate person, medication, dosage, time, and route.

5.3. Insulin Administration (Please refer to MDSTM P-E-10.1, Discharge Planning/Transition to the Community for information about patient education on insulin administration upon release to the community.):
5.3.1. Insulin syringes will be signed out from the sharps inventory.

5.3.2. Insulin will be drawn up and administered by the nursing staff.
5.3.2.1. Regular insulin shall be administered by nursing staff within 30 minutes of the patient's meal.
5.3.2.2. Fast-acting insulin shall be administered by nursing staff within 15 minutes of the patient's meal.
5.3.3. The syringe will be discarded by the CHP staff member who administered the injection in an approved sharps container as soon as possible.
5.3.4. For patients with personal insulin pen, nursing staff shall dial the appropriate dose, affix the needle to the pen, and allow the patient to self-inject.
5.3.4.1. Following the injection, the patient will return the insulin pen to the nurse who shall dispose of the needle in an appropriate sharps container.
5.3.5. DOT medications may be administered during insulin administration line.
5.3.6. KOP medications may be issued to patients during insulin administration in accordance with site-specific policy.

5.4. Delivery of KOP Medication
5.4.1. KOP medications will be prepared for delivery to the patient by the CHP Pharmacy, Inventory Coordinator (IC), or designee, under the supervision of the Facility Health Administrator (FHA).
5.4.2. KOP medications shall be delivered to patients by CHP health staff to ensure continuity of treatment.
5.4.3. For patients who are suspected of hoarding or diverting KOP medications the CHP staff member may require one-for-one exchange for KOP medication delivery.
5.4.4. CHP staff shall document in the MAR the delivery of a patient's KOP medication.
5.4.5. The CHP may implement signature forms to confirm KOP delivery of medications to patients (e.g., hepatitis C medication).
5.4.6. Delegation agreements shall be kept on file and updated by the FHA for any health staff who deliver KOP medication to patients if it's outside of their customary scope of practice.
5.4.6.1. Routine reporting through random sampling shall take place monthly to ensure that patients are receiving their medications appropriately.
5.4.7. Primary care teams consisting of providers and nursing staff shall review KOP medication cards at routine encounters (e.g., chronic care) to ensure patient adherence with their medications.
5.4.8. CHP nursing staff (RN) may temporarily restrict a patient's KOP medication to DOT if clinically indicated for a period not to exceed ten days, and the prescribing provider or their designee will be notified immediately to change the order.
5.4.8.1. Nursing staff shall document all information supporting the need for temporary restriction in the patient's health record.
5.4.8.2. The nurse shall notify the treating provider and schedule the patient to be seen within ten days.
5.4.8.3. If the patient has not seen the practitioner by the tenth day, the restriction will end, unless extended by authorization of the site Medical Director or designee, in consultation with the Director of Nursing (DON).
5.4.8.3.1. The Site Medical Director or designee shall document any decision to continue the medication in the patient's health record.

6.0. Documenting Medication Services
6.1. All documentation of medication administration or non-administration shall be made on the MAR in the patient's health record and include the identity of the medication administrator.
6.1.1. When documenting a non-administration, recording a "no-show" or "medication not available" are not valid reasons for no administration.

6.1.1.1. If a patient does not show up for their medication dosing, then the nurse shall attempt to educate the patient on medication adherence, and utilize the refusal process if necessary. If a medication has not yet arrived, then the nurse shall identify the reason that the medication has not arrived yet arrived and confirm an estimated date of arrival.

6.1.2. The documentation will also include the medication name, medication strength, the quantity of the medication (unit count), and the authorized signature of the individual(s) performing the above functions.

6.2. Nursing staff administering DOT medications shall document the actual time of medication administration or non-administration of unit dose (DOT) medications on the patient's MAR.

6.2.1. Pre-charting of medication administration on the MAR is not authorized.

6.2.2. Variances from the complete dose being administered shall be documented on the MAR (e.g., "refused", "1 tab").

6.2.3. Nursing staff shall document the use of clinic stock medications for each dose given accurately and in accordance with the prescription on the patient's MAR.

6.2.3.1. 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.

6.3. CHP nursing staff shall document the delivery of KOP medication to the patient on the patient's MAR.

6.3.1. Undeliverable medications shall be documented in the patient's health record and on the MAR and returned to the pharmacy in accordance with procedures outlined in the MDSTM P-D-01.01, Pharmaceutical Operations.

6.4. Refusal of Medications:

6.4.1. The CHP staff attempting to administer or deliver medication shall document a patient's refusal immediately on the patient's MAR.

6.4.2. Nursing staff, while face-to-face with the patient, shall have the patient sign a Refusal to Submit to Treatment, Form 1101-4, or approved electronic equivalent.

6.4.3. CHP nursing staff shall report any patient who refuses doses of a prescribed DOT medication based on the parameters below.

6.4.3.1. "Critical medications" include, Warfarin, Clozaril, TB disease medications, Hepatitis C, and HIV medications.

6.4.3.1.1. Provider notification of patient refusal of all "critical medications" shall be made within 24 hours of refusal of any missed doses of such medications.

6.4.3.2. "Essential medications" include, anti-psychotics, anti-epileptics, and Insulin products.

6.4.3.2.1. If a patient refuses more than 3 consecutive doses or more than 50% of their doses of "essential medications" within 7 days (i.e., 4 doses within one week), the provider shall be notified within 7 days.

6.4.3.3. Medications prescribed to treat other chronic disease or infection such as hypertension, diabetes (other than insulin), latent TB infection, other psychotropics, and autoimmune diseases will be reviewed by providers for medication compliance at each chronic care or psychiatric visit or upon notification of the treating provider by nursing staff or other members of the healthcare team.

6.4.3.4. An RN or practitioner is responsible for:

6.4.3.4.1. Determining the reason for the refusal,

6.4.3.4.2. Finding a clinically appropriate alternative treatment (if indicated) (practitioner only),

6.4.3.4.3. Assuring that the patient is making an informed decision to refuse, or

6.4.3.4.4. Assuring any action ordered by the prescriber is executed.

6.4.4. After a third missed dose of prescribed psychotropic medication the nursing staff shall notify mental health personnel immediately upon returning from medication administration rounds.

6.4.4.1. If no mental health personnel are present on site, the urgent notification list for mental health personnel shall be utilized.

6.4.5. If the patient refuses any delivery of KOP medication, a Refusal to Submit to Treatment, Form 1101-4, or approved electronic equivalent must be completed and a practitioner must be notified.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-D-03, Clinical Space, Equipment, and Supplies NCCHC Standard O-D-03, Clinic Space, Equipment, and Supplies
	Effective Date: 10/01/2024 Supersedes only as it relates to State Prisons: N/A

P-D-03.01 Clinical Space

PURPOSE: A guideline to ensure sufficient and suitable space is available for the delivery of health care services.

RESPONSIBILITY: It is the responsibility of ADCRR in collaboration with the Contract Healthcare Provider (CHP) to ensure healthcare is delivered in a confidential, appropriate, and suitable space.

PROCEDURES:

1.0. Clinic Space
- 1.1. Examination and treatment rooms must be large enough to accommodate the necessary equipment, supplies, and fixtures and to permit privacy during clinical encounters.
- 1.2. Office space and ancillary areas must be sufficient to support the provision of health care services in a confidential manner.
- 1.3. Storage space for administrative files, health records, and other clerical areas must be sufficient to provide unhindered health care.
- 1.4. Waiting areas will be sufficiently designed and controlled to provide adequate seating and access to drinking water and toilets.

2.0. Periodic Inspections
- 2.1. The CHP Facility Health Administrator (FHA) or designee shall conduct periodic inspections, at a minimum of one time per week, or more regularly, and regular tours through each health unit in their assigned complex to ensure a clean and sanitary working environment.
  - 2.1.1. Areas inspected should include nurse's stations, storage areas, exam rooms, medication storage areas, medication rooms, treatment rooms, radiology and laboratory areas, health records offices, and other administrative clinic office areas.
    - 2.1.1.1. Patient living areas in the Inpatient Component (IPC) or Special Needs Unit (SNU) should be inspected at least two times per week.
  - 2.1.2. FHA shall complete and submit a report of inspection findings, at a minimum of one time per week, or more regularly, to the CHP Director of Operations or designee.
  - 2.1.3. Documentation of inspection results shall be maintained for one year.

P-D-03.02 Equipment and Supplies

PURPOSE: To ensure adequate supplies and equipment are available for the delivery of health care and 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 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. Equipment

1.1. The CHP Facility Health Administrator (FHA) or designee is responsible for ensuring that the facility has sufficient equipment, durable supplies, and consumables to provide health care to the patient population.

1.2. Basic equipment for medical services includes but is not limited to:

1.2.1. Computers, monitors, and internet access for documentation
1.2.2. Hand washing facilities or other approved hand sanitation methods
1.2.3. Examination tables and/or surfaces
1.2.4. Adequate direct illumination lighting for clinical examinations
1.2.5. Access to weight scales, thermometers, blood pressure measurement equipment, and stethoscopes
1.2.6. Ophthalmoscopes
1.2.7. Otoscopes
1.2.8. Oxygen
1.2.9. Wheeled transportation equipment for patients (i.e., wheelchair, stretcher)
1.2.10. Biohazard-identified (i.e., red) material trash containers and puncture-resistant sharps containers
1.2.11. Personal protective equipment (e.g., gloves, eye protection, gowns, masks)
1.2.12. Equipment and supplies for pelvic examinations (female units only)
1.2.13. Automated External Defibrillator (AED)

1.3. Basic equipment for dental services includes but is not limited to:

1.3.1. Hand washing facilities or other approved hand sanitation methods
1.3.2. Dental examination chairs and a dentist's stool
1.3.3. Adequate direct illumination lighting for clinical examinations
1.3.4. Sterilization equipment
1.3.5. Blood pressure measurement equipment

1.3.6. Dental electronic, hydraulic, or hand-powered equipment
1.3.7. Biohazard identified (i.e., red) material trash containers
1.3.8. Sharps (biohazard, puncture resistant) containers
1.3.9. Dental care delivery equipment including:
1.3.9.1. Intraoral X-ray equipment
1.3.9.2. Personal protective equipment
1.3.9.3. Oxygen

2.0. Equipment Inventory and Accountability
2.1. The 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.
2.1.1. The FHA or designee may appoint a facility property custodian to assist in accounting for inventorial and non-inventorial equipment.
2.1.2. The CHP shall ensure that the annual year-end equipment inventory is completed, signed, and returned in the specified period of time.
2.2. The FHA or designee shall ensure all equipment is maintained and used according to the manufacturer's recommendations.
2.2.1. The FHA or designee shall ensure annual inspection of all equipment used in the delivery of health care is completed with a copy of the maintenance report available upon request.
2.3. The ADCRR Healthcare Services Division (HSD) Property Compliance Manager shall ensure that all inventorial equipment is assigned an ADCRR equipment tag number, the assigned tag is affixed to the appropriate piece of equipment, and inventoried equipment is maintained in accordance with DO 304 Inventory and Fixed Assets Management.
2.3.1. Movement of any ADCRR tagged equipment from one assigned location to another requires a Fixed Asset Transfer, Form 304-3, to be submitted to the ADCRR Healthcare Coordinator for review and approval by the ADCRR Property Compliance Manager.
2.4. Reporting State Property Losses: The CHP shall contact the ADCRR Property Compliance Manager for forms, claim numbers, and any further reporting requirement instructions.

3.0. Supplies, Sharps, and Tools Designation and Storage
3.1. The FHA or designee will identify and designate instruments for use in providing patient care 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. Storage: Sharps and tools, used in the provision of medical and/or dental health care shall be maintained in a secure area consistent with professional health services practice and in accordance with the appropriate Department Order, Healthcare Services Division Technical Manuals, or Facility Post Order.
3.4. All locking mechanisms used by ADCRR CHP to control access to CHP tools and sharps, must be approved and/or installed by ADCRR locksmiths.
3.5. 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.
3.6. Bulk supplies of needles and disposable syringes should be stored in the area designated by the FHA.
3.6.1. 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.
3.7. 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.
3.8. Dental tools/instruments are to be engraved for identification in accordance with Department Order #712, Tool Control.

4.0. Supplies, Sharps, and Tools Inventory and Accountability
4.1. Tools

4.1.1. The Master Tool Inventory, Form 712-5, shall be maintained by the 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.

4.1.1.1. The master tool list only needs to be updated when items are purchased or discarded. All supplies that have an expiration date should be checked monthly. If the item is within 30 days of expiration, it should be flagged and disposed of when it expires such as anesthetic carpules that are to expire shall be disposed of.

4.1.2. No loose instruments are to be stored in any health facility location; rather, extra instruments should be kept in areas off limits to inmates.

4.1.3. Tools used within the unit are not to be logged out but are to be returned to the secure location upon procedure completion.

4.1.4. During cleanup and sterilization, instruments should be verified by a visual check at the completion of each patient visit.

4.1.5. 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.

4.1.5.1. Dental instruments should be verified by a visual check at the completion of each patient visit. The packet or cassette will be wrapped and the dental assistant checking and packing the instruments with date and initial the package. By placing their initials on the pack, they are attesting to the fact that all instruments, in the pack, are accounted for and contained in the pack.

4.1.6. During repair, medical/dental tools shall be removed from the inventory as directed in Department Order #712, Tool Control.

4.1.7. Disposal and destruction of instruments shall be accomplished and documented in accordance with Department Order #712, Tool Control.

4.2. Sharps

4.2.1. Medical supplies and sharps (such as needles and syringes) will be procured, received, and stored to ensure a sufficient supply for normal clinic operations.

4.2.1.1. Supplies on hand in a clinic will be limited to a one-week supply.

4.2.2. CHP health unit staff requests medical supplies such as needles and syringes on an as needed basis to maintain par level, per local policy or general post order.

4.2.2.1. Original requisition forms or an approved electronic equivalent shall be maintained for three years by the FHA.

4.2.3. All needles and syringes issued to a health unit will be logged out of bulk supply inventory, signed for by CHP nursing staff in the receiving health unit, and be accounted for on a perpetual inventory log with a current balance.

4.2.4. 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.

4.3. Dental Material Expiration Dates

4.3.1. Any dental materials and dental pharmaceuticals that have a manufacturer's expiration date and are placed or inserted permanently into a patient will be identified and noted in the expiration log.

4.3.1.1. A written entry denoting the name of the item and its expiration date will be made in the log. This date will correspond to the date that is 90 days prior to the manufacturer's expiration date.

4.3.2. On the first Monday of each month, the dental assistant will review the expiration log and note all items that are due to expire within the 90-day timeframe.

4.3.2.1. Upon receipt of the new stock, it will be checked for its expiration date and an entry made per section. If the item expires within six months of receipt, it will be returned to the vendor as unacceptable. A vendor deficiency report will be completed.

4.3.3. The expiring item will be properly disposed of and the replacement item will be added to the current inventory.

4.4. Daily Counts:

4.4.1. A count of all medical sharps and tools shall be conducted at the beginning and end of each shift that is staffed by CHP personnel.

4.4.2. Inventory for dental instruments will be performed before the first patient and again after the last patient of the day.

4.4.3. A Daily Tools Inventory Count sheet(s) including disposable sharps are to be maintained within the dental clinic, lab, health unit, etc., where instruments are kept.

4.4.3.1. The count sheet must accurately reflect the number and type of instruments kept in the respective drawer, cupboard, etc.

4.4.4. A count of the inventory will be maintained as a rolling total including all additions, removals, distributions, deletions, and disposals of the identified item.

4.4.5. If during the count only one CHP staff member is available and a correctional officer (CO) is not able to attend, the CHP staff member will complete the count and provide an Information Report (IR) to the FHA documenting the attempt to acquire a CO and the outcome of the count. The FHA will share the IR with the appropriate Deputy Warden and develop systems to prevent future single-count events.

4.4.6. The staff conducting the count and one witness will sign the Health Unit End of Shift Summary Count. Each shift should be annotated on each line.

4.5. Month End Counts

4.5.1. The CHP staff shall conduct an inventory to ensure any material or supply on hand in the health unit or used in the provision of health care is within the manufacturer's expiration date.

4.5.1.1. Any item found to be expired will be removed and replaced.

4.5.2. At the end of each month, the CHP unit staff member responsible for each area will forward a copy of the individual Daily Tools Inventory Count to the supervisor for review and development of the Master Tool Inventory.

4.5.3. The supervisor or designee of each discipline shall ensure that a Master Tool Inventory report for the prior month is completed and submitted to the FHA no later than the third business day of the month for the immediately preceding month or more often as directed by the FHA.

4.5.4. The Inventory Coordinator (IC) shall perform an inventory of all bulk sharps and tools maintained in the clerk's area and submit this report to the FHA no later than the third business day of the month for the immediately preceding month or more often as directed by the FHA.

4.5.5. The 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 according to local procedure.

4.5.5.1. The FHA maintains the Master Tool Inventory on a month-by-month basis.

4.5.5.1.1. Individual health units are not required to retain prior month inventories unless directed by the respective FHA.

P-D-03.03 Emergency Response Medical Equipment

PURPOSE: To ensure that required emergency equipment is available at all times.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure emergency response equipment contains all items required by policy with equipment in working order and unexpired medications at all times.

PROCEDURES:

1.0. Automated External Defibrillators (AEDs) shall be maintained and readily accessible to all healthcare and dental staff. Daily checks of the equipment shall be done with documentation in the daily log.

2.0. Portable oxygen and masks shall be readily available and accompany healthcare staff responding to medical emergencies.

3.0. "Emergency Response Bag": The purpose of the emergency response bag is to provide immediate first aid to a patient in the field, satellite clinic, or dental treatment area until they can be transferred to the triage room or the Emergency Medical Services (EMS) personnel arrive.

3.1. Medical and Dental Services Technical Manual (MDSTM) Attachments P-D-03.01A, Emergency Response 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 ADCRR Healthcare Services Division (HSD).

3.1.1. Following the use of supplies during an emergency response a complete count and inventory of all necessary content must be completed and items that were used shall be replaced.

3.2. The emergency response bag/box shall be inventoried a minimum of once per month and shall reflect the accurate amount(s) of each item/medication on the MDSTM Attachments P-D-03.03A, Emergency Response Bag Minimum Requirements listing and also reflect medication expiration dates.

4.0. A stock of supplies determined by the complex Director of Nursing (DON) and Site Medical Director must be created and maintained in a readily accessible area of the unsecured perimeter to ensure availability if a yard or specific unit is inaccessible.

4.1. The approved listing of stock supplies must take into account the needs of either multiple individual events or single-site mass casualties.

5.0. Medical Equipment: During an emergency, all efforts shall be taken by the CHP nurse to retain equipment that is the property of ADCRR or the CHP. This includes full and halfback boards, wheelchairs, stretchers, and any other equipment that may be utilized by emergency transport services.

5.1. In the event such equipment is taken, the nurse will complete an Incident Report (IR), Form 105-2, noting the agency that took the equipment and submit it to the FHA designee.

P-D-04.01 On-Site Diagnostic Laboratory Procedures

PURPOSE: To provide necessary laboratory procedures to aid in the assessment, diagnosis, and/or monitoring of a patient's health.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) shall provide on-site and off-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 (e.g., a Clinical Laboratory Improvement Activities (CLIA) waiver).

2.0. A procedure manual shall be in place for all laboratory services provided on-site which includes protocols for the calibration of testing devices to assure accuracy.

3.0. Laboratory specimens shall be collected upon a written or verbal provider order.

4.0. The timeframe for completion of an on-site diagnostic test shall be based on the timeframe designated by the ordering provider or on the specific date designated in the provider's order.
- 4.1. If a provider does not put a date on the lab request, it will default to the date ordered.
- 4.2. Radiology ordered that are needed on a different timeline shall be designated in the comments section of the order.

5.0. Labs
- 5.1. Routine: as scheduled on a specific date
- 5.2. Stat: immediately
- 5.3. Necessary laboratory supplies and courier services shall be identified and provided by the contracted laboratory vendor.

6.0. Venipuncture and specimen collection, performed by authorized CHP health staff, shall be done in accordance with approved medical techniques and standards.
- 6.1. Refer to contract laboratory requirements for specimens that need special patient preparation, handling, or precautions.

7.0. Specimens shall be labeled, processed, and stored according to the contracted laboratory requirements.
- 7.1. Specimen preparation or storage and handling may require the use of the following equipment:
  - 7.1.1. A refrigerator, used for laboratory specimens only, located in the lab area of each lab draw site and one at the main collection/vendor pick-up point.
  - 7.1.2. A centrifuge for each lab draw site.

7.1.2.1. Centrifuge calibration maintained by the contract vendor laboratory.
7.1.2.2. The centrifuge routine cleaning will be maintained by the laboratory technician on-site.

8.0. Safety in the Laboratory:
8.1. Universal precautions shall be followed.
8.2. Personal protective equipment (PPE) including but not limited to gloves, protective eyewear, and face shield must be available and used as appropriate.
8.3. 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.

9.0. On-Site Laboratory Testing (CLIA waived point-of-care tests)
9.1. The following tests may be performed on-site by fully trained CHP health staff. The following list is not all inclusive and may include other types of testing (e.g., rapid flu testing, rapid RSV testing, etc.)
9.1.1. Blood glucose level by glucometer
9.1.2. Urinalysis by manual dipstick
9.1.3. Hemoccult testing of stool samples
9.1.4. Urine Pregnancy Test (hCG) for individuals who may become pregnant
9.1.5. Urine drug screens when indicated medically
9.1.6. International Normalized Ratio (INR) measurement for warfarin therapy monitoring
9.1.7. COVID antigen tests
9.2. CHP staff shall be trained on the utilization of on-site Point-of-Care Testing, with competencies verified at appropriate intervals.

10.0. Off-Site Laboratory Testing
10.1. All general laboratory services are provided by the CHP or their chosen subcontractor utilizing the full service of a reference laboratory.
10.2. Paternity testing can only be ordered by health staff when requested by the patient.

11.0. Notification of critical laboratory values as outlined by CHP's contracted laboratory is to be reported to the site Medical Director or designee immediately for review and acted upon as clinically indicated.

12.0. All laboratory test results are to be reviewed by a CHP medical practitioner, qualified mental health practitioner, or dentist within four business days of receipt.
12.1. Routine test results are received and are attached to the patient's health record for provider review, signature, and disposition.
12.2. A CHP practitioner shall inform the patient of the results of the diagnostic study and any request for additional consultation in a timely manner, no greater than seven calendar days from the date of the request.

13.0. Contaminated needles/materials shall be disposed of in appropriate bio-hazardous collection devices.

14.0. The lab work area shall be disinfected regularly and when contamination occurs with the use of an appropriate cleaning agent, based on industry standards.

P-D-04.02 On-Site Diagnostic Radiologic Imaging Procedures

PURPOSE: To provide guidance on the availability of on-site diagnostic studies to aid in the assessment, diagnosis, and/or monitoring of a patient's health.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) shall ensure only appropriately trained, licensed, and credentialed CHP staff order and conduct on-site diagnostic procedures.

PROCEDURES:

1.0. On-site diagnostic testing may include but is not limited to electrocardiogram (EKG), on-site vision or hearing screening, or radiology such as ultrasound or x-ray.

2.0. Radiology

- 2.1. 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 is in place which includes protocols for the calibration of testing devices to ensure accuracy.
  - 2.1.1. CHP is responsible for medical vendor clearance to ensure no disruption in services.
- 2.2. An x-ray unit registration certification, issued by the Arizona Radiation Regulatory Agency (ARRA), must be posted for each machine on the complex.
- 2.3. Current certification from the Arizona Medical Radiologic Technology Board of Examiners for all CHP Radiologic Technologists shall be posted in the work area.
- 2.4. X-ray Procedures
  - 2.4.1. Radiographic procedures shall be ordered by a medical or dental practitioner when clinically indicated.
    - 2.4.1.1. 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.
    - 2.4.1.2. Other examinations that may be authorized and performed at designated facilities may include the following studies:
      - 2.4.1.2.1. Esophagus: barium swallow
      - 2.4.1.2.2. Stomach: upper gastrointestinal series
      - 2.4.1.2.3. Small bowel follow-through
      - 2.4.1.2.4. Colon: barium enema
  - 2.4.2. The timeframe for completion of an on-site diagnostic procedure shall be based on the timeframe designated by the ordering provider (e.g., routine, priority) or on the specific date designated in the provider's order.
    - 2.4.2.1. If a provider does not put a date on the lab request, it will default to the date ordered.
    - 2.4.2.2. Radiology ordered that are needed on a different timeline shall be designated in the comments section of the order.

2.5. Radiology:
- 2.5.1. Routine: within 60 days
- 2.5.2. Priority: within 30 days
- 2.5.3. Stat: immediately (if available)
- 2.5.4. The CHP shall have a protocol for completing, reporting, reviewing, and filing the results of onsite radiologic procedures.
- 2.5.5. Following a review by the provider, all diagnostic studies need to be signed and dated, whether through an electronic signature or a handwritten signature with a stamp or printed name and title.
- 2.5.6. During the x-ray procedure, the operator or radiologic technician shall be protected from radiation by standing in the protective designated area (at least six feet away) or wearing appropriate lead protection.
- 2.5.7. Reasonable precautions shall be taken to protect the patient from radiation exposure.
  - 2.5.7.1. Pregnancy status must be determined prior to performing any radiographic procedure.
    - 2.5.7.1.1. A pregnant patient may not receive routine x-rays unless the healthcare practitioner determines the existence of medical necessity.
  - 2.5.7.2. Lead shielding including but not limited to lead aprons, gonad shields (used on all patients, male and female of child-bearing age), lead gloves, and thyroid shields are available and shall be used when appropriate.

2.6. Radiograph Interpreting and Reporting
- 2.6.1. The radiologist interpreting and issuing reports must have a current license issued by the State of Arizona, the Board of Medical Examiners, or the Arizona Board of Osteopathic Examiners in Medicine and Surgery.
- 2.6.2. Abnormal diagnostic study results are to be reported to the site Medical Director or designee immediately for review and action as clinically indicated.
- 2.6.3. All diagnostic test results are to be reviewed by a practitioner within four business days of receipt.
- 2.6.4. A practitioner shall communicate the results of the diagnostic study and any request made for additional consultation related to those results to the patient upon request, in a timely manner, but no greater than seven calendar days from the date of the request.

2.7. Safety & Maintenance
- 2.7.1. Safety data sheet (SDS) specific to the processing fluids shall be available in the radiology department (if applicable).
- 2.7.2. The door to the x-ray room must be closed during radiographic procedures to avoid inadvertent entry and radiation exposure.
- 2.7.3. A sign stating "Caution Radiation Area" with the three-blade radiation symbol shall be posted at all entrances to the radiology room.

2.8. Equipment Maintenance
- 2.8.1. X-ray units shall be calibrated and maintained regularly by the CHP or their approved subcontractor.
  - 2.8.1.1. X-ray unit calibration is verified by the ARRA and posted within the X-ray department.
- 2.8.2. Processor maintenance shall be performed regularly by CHP or an approved subcontractor. This shall include:
  - 2.8.2.1. Equipment cleaning and inspection
  - 2.8.2.2. Changing of processing fluids, if applicable
  - 2.8.2.3. Disposal of processing fluids, if applicable
  - 2.8.2.4. Repairs as needed

2.9. Radiograph Storage & Transfers
- 2.9.1. Active patients with historic radiograph files will have films stored at the complex and/or unit where the patient resides.

2.9.2. For additional information regarding storage and transfer, please refer to the Medical and Dental Services Technical Manual (MDSTM) P-A-08.04, Health Record Security, Accountability, and Transfer.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #912, Food Service Food Service System Technical Manual Diet Reference Manual NCCHC Standard P-D-05 Medical Diets
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-D-05.01 Medical Diets

PURPOSE: A daily diet, that incorporates the United States Department of Agriculture's (USDA) Recommendations and Dietary Guidelines, is available to all incarcerated individuals. Patients 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 medical diets are provided to patients when clinically indicated. The contracted dietitian is responsible for providing adequate foods to meet current industry standards of provision of nutrition.

PROCEDURES:

1.0. An order for a medically prescribed diet must be communicated in writing to dietary staff, including the type of diet, the duration for which it needs to be provided, special instructions if any, and be consistent with the diets listed in the diet manual.
   1.1. Medical diets shall be supported by documentation made in the health record by the prescribing CHP and must include a diagnosis and treatment plan.

2.0. When patients refuse a prescribed diet for three consecutive days, follow-up nutritional/medical counseling shall be provided by a qualified healthcare professional.
   2.1. Patients who fail to adhere to medical diets are not disciplined but counseled by CHP staff.

3.0. A prescriber's decision to stop a patient's medical diet 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 a prescribed medical diet, 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 diet, the medical diet process, and the process for ensuring that patients who are on a prescribed diet and transfer continue to receive the diet at their new location.

4.0. Upon receipt of the 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.
   5.1. Medical diets conform as closely as possible to the centralized menu.
   5.2. A registered dietitian is notified whenever the medical diet menu is changed.
   5.3. Medical diets shall be evaluated by a registered dietitian at least annually to ensure nutritional adequacy.
   5.4. A review must also take place whenever a substantial change in the menus is made and the review shall be documented in accordance with Department Order #912, Food Service.

6.0. Food services managers shall ensure that inmate workers who prepare regular and medical diets are trained in preparing the diets, including appropriate substitutions and portions.

7.0. Any special medical diet not listed in the Diet Reference Manual may be prescribed on a case-by-case basis by the practitioner with the approval of the ADCRR Medical Director (or designee) in collaboration with the ADCRR Registered Dietician.

7.1. The following items must be addressed with the request:

7.1.1. Description of the desired diet and identification of the diagnosis that supports such a diet order. Include the negative impact seen as a result of the lack of the special diet.

7.1.2. Describe all pertinent treatments to date provided to ameliorate the apparent negative impact of the current diet.

7.1.3. Document that a discussion was held with the patient regarding their diagnosis and that the patient understands the need for adherence with the requested diet.

7.1.4. Provide any specialist or consultative documents that support the recommendation.

	Medical and Dental 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 NCCHC Standard, O-E-11, Patient Escort
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-D-06.01 Patient Escort On-Site

PURPOSE: To provide Contract Healthcare Provider (CHP) information related to the on-site patient escort process and to ensure that patients have unimpeded access to healthcare services and visits.

RESPONSIBILITY: It is the responsibility of the CHP Facility Health Administrator (FHA) in collaboration with the complex Warden or designee to arrange appropriate appointment times for the provision of health services based on the patients' needs. The FHA is also responsible for monitoring and reporting as necessary to the appropriate unit Deputy Warden or designee any impediments to patients attending appointments. It is the responsibility of all CHP staff to report all potential or observed barriers to patient access to healthcare to the FHA.

PROCEDURE: The patient's arrival to appointments may vary depending upon the classification of the patient, the unit's level of custody, and open circulation or controlled movement of the population on that unit. Some health services may be delivered in satellite locations closer to the patient's housing unit.

1.0. On-Site Open Yard Escorting
- 1.1. Movement on a unit may be open allowing a patient to attend an appointment unescorted or may be more restricted and controlled under certain circumstances.
- 1.2. Units with closed or supervised movement only will have a correctional 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 (for restraint policies on pregnant individuals, see Department Order #705, Inmate Transportation). For patients who have disabilities or impairments and may need special restraint accommodations, coordination between health staff and custody shall take place. Where restraints may impede clinically necessary care, health care staff and custody staff shall work together on reasonable accommodations while maintaining the safety and security of staff and patient.
  - 1.2.1. Patient confidentiality shall be maintained at all times during escort and while in the health unit, but custody staff should remain in line of site as necessary per custody protocol.
- 1.3. Patients will be escorted to urgent or emergent "add-on" appointments if requested by CHP staff.
  - 1.3.1. If a patient feels they need to see health services for an unscheduled appointment/visit to medical, dental, or mental health the correctional officer to whom the patient requests was made shall, without inquiring as to the nature of the need or symptoms, immediately ensure the patient's safety and contact healthcare staff for further direction.

2.0. On-Site Closed Yard/Lockdown Escorting
- 2.1. In lockdown areas such as the Maximum Custody units or Complex Detention Units (CDUs) the patient is escorted by a correctional officer (or officers) to the health unit for medical attention.

2.2. CHP staff shall not cancel appointments due to a lack of security escorts without consultation with the Deputy Warden or designee first.

2.3. Health services such as medication administration or delivery may be provided in satellite locations from the main health unit when clinically appropriate.

2.3.1. If necessary, security will provide an escort of the patients from their individual housing areas to the satellite treatment area.

2.3.2. Exam rooms shall be equipped appropriately for a clinical visit (e.g., exam table, sink, soap, paper towels).

3.0. Telemedicine Services

3.1. Telemedicine appointments will be pre-scheduled by CHP staff similar to off-site specialty appointments to allow security optimum notice to plan for escorting the patients to their appointments.

3.2. Security will provide escorts and transportation as necessary from the complex housing locations to the health services unit.

3.3. CHP staff shall not cancel telemedicine appointments due to a lack of security escorts without consultation with the Deputy Warden or designee first.

3.3.1. Refer any delay in patient arrival to the unit Deputy Warden or designee, if necessary, to assist in providing adequate escort personnel.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #705, Inmate Transportation Department Order #1101, Inmate Access to Health Care NCCHC Standard P-D-06, Patient Escort NCCHC Standard O-E-09, Continuity and Coordination of Care During Incarceration
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-D-06.02 Patient Escort Off-site

PURPOSE: To ensure patients have unimpeded access to healthcare services regardless of their housing location, temporary placement, and/or security classification.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) Facility Health Administrator (FHA) and the Warden or designee shall collaborate and implement processes to ensure continuity of care takes place whenever a patient is transported off-site to receive health services.

PROCEDURES:

1.0. Security staff shall provide escort and transportation for patients in accordance with Department Order #705, Inmate Transportation.

1.1. Correctional officers assigned to escort or provide patient transportation to off-site appointments are responsible for maintaining confidentiality, transporting sealed 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.

1.2. For patients who have disabilities and may need special restraint accommodations, coordination between health staff and custody shall take place.

1.3. Pregnant patient – See pregnant policy.

2.0. Upon return to the complex, escorting officers shall bring the patient into the designated complex health unit for CHP to review the medical information, complete an assessment of the patient, and determine if medication(s) and/or intervention(s) are clinically indicated for the patient.

3.0. Patients with special needs (e.g., diabetes, wheelchair, limited mobility) shall have their needs met through communication between the Clinical Coordinator or medical staff designee and the Operations Transportation Group.

4.0. Security initiated patient transportation: When the health staff is informed that a patient 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 their off-site travels. The transportation supervisor shall coordinate with CHP staff as outlined in 6.0.

5.0. CHP initiated patient transportation: The Outside Consult Request, Form 1101-63, or an approved electronic equivalent, shall be completed by the ordering practitioner and note all special needs the patient may have for transportation.

6.0. The sending complex transportation supervisor shall coordinate with CHP staff to ensure the necessary accommodations, meals, and medications are provided to patients as specified in collaboration with CHP staff and in accordance with Department Order #705, Inmate Transportation.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #706, Incident Command System (ICS) [Restricted] Department Order #1101, Inmate Access to Health Care MDSTM Attachment P-D-03.03A, Emergency Response Bag Minimum Requirements NCCHC Standard P-D-07, Emergency Services and Response Plan NCCHC Standard O-A-07, Emergency Response Plan NCCHC Standard O-E-07, OTP Emergency Services
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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.
  - 1.2.1. The emergency support provided by CHP staff may include such things as advice in contacting emergency first responders, application of basic first aid and life-saving measures to include CPR while waiting for emergency response personnel to arrive, or serving as on-scene medical managers of acute situations.
- 1.3. Each prison complex shall, in collaboration with the CHP Facility Health Administrator (FHA), medication assisted treatment (MAT) program sponsor (where applicable), and ADCRR complex Warden identify personnel responsible for responding to medical emergencies.
- 1.4. Security staff shall contact 911 directly to ensure vital health services necessary for the preservation of life is maintained. Examples include, but are not limited to, situations in which a patient is found unconscious, needs cardiopulmonary resuscitation, or is bleeding profusely.
- 1.5. Whenever possible, clinical encounters shall be conducted in a location to allow for auditory and visual confidentiality. An exception may be made for encounters such as emergency situations where in these cases breaches of confidentiality may be limited to the measures required to ensure safety.
  - 1.5.1. All staff shall maintain the confidentiality of any information acquired as the result of the breach.
- 1.6. Emergency Supplies:
  - 1.6.1. At least one emergency response bag shall be kept in a readily accessible area, to be used by CHP staff in response to an emergent situation or activation of the incident command system (ICS).
    - 1.6.1.1. The contents of the emergency response bag shall be monitored routinely in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-D-03.03, Emergency Response Medical Equipment and MDSTM Attachments P-D-03.03A, Emergency Response Bag Minimum Requirements.

1.7. All staff shall assess and render aid to ALL medical emergencies, including an unforeseen medical emergency of a dental patient during treatment and events of self-harm, immediately when two or more staff are present. Those staff shall immediately render emergency aid upon becoming aware of a non-responsive inmate or an inmate in medical crisis.
  1.7.1. CHP staff shall activate ICS to notify supervisory staff and medical responders as required.
  1.7.2. The CHP nurse coordinating off-site emergency transfers will ensure that the unit shift commander is immediately informed of the emergency so that security escort staff can be assigned to transport if necessary.
1.8. Individual emergencies:
  1.8.1. It is the standard of the ADCRR for custody staff to assess and render aid to all medical emergencies, including suicide attempts, immediately upon becoming aware of a non-responsive patient or a patient in a medical or mental health crisis.
    1.8.1.1. Emergency response and care provided by custody staff shall be appropriate given the skill level and knowledge expected of custody staff.
1.9. Multiple Simultaneously Emergent Events
  1.9.1. When multiple emergent events are occurring simultaneously details regarding general staff assignments may be located in Department Order #706, Incident Command System (ICS).
  1.9.2. Patient Triage:
    1.9.2.1. Primary triage shall be conducted by the person with the greatest amount of healthcare experience on the scene.
      1.9.2.1.1. When possible, staff members shall be triaged in separate areas from patients.
    1.9.2.2. Triage tags shall be used to identify the treatment and transportation needs of victims based on a four-level classification such as the following:
      1.9.2.2.1. Priority 1: Patients needing immediate care that have a high likelihood of survival.
        1.9.2.2.1.1. Examples include patients with airway obstruction and early signs of hemorrhagic shock.
      1.9.2.2.2. Priority 2: Patients whose transport and treatment can be delayed for a few hours.
        1.9.2.2.2.1. Examples include patients with fractures or sprains and soft tissue injuries.
      1.9.2.2.3. Priority 3: Patients whose injuries do not threaten life or functions.
      1.9.2.2.4. Priority 0: Patients who are dead or whose injuries are so severe that prognosis is poor.
    1.9.2.3. Medical Emergency/Disaster Log, Form 1101-48, shall be kept indicating the disposition of victims in an emergency.
      1.9.2.3.1. A separate form is to be used for staff and patients.
  1.9.3. 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.
  1.9.4. Medication Administration in a Disturbance
    1.9.4.1. The FHA or designee shall develop a local response for each incident with the input of the Site Medical Director, Director of Nursing (DON), and other supporting personnel as needed.
    1.9.4.2. The plan must include the following elements:
      1.9.4.2.1. Methods for identification of patients in varying need of medications or treatment.
      1.9.4.2.2. Methods of delivery of medication and treatment in highly controlled or unsecured areas.
      1.9.4.2.3. Coordination of communication under ICS restrictions.
      1.9.4.2.4. Methods of control and monitoring of staff safety.
      1.9.4.2.5. Personnel relief plans should the ICS overlap shifts.

1.10. 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 Healthcare Coordinator by the end of the fifth business day.
1.10.1. The Continuous Quality Improvement Committee (CQI) must review the written ICS critique evaluation at the next meeting.
1.10.2. Findings of the ICS critique shall be discussed with onsite CHP staff at the next scheduled staff meeting.

2.0. Emergency Response Plan
2.1. The 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 FHA or designee shall be notified of the activation of an ICS by the CHP staff on-site.
2.2.1. FHA or designee will elevate notification as necessary in accordance with CHP policies.
2.3. Urgent Notifications
2.3.1. An urgent notification list shall be created, published, and provided to all staff by the FHA and must include CHP medical, dental, nursing, mental health staff, and leadership as applicable.
2.3.1.1. The urgent notification list will identify both a primary and a secondary staff member responsible for coverage of assigned complexes and shall include current contact information including mobile and backup phone numbers.
2.3.1.2. The urgent notification list will identify the dates that each staff member is providing coverage for each calendar month.
2.3.1.2.1. Any changes to a published urgent notification list will require notification to all CHP staff to prevent any lapse in coverage.
2.3.2. Any call made to CHP staff members on the urgent notification list is to be documented in the patient health record and must indicate the time the call was placed, the time of the response, and event details.
2.4. Emergency Transportation
2.4.1. If a medical emergency is considered life-threatening, 911 shall be immediately contacted by custody, medical, or mental health staff.
2.4.2. After hours, nursing personnel shall immediately ask that 911 be called if an emergency medical condition is determined to be life-threatening.
2.4.2.1. If the medical emergency is not immediately life-threatening, the nurse shall contact the provider on call in accordance with local policies and procedures.
2.4.2.2. After hours, following the departure of a patient by emergency medical transportation, the nurse will contact the FHA or designee by approved local process.
2.4.3. Emergency Medical Transportation Services may be provided by either ground-transport ambulance or air ambulance.
2.4.4. CHP health staff shall immediately notify security of a medical emergency that may require send out to allow for quick identification of the required number of security escorts that may be needed.
2.4.4.1. The nurse will continually monitor and attend to the needs of the patient in an emergency until the patient departs.
2.4.5. Any change to the type of transport or destination by CHP staff or by the accepting EMS responders shall be communicated to the security escorting officer(s).
2.4.5.1. This may involve an upgrade to a helicopter transport if the patient's condition becomes more critical.
2.4.6. The nurse shall immediately notify 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.
2.4.7. The time 911 is called and the time of arrival shall be documented in the patient chart. Any significant delay in the transportation of an emergency send-out will be reported to the complex Warden for follow up and review.

2.4.8. The nurse shall notify the clinical coordinator and DON of any patient sent out in accordance with local policy.

2.5. Emergency Health Record Package

2.5.1. Specific portions of the health records must be transported with a patient when emergency transportation is utilized.

2.5.2. The following will be packaged by the nurse initiating send out or designee:

2.5.2.1. Transfer Summary Continuity of Care (1101-8P)

2.5.2.2. Request for Medical Records (1104-1)

2.5.2.3. Outside Consult Request (1101-63P)

2.5.2.4. A copy of the Declaration of Intent to Limit Life-Support Procedures, Form 1101-9P, if established

2.5.2.5. For pregnant patients, copies of the Pregnancy Packet

2.5.3. CHP staff shall ensure a system is in place to access MAT records in the event of a medical or mental health emergency.

3.0. Mass Disaster and Health Emergency Drills

3.1. The emergency plan developed in coordination with the Warden must be practiced, documented, and critiqued at least annually by security, CHP staff, and MAT program staff.

3.2. Wardens and CHP staff are expected to coordinate emergency response exercise scenarios that require an emergency response within the time frame required by ADCRR Department Orders.

3.2.1. 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.

3.2.2. Wardens and FHA shall conduct exercises and drills that test staff response time to emergent situations.

3.3. Individual 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.

3.3.1. Emergency drills will include MAT program staff with some drills taking place at the time of medication dosing.

3.4. "Mass disaster" drills, affecting more than one individual must involve staff on all shifts and must be practiced so that over a three-year period each shift has participated.

3.5. Simulations and Plan Evaluation:

3.5.1. Prior to any drill or simulation, the FHA shall appoint one to three people to serve as evaluators of the ICS simulation.

3.5.1.1. One evaluator shall be a representative from Prison Operations.

3.5.1.2. The evaluators are to fill out the ICS critique and submit it to the FHA.

3.5.1.3. The results of the critique shall be shared with involved CHP staff and incorporated into future ICS training sessions.

3.5.1.4. The FHA will forward a copy of the critique to the CHP Regional leadership or designee and ADCRR Healthcare Coordinator by the end of the fifth business day.

3.5.1.5. The critique shall be discussed with CHP staff at the next on-site scheduled multidisciplinary meeting within 30 calendar days.

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 the management of specialty care and to be aware of local and regional options available in the community to meet the health care needs of the patient population.

PROCEDURES:

1.0. Off-site Specialty Services

1.1. The FHA or designee in consultation with the ordering practitioner shall ensure that all requests for off-site specialty services submitted are accurate and complete.

1.1.1. The FHA neither approves nor denies any requests for specialty services.

1.2. The practitioner ordering the referral has an established patient-practitioner relationship with the patient, assumes clinical responsibilities for the decision, and therefore is the controlling order and not simply requesting authorization. Suggestions or recommendations may be made by others however, the order is only modifiable by the ordering practitioner, their direct clinical supervisor, or in the ordering practitioner's absence, a designee covering for them.

1.3. When an appointment is scheduled, the CHP shall communicate with the specialist any auxiliary aids or services that are required for effective communication or if the patient has language access needs (e.g., an interpreter) that needs to be coordinated in advance.

1.4. The CHP shall ensure all specialty referrals are completed within the timeframe specified by the ordering practitioner not withstanding any time required for processing, reviewing, or consideration of alternative treatment plans.

1.4.1. If a practitioner orders or informs a patient of an order for an off-site test or referral the patient shall be informed of any modification to or change in the order status within one month of the change.

1.4.2. The CHP health staff shall not notify patients of specific dates, times, or locations of upcoming appointments for off-site specialty care.

1.5. The Clinical Coordinator (CC) shall serve as the facilitator and utilize a system that tracks and monitors requests for specialty care both on-site and off-site.

1.6. If not completed electronically, all consult requests are entered into a database by the CC.

1.6.1. The CC shall ensure all pertinent information regarding the patient's health needs is communicated between the practitioners and the outside entity upon referral for care to facilitate timely approval and scheduling.

1.6.2. The CC will follow up with the CHP approving authority on any outstanding consultation requests that remain in a "pending approval" status after five business days.

1.6.3. 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 the Medical and Dental Services Technical Manual (MDSTM) guidance and complex procedures to guarantee that the patient is not moved to another facility prior to the consultation appointment.

1.6.3.1. Dental procedure requests requiring a medical hold include:

1.6.3.1.1. Reduction of fractured facial bones

1.6.3.1.2. Endodontic treatment

1.6.3.1.3. Prosthetics

1.6.3.1.4. Any other condition requiring continued observation or follow-up by the attending dentist.

1.6.4. All specialty referrals shall be completed within the timeframe ordered by the provider.

1.6.5. The practitioner may order a referral to be completed in a specific timeframe. For any order or referral with a specified timeframe, the timeframe supersedes any categorical classification of the referral and must be completed in a specified timeframe.

1.6.5.1. If the appointment is unable to be scheduled within the specified timeframe the provider needs to be notified so that they can call the outside provider to explain the urgency or issue as clinically appropriate.

1.6.6. The CHP is responsible for ensuring a patient referral is completed in the timeframe established in the practitioner's order.

1.6.6.1. The ordering practitioner may extend the timeframe, only if clinically appropriate and with documented justification, to complete the referral and the completion is considered timely provided the referral is completed within the extended timeframe and the extension was ordered before the original timeframe had expired.

1.6.7. Documentation of alternate treatment plans recommended by utilization review shall be sent to the requesting practitioner and resolved, in writing, prior to the timeline set forth by the ordering provider and documented in the health record.

1.6.8. The CC shall make appropriate documentation in the health record of scheduled, rescheduled, and completed consults noting reasons for postponements if any.

1.6.9. The CC is responsible for all travel arrangements and appropriate documentation preparation to accompany the patient for any consultations.

1.7. The CC shall maintain the required statistical reports as defined in the Contract and provide them to the ADCRR Healthcare Services Division (HSD).

1.8. Upon completion of any off-site specialty care appointment the patient shall be evaluated by nursing staff prior to returning to their housing location.

1.8.1. The nurse completing the evaluation shall obtain vital signs, conduct a clinically indicated exam, and document recommendations in the patient's health record.

1.8.2. The nurse shall forward the nursing evaluation and any accompanying health records received to the primary care provider.

1.8.3. The nurse will have written documentation or at a minimum verbal report of the visit recommendations at the time of this encounter.

1.9. Military veterans shall be provided care by the CHP and shall not be referred out to Veterans Administration (VA) Hospitals or clinics for medical care.

1.9.1. The VA representatives may be authorized, (with the appropriate security clearance); to provide on-site benefits evaluation or delegate such benefits evaluations to the CHP.

1.10. Interstate Compacts

1.10.1. The FHA, health record staff, and CC shall jointly monitor the existence of interstate compact incarcerated individuals within their complex.

1.10.2. In the event that a costly medical procedure becomes necessary, the sending state should be consulted ahead of the appointment. Prior approval should be obtained, as time allows.

1.10.2.1. The FHA in conjunction with the Interstate Compact Administrator or designee shall facilitate this consultation.

2.0. Hospitalization

2.1. CHP shall coordinate the development and maintenance of written contracts for the hospitalization of patients beyond the confines of the prison complexes.

2.1.1. The contract documents will specify the agreed-upon reimbursement arrangements and billing practices.

2.1.2. Copies of contracts detailing local arrangements shall be provided to the ADCRR Assistant Director for Healthcare Services.

2.2. Responsibility for the patient's health care will be transferred to the practitioners licensed to practice medicine in the state and credentialed in good standing by the contracted hospitals.

2.2.1. The CHP is responsible for advising the ADCRR Assistant Director for Healthcare Services or designee, ADCRR Medical Director, and ADCRR Director of Nursing 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 during an outpatient visit.

2.2.2.1. Direct admission to the hospital may also be made in an urgent situation by a practitioner on the prison complex consulting directly with the hospital-based specialist. The patient may be admitted directly to the hospital under the care of the specialist, avoiding 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. Patients will be informed of the reason for their off-site visit.

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 medical practitioner employed by the CHP.

2.2.3.1. The FHA or designee shall be notified of any "send-outs" to the hospital or emergency facilities made by parties other than CHP staff.

2.2.3.2. During a medical emergency any staff member, including custody, medical, or mental health may activate emergency medical services, which may result in a medically-related transport to the hospital.

2.2.4. 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, or approved electronic equivalent in a well-sealed envelope for significant other medical issues if indicated.

2.2.5. The 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.

2.2.6. In emergency situations, the practitioner (or attending nurse) shall contact the receiving hospital facility to advise of the impending transfer.

2.2.7. The CHP staff shall monitor the status of hospitalized patients and track the status of any additional procedures that the hospital and/or specialist may request following admission.

2.2.7.1. The CHP shall provide emergency department/hospitalized/inpatient reports daily to the HSD staff.

2.2.8. Any notification to next of kin request will be carried out by Security Operations and/or Faith Services according to established policy at the local prison complex and Department Order #711, Notification of Inmate Hospitalization or Death.

2.2.8.1. The FHA or designee is responsible for responding to any requests or inquiries from the patient's designated emergency contact in accordance with the current release of information form(s) on file.

2.3. Patient's Returning to the Prison Complex

2.3.1. Hospital discharge planning and the return of the patient to the prison complex shall be coordinated by the CHP Utilization Review staff, the hospital, and the receiving facility.

2.3.1.1. Additional medical needs following discharge may determine alternate placement in an inpatient component (IPC/infirmary) or special needs unit (SNU) bed.

2.3.2. Upon arrival to the prison complex, security staff shall bring the patient directly to the health unit of the patient's assigned housing yard upon return. The Registered Nurse (RN) 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 hospitalization or emergency department transport shall have the hospital discharge paperwork with treatment recommendations reviewed and acted upon within 24 hours.

2.3.3.1. Upon return from the emergency department or following a hospitalization, a patient should undergo an evaluation by an RN or higher that includes vital signs, clinically indicated exam, and a documentation of recommendations in the patient's health record.

2.3.3.2. The nurse shall also forward the nursing evaluation and any accompanying health records to the PCP.

2.3.3.3. The nurse shall have and review written documentation (discharge summary, physician report) for the evaluation.

2.3.3.3.1. Where written documentation (discharge summary, physician report) are not available, or not provided, the nurse shall document what is obtained by verbal report at the time of the visit.

2.3.3.4. Recommendations and orders should be from the PCP, as well as a follow-up visit.

2.3.3.5. After-hours orders may be initiated by an on-call provider.

2.3.3.5.1. The PCP shall be notified during the morning huddle and/or electronically about any after-hours orders placed by the on-call provider.

2.3.3.6. If the PCP or designee determine that a deviation from the hospital recommendations is clinically indicated, this shall be documented in the patient's health care record with a justification for not following the recommendations.

2.3.4. Patients returning from a hospitalization or emergency department transport shall be scheduled for and receive a face-to-face provider appointment the next day a CHP provider is on-site.

P-E-01.01 Information on Health Services

PURPOSE: To ensure all incarcerated individuals are informed of the availability of health care services and how to access them.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to inform incarcerated individuals in a language or manner they understand that healthcare services are available and how they may access them.

PROCEDURES:

1.0. Incarcerated individuals shall be educated on access to health care.

1.1. CHP shall provide all newly arriving incarcerated individuals information on how to access health care in a format or manner they understand within 24 hours of 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-services provided, if applicable.

1.1.1.3. The grievance process for health-related complaints.

1.1.2. Written notification shall be provided in the ten most common languages in Arizona notifying patients of the availability of interpretation services which may be used to communicate with health care staff.

1.1.2.1. Available interpretation services must allow for oral or written communication in any language or sign language.

1.2. Each prison complex will:

1.2.1. Upon patient transfer the receiving complex shall provide an orientation packet containing information on how the patient may access health care services at the designated complex.

1.2.1.1. Printed orientation packets shall be available in English and Spanish.

1.2.1.2. Interpretation services must be available for oral or written communication of orientation packet information in any language including sign language.

2.0. Access to Health Care Poster:

2.1. Ensure the approved poster or sign, located in Medical and Dental Services Technical Manual (MDSTM) Attachments P-E-01.01A, Preventive Health Services and Screenings, is hung in the Intake/Processing area, in all housing units, in medical clinics, and throughout the complex in other high traffic areas such as on informative bulletin boards.

2.2. Posters must be hung in all living units and clinical areas about the availability of translation services in the ten most common languages in Arizona. The posters should inform patients that they can tell staff at any time, in any language, verbally or in writing that they are not fluent in English.

3.0. Fee-for-Service:

3.1. Patients may be charged a reasonable fee for health care visits they initiate pursuant to a health needs request form or for emergency treatment in accordance with Department Order #1101, Inmate Access to Healthcare.

3.2. A copay is a fixed amount that a patient pays for health services.

3.3. Paying a copay makes the patient part of the shared decision-making process to address a patient's health needs.

3.4. Incarcerated individuals are educated about copays in the inmate handbook, during the intake process, and via their tablets.

3.5. No one will be denied health services based on inability to pay.

3.5.1. If an individual is on indigent status, health charges will not apply.

3.5.2. In addition, indigent individuals will NOT accrue debt on their account for any unpaid or waived copays.

3.6. The copay amount is $0.50.

3.7. Copays are charged to patient accounts based on the type of visit or service.

3.7.1. The decision about whether to charge a patient is NOT decided by the healthcare professional delivering services.

3.8. Patients may refuse a visit with no charge applied.

3.9. There is no charge to submit a Health Needs Request (HNR), but patients may be charged for the visit resulting from the HNR submission.

3.10. Patients who are NOT charged copays:

3.10.1. Patients with serious mental illness (SMI)

3.10.2. Patients with developmental disabilities who are housed in a special programs unit

3.10.3. Juvenile patients

3.10.4. Pregnant patients

3.10.5. Patients on indigent status

3.11. Account Statements and Copay Disputes:

3.11.1. Patients may request an Inmate Trust Account (ITA) statement from Inmate Banking by submitting an Inmate Letter (Form 916-1) to their assigned Correctional Officer III or Case Manager, as stated in Department Order #905, Inmate Trust Accounts.

3.11.2. Copay disputes are resolved by submitting an Inmate Letter (Form 916-1) to ADCRR Healthcare Services Division (HSD), within six months of the posting date of the charge, per Department Order #905, Inmate Trust Accounts.

3.11.2.1. Attached to the inmate letter shall be the ITA statement, including the patient's name, ADCRR number, complex and unit on the date of service, date of chargeable event, and type of chargeable event.

3.11.2.2. The ADCRR HSD mailing address is: 701 E. Jefferson St., Phoenix, AZ 85034.

3.11.3. Patients should NOT submit a Health Needs Request (HNR) for copay disputes.

3.12. Services that are charged a copay:

3.12.1. Medical provider visits ("sick call", including episodic care/self-scheduling visits)

3.12.1.1. See exceptions in the section titled, "Services that are NOT charged a copay."

3.12.2. Nursing visits ("sick call", including HNR visits/self-scheduling visits)

3.12.2.1. See exceptions in the section titled, "Services that are NOT charged a copay."

3.12.3. Dental visits, as follows:

3.12.3.1. Extractions, Fillings, Prosthetics

3.12.4. Commonly prescribed medications from a defined list, which consists mostly of PRN medication.

3.12.4.1. Medications are charged based on new orders or renewals.

3.12.5. Off-site treatment refusals that occur less than 24 hours before the appointment.

3.13. Services that are NOT charged a copay:

3.13.1. Psychiatric medications
3.13.2. Intake screening and assessment visits
3.13.3. Heat-related visits
3.13.4. Provider visits that are NOT charged:
    3.13.4.1. Medical visits to a provider by inmates who are referred by a physician assistant or nurse practitioner.
    3.13.4.2. Chronic care visits
    3.13.4.3. Preventive care visits (i.e., annual physical exams and immunization visits)
    3.13.4.4. OB/GYN visits
    3.13.4.5. Offsite visits (including specialty visits, hospitalizations, and emergency department visits)
    3.13.4.6. Off-site treatment refusals that occur 24 hours or more before the appointment
    3.13.4.7. Medication assisted treatment (MAT) visits
    3.13.4.8. Hepatitis C visits
    3.13.4.9. Admission and follow up visits to the IPC or SNU
3.13.5. Nursing visits that are NOT charged:
    3.13.5.1. Preventive care visits (i.e., annual physical exams and immunization visits)
    3.13.5.2. Admission visits and follow up visits to the IPC or SNU
3.13.6. Dental visits that are NOT charged:
    3.13.6.1. Preventive visits (i.e., comprehensive oral exams, periodic oral exams, and cleanings)
3.13.7. Mental health visits
3.13.8. Substance use counseling visits
3.13.9. Hospital admissions
3.13.10. Care provided in response to an ICS
3.13.11. Medical visits initiated by medical or mental health staff
3.13.12. Certain medications, mainly those taken as-needed
3.13.13. Physical therapy
3.13.14. Optometry visits
3.13.15. Audiology testing
3.13.16. Administrative physical examinations for statewide driver status and firefighting crews
3.13.17. Inmates who are inpatients at the facilities within ADCRR that are licensed as Level 1 Behavioral Health Treatment Facilities by the Arizona Department of Health Services
3.13.18. Female inmates for feminine hygiene products

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-F-04.01, Medically Supervised Withdrawal and Treatment NCCHC Standard P-E-02, Receiving Screening
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-02.01 Receiving Screening

PURPOSE: To provide guidance on the receiving screening process for all incoming incarcerated individuals to identify health care needs and provide continuity of care when applicable.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure all arriving incarcerated individuals 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. Healthcare staff will conduct a rapid receiving screening immediately upon arrival at the intake facility.

1.1.1. Any yes responses on the rapid receiving screen shall be communicated to a Registered Nurse (RN) for further evaluation.

1.2. A comprehensive receiving screening by an RN takes place as soon as possible but no greater than four hours after arrival, is completed on the approved form(s), and is documented in the patient's health record.

1.3. The RN shall assess the English fluency of all newly arriving patients and document the preferred language in the electronic health record in a place that shall be visible on all relevant screens.

1.4. Patients who present with a possible life-threatening condition or are 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.

1.4.1. After normal business hours, if time allows, the nurse shall contact the practitioner on call for orders to send the patient to the emergency room.

1.4.2. If they are referred to a community hospital and then returned, admission to the facility is predicated on written medical clearance from the hospital.

1.4.2.1. The receiving screening process shall take place for patients returning from a hospital as outlined in this policy.

1.5. The nursing staff shall complete the receiving screening documentation, to include the following:

1.5.1. 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).

1.5.2. All newly arriving patients shall be screened for and referred as necessary to be evaluated for substance use disorder.

1.5.2.1. Drug and alcohol history and evaluation for current drug or alcohol intoxication in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-F-04.01, Medically Supervised Withdrawal and Treatment.

1.5.2.2. Screening shall include assessment of history of opioid overdose.

1.5.3. Inquiries as to the patients:

1.5.3.1. Current and past illnesses, infectious diseases, health conditions, or special health requirements (e.g., hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine).

1.5.3.2. Symptoms of a communicable illness (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats).

1.5.3.2.1. Any patient identified as being potentially infectious shall be reported to the complex security personnel and isolated from the general inmate population.

1.5.3.3. Past or current mental illness, including diagnoses, treatment, and hospitalizations.

1.5.3.4. History of or current suicidal ideation.

1.5.3.5. Dental problems (decay, gum disease, abscess).

1.5.3.5.1. Any patient identified with an emergent dental need is immediately referred to a dentist if available on-site or a medical provider for further evaluation and treatment.

1.5.3.5.2. Newly arriving patients with orthodontic appliances in place will be referred to the dentist for further evaluation to ensure treatment is not interrupted or changed in accordance with Clinical Practice Guideline, Orthodontic Treatment.

1.5.3.6. Allergies.

1.5.3.7. Dietary needs.

1.5.3.8. Prescription medications (including type, amount, and time of last use).

1.5.3.9. Legal and illegal drug use (including type, amount, and time of last use).

1.5.3.10. Current or prior withdrawal symptoms.

1.5.3.11. Possible, current, or recent pregnancy.

1.5.3.12. Other health problems as specified by the responsible physician.

1.5.4. A full set of vital signs shall be performed including the patient's height and weight.

1.6. All arriving incarcerated individuals 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.

1.6.1. The applied PPD skin test must be read between 48 to 72 hours following administration.

1.6.2. If the administered PPD test is inconclusive upon reading, order a repeat PPD in 7 to 12 days.

1.6.3. 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.

1.6.4. A tuberculosis (TB) symptom checklist shall be completed.

1.7. Intake and return to custody patients who arrive with documented current prescriptions shall be bridged or continued on their medications.

1.7.1. Newly arriving patients will have documented current prescriptions continued if based on the patient's history there is a significant risk of worsening of the condition if a different medication is prescribed.

1.7.2. The practitioner shall have the authority to discontinue or change existing therapy upon a face-to-face documented evaluation of the patient.

1.8. 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 Facility Health Administrator (FHA) and Warden of all non-reception center complexes shall develop local policy to ensure that the healthcare staff are informed when a new incarcerated person arrives at the complex.

2.2. Individuals returning on parole must be screened by nursing staff, as soon as possible but no greater than four hours after 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 and it less than one year since their last TST.
  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 patients 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 shall be offered to patients on an opt-out basis, including patients returning to custody within 90 days of their previous release date from ADCRR custody.
2.4. Parole violators in need of medical care/prescription medication shall be seen by the practitioner or a verbal order may be obtained at the time of reception and assessment.

3.0. Access to Care
3.1. At the time of admission/intake all incarcerated individuals are informed about procedures to access health services, including any copay requirements (if applicable), as well as procedures for submitting grievances, as stated in P-E-01.01, Information on Health Services.
  3.1.1. Medical care is not denied based on the patient's ability to pay.
  3.1.2. Copayment fees shall be waived when appointments or services, including follow up appointments, are initiated by medical staff.
  3.1.3. This information is communicated orally and in writing and is conveyed in a language that is easily understood by the inmate.
  3.1.4. When a literacy or language problem prevents an incarcerated individual from understanding written information, only health services staff that are certified in medical translation by ADCRR can be used for medical related issues; otherwise it must be a licensed translation service.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-E-03, Transfer Screening NCCHC Standard, O-H-03, Management of Health Records
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-03.01 Transfer Screening

PURPOSE: To provide guidance for ensuring continuity of care for patients transferring between facilities within the ADCRR system.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) staff to review the patient's health record at the time of transfer to ensure continuity of care. The CHP is responsible for ensuring patients transferring to another facility do not experience an interruption in treatment.

PROCEDURE:

1.0. Transfer Sending: All patients shall have their needs communicated from the sending facility to the receiving facility by nursing staff completing a Continuity of Care/Transfer Summary, Form 1101-8, or approved electronic equivalent (and verbally if necessary) at the time of transfer, or an approved electronic equivalent (and verbally if necessary) at the time of transfer.

- 1.1. Sending facility nursing staff shall review current medication orders, both direct observed therapy (DOT) and keep-on-person (KOP), and ensure medications accompany the patient at the time of transfer.
  - 1.1.1. A minimum of a seven-day supply of all prescription medications shall accompany all patients transferred.
- 1.2. Sending facility health record staff shall package any volumes of paper health records for patients who are being transferred in a sealed container clearly addressed to the receiving facility and deliver packaged health records to a designated location where security and/or transportation staff shall pick up the health records and medications prior to departure.
- 1.3. Patients transferring to an off-site facility for court appointments or any other legal actions shall have their medical needs communicated via Continuity of Care/Transfer Summary, Form 1101-8, or approved electronic format.
  - 1.3.1. 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. Patients shall be assigned a primary care provider and a primary therapist prior to or at the time of arrival to a new facility.
- 2.2. Receiving facility nursing staff is responsible for performing a chart review within 12 hours of arrival.
  - 2.2.1. Nursing staff shall verify that the patient has all required medical equipment and supplies.
  - 2.2.2. Nursing staff shall ensure all patient medications DOT and KOP were received upon arrival and shall be provided according to prescription without interruption.
- 2.3. The receiving facility nursing staff shall physically assess the arriving patient(s) within 24 hours of arrival at assigned facility.

2.3.1. 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. Examples of when this may happen include, but are not limited to, a direct admit to an infirmary or mental health acute care unit.

2.3.2. Ensure the patient has a current Purified Protein Derivative (PPD) result on file.

2.4. The nursing staff shall complete the approved Initial/Inter-Facility Assessment within the electronic health record or Initial/Inter-Facility Assessment, Form 1101-67.

2.4.1. The nursing staff shall refer the patient for appropriate emergency or routine healthcare service as determined by the chart review and assessment.

2.5. Receiving nursing services may continue a patient's medication order up to the date of the prescription expiration.

2.5.1. The primary care provider or designee shall ensure medication continuity (e.g., prescription expiration or transferring to or from a private facility).

2.6. The dental assistant (who is trained by a dentist)/dentist should perform a chart review of the dental records within 12 hours of arrival.

2.6.1. Evaluation of dental record and dental treatment plan to determine if any high-priority dental procedures are in the process.

2.6.2. If any dental treatment is needed, schedule the patient for continuing treatment as indicated.

2.6.3. Verify the patient's routine dental health needs and schedule as indicated.

2.6.4. If the patient has not received a Comprehensive Oral Examination by a dentist the patient should be scheduled to see the dentist within 30 days of the initial arrival at ADCRR.

2.7. If the needs of an arriving patient exceed the level of care that a receiving facility can provide, nursing staff shall report immediately to the CHP Facility Health Administrator (FHA) who shall take appropriate action as necessary.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-E-02.01, Receiving Screening MDSTM P-E-06.01, Oral Care NCCHC Standard P-E-04 Initial Health Assessment NCCHC Standard O-E-02, Health Assessments
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-04.01 Initial Health Assessment

PURPOSE: To provide guidance in the completion of the required initial health assessment for newly arriving and/or returning incarcerated individuals.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to complete an initial health assessment and physical examination to identify a patient's health needs and establish a plan for meeting those needs.

PROCEDURE:

1.0. The practitioner shall review receiving screening results done in accordance with Medical and Dental Services Technical Manual (MDSTM) P-E-02.01, Receiving Screening, by the end of the second full day of the patient's arrival, sooner if immediate health care needs are identified.

2.0. All patients receive an initial health assessment and 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 qualified healthcare professional collecting additional data to complete the medical, dental, mental health histories and substance use history, including any follow-up from abnormal findings obtained during the receiving screening and subsequent encounters.
  - 2.1.2. A qualified healthcare professional recording vital signs (including height and weight).
  - 2.1.3. A Snellen eye test shall be performed.
  - 2.1.4. A physical examination (as indicated by the patient's gender, age, and risk factors) performed by a physician, physician assistant, or nurse practitioner.
  - 2.1.5. Pregnancy test for all females.
  - 2.1.6. Opt-out testing for communicable diseases, including HIV, hepatitis C, syphilis, gonorrhea, and chlamydia, shall be offered. Additional labs shall be ordered by the practitioner, as clinically appropriate.
    - 2.1.6.1. All newly arriving patients shall be offered screening for the hepatitis C virus (HCV) within one month of their arrival.
  - 2.1.7. When clinically indicated, a pelvic exam, or referral for a pelvic exam, with or without cervical cancer screening.
  - 2.1.8. Assessment of current medication assisted treatment (MAT) program participation.
  - 2.1.9. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider.
  - 2.1.10. Specific problems, including pertinent medical history, are integrated into an initial problem list and shall be maintained in accordance with P-F-01.01.

2.1.10.1. The problem list must be accurate and complete with resolved or historical conditions or diagnoses kept separate from current conditions.
2.1.10.2. The problem list shall include the date of onset or resolution of a resolved or historical condition or diagnosis if known.
2.1.10.3. Ensure similar or identical diagnoses of current conditions are listed only once.
2.1.10.4. Where a previous incarceration exists, problem lists from those prior incarcerations shall be reviewed and updated.

2.1.11. Diagnostic and therapeutic plans for each problem are developed as clinically indicated, including scheduling of the next clinical encounter within a time frame that is clinically appropriate.

2.1.12. All assessment findings shall be documented in the patient's health record.

3.0. Patients with a high degree of medical complexity shall be assigned to a physician, as opposed to an APP, during the Intake Health Assessment and this assignment shall be documented in the patient's health record.

4.0. The CHP responsible physician reviews the required components of the initial health assessment to determine the effectiveness of this process.

5.0. Dental – Intake Initial Oral Screening

5.1. All new arrivals shall receive an oral screening with results documented in the patient's health record.

5.1.1. The oral screening includes visual observation of the head and neck as well as the hard and soft tissues of the oral cavity including a cancer screening, noting the presence and condition of the prosthetic appliance(s) and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

5.1.2. If during oral screening the patient is found to have an urgent dental need, the patient will be referred to the dentist for further evaluation and/or treatment.

5.2. Oral hygiene instructions are to be given along with orientation materials.

5.3. Within seven days of admission to ADCRR, new arrivals including parole violators, shall receive a Panorex x-ray in addition to any other radiographs needed and a dental screening by a dentist or qualified health care staff trained by the dentist.

5.3.1. If x-rays and/or screening are refused, a Refusal to Submit to Treatment, Form 1101-4, shall be completed and documented in the dental chart.

5.4. Comprehensive Oral Examinations are completed on all newly arriving patients within 30 days in accordance with the MDSTM P-E-06.01, Oral Care and the Clinical Practice Guidelines, Oral Examinations.

5.5. Process Specific to Arizona State Prison Complex (ASPC) Perryville

5.5.1. ASPC Perryville will complete the intake screening within 7 days of admission unless, under the discretion of the provider, if time allows for the intake screening and the Comprehensive Dental Examination to take place together at the same appointment time within 7 days of admission into ADCRR.

5.5.1.1. In this case, all requirements of both the intake screening and the 30 day comprehensive oral exam must be met.

5.5.2. If time is limited, the Preliminary Dental Screening (intake screening) will occur within 7 days of admission into ADCRR and the Comprehensive Dental Examination is to be completed within 30 days of admission into ADCRR.

	Medical and Dental Services Technical Manual
	REFERENCES: MHTM Chapter 3, Sec.1.0, Initial Mental Health Assessment NCCHC Standard P-E-05, Mental Health Screening and Evaluation NCCHC Standard O-E-03, Mental Health Screening and Evaluation
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-05.01 Mental Health Screening and Evaluation

PURPOSE: To ensure that all incarcerated individuals upon their arrival to ADCRR have an initial mental health assessment completed 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. Patients who screen positive for mental health problems are referred for further evaluation.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-E-07.01, Non-emergency Health Care Requests and Services NCCHC Standard P-E-06, Oral Care
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-06.01 Oral Care

PURPOSE: To ensure each patient is afforded a standard of dental care similar to that of the community at large and appropriate dental health standards and practices are maintained for all patients according to current American Dental Association guidelines and the Arizona State Board of Dental Examiner requirements.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) dental providers are responsible for completing a Comprehensive Oral Examination to determine individual dental care needs and to provide quality oral healthcare to incarcerated patients for emergent, specialty, and ongoing dental needs.

PROCEDURES:

1.0. Within 30 days of admission to ADCRR, all patients (including parole violators) will receive a Comprehensive Oral Examination (COE).

2.0. The COE includes:
- 2.1. Clinically adequate and diagnostic Full Mouth Series radiographs (FMX) is required. An FMX shall be retaken every 3-5 years.
- 2.2. Radiographs shall be labeled with the Inmate's Name, ADCRR number, Date of Birth, Date, Name of Doctor, and Facility where taken.
- 2.3. An examination of the head and neck as well as the hard and soft tissues of the oral cavity with a mouth mirror, explorer, and adequate illumination, which includes at least:
- 2.4. Cancer screening.
- 2.5. Charting of missing and existing teeth, restorations, dental caries, oral conditions, and pathology.
- 2.6. A Comprehensive Periodontal Examination (including full mouth probings) is required. Do not complete a Periodontal Screening and Recording (PSR).
- 2.7. Formulation and documentation of a dental treatment plan. The patient is to sign and date the Dental Treatment Plan form.
- 2.8. Complete the Dental Chart and Dental Treatment Plan Form
- 2.9. Provide Oral Hygiene Instructions and review and demonstrate brushing and flossing. Document as completed on the Dental Treatment plan form and in electronic health record as well.
- 2.10. Complete the Routine Prophylaxis, Full Mouth Debridement, or begin Scaling and Root Planing (SRP).
  - 2.10.1. If the patient requires remaining Scaling and Root Planing, the patient shall be scheduled for a follow up appointments to complete treatment.
- 2.11. Any additional treatment can be completed at this visit. Completing as much treatment as possible is highly encouraged at all visits.
- 2.12. Fluoride is to be provided at the end of the cleaning procedure such as Routine Prophylaxis, Full Mouth Debridement, or at the end of the final Scaling and Root Planing visit.

2.13. Dental providers and/or dental staff members are to educate and advise patients on the recommended schedule of Periodic Oral Exams (POE) and Routine Prophylaxis.
  2.13.1. Patients are qualified for Routine Prophylaxis and POE yearly.
  2.13.2. Patients identified with periodontal disease shall receive periodontal maintenance every six months and an annual POE.
  2.13.3. Periodontal Maintenance treatment will occur during the same visit as the POE.

2.14. If the patient refuses an initial COE or radiographs, a Refusal to Submit to Treatment, Form 1101-4, or approved electronic equivalent is to be completed and documented in the electronic health record.

3.0. Dental staff shall advise patients they may request dental care for routine dental needs by submitting a Health Needs Request (HNR), Form 1101-10ES or an approved electronic equivalent, in accordance with the process outlined in the Medical and Dental Services Technical Manual (MDSTM) P-E-07.01, Non-Emergency Health Care Requests and Services.

4.0. A patient who presents with an emergent dental need or submits an HNR with an urgent dental complaint is seen the same day on by dental staff.

4.1. If dental staff are not available, the patient will be seen by qualified CHP health staff and shall be referred to and seen in person immediately by a dentist for any complaint of pain or infection.
  4.1.1. A dental urgent notification list must be established by the CHP for the times a dentist is not available after hours.

4.2. Since dentists are not present on weekends or holidays, the patient may be seen by a nurse or medical provider for an emergent or urgent need and referred to the next soonest dental line.

4.3. If an onsite dentist is not present during regular clinic hours, the patient will be transported to the closest site with a dentist present.

5.0. Patients requesting a routine dental visit through the non-urgent/non-emergent care process shall be seen and completed by a dentist within 90 days of receiving the request.

5.1. Patients on the routine care list will not be removed from the list if they are seen for emergent/urgent pain appointments that do not resolve their routine care issues or needs.

6.0. Any patient who experiences a medical emergency during dental treatment should have medical clearance prior to the continuation of routine dental treatment.

7.0. For those undergoing continuation of dental treatment such as root canal therapy, prosthetics, serial extractions, scaling and root planing, and periodontal re-evaluation or any follow-ups, scheduling for continuation of treatment shall be initiated by the dentist.

7.1. Patients submission of an HNR is not necessary for follow-up care.

8.0. Newly arriving patients with orthodontic appliances in place will be referred to the dentist for further evaluation to ensure treatment is not interrupted or changed in accordance with Clinical Practice Guideline, Orthodontic Treatment.

9.0. All dental treatment including The Tooth Chart, Dental Treatment Plan, Form 1101-1, and other pertinent and appropriate documentation shall be made in the patient's health record.

P-E-06.02 Dental Classification System

PURPOSE: To provide a standard classification system for the prioritization of dental treatment provided to patients.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) at each facility will be responsible for compliance with the requirements of this procedure.

PROCEDURES:

1.0. **Emergent Care** – A dental emergent condition includes any dental condition for which evaluation and treatment are immediately necessary to prevent death, severe, or permanent disability. Patients requiring treatment for a dental emergency shall be seen immediately. Examples include, but are not limited to:
- 1.1. Postoperative uncontrolled bleeding.
- 1.2. Facial swelling that is of a life-threatening nature or is causing facial deformity.
- 1.3. Fracture or the mandible, maxilla, or zygomatic arch.
- 1.4. Avulsed dentition.
- 1.5. An extremely painful condition that is non-responsive to the implementation of dental treatment guidelines.
- 1.6. Intraoral lacerations that require suturing.
- 1.7. Conditions causing loss of airway.
- 1.8. Closed-lock or dislocation of TMJ.
- 1.9. Rapidly spreading oral infection such as Ludwig's Angina.
- 1.10. Uncontrolled or spontaneous severe bleeding of the mouth.

2.0. **Urgent Care** – A dental condition of sudden onset or in severe pain, which prevents the patient from carrying out essential activities of daily living. Patients with urgent dental conditions shall be seen for a face-to-face encounter by a Registered Nurse (RN) on the same day that the Health Needs Request (HNR), Form 1101-10ES, or approved electronic equivalent is received. The patient will then be referred to and seen by a dentist on the same day. If a dentist is not on-site, the patient will be seen by a medical provider for pain control, etc. The patient will then be seen at the next soonest dental line. Examples include, but not limited to:
- 2.1. Fractured dentition with pulp exposure.
- 2.2. Acute dental abscess.
- 2.3. Oral pathological condition that may severely compromise the general health of the patient.
- 2.4. Acute Necrotizing Ulcerative Gingivitis.
- 2.5. Pain, swelling, or bleeding that is likely to remain acute or worsen without intervention.

3.0. **Routine Care** - Conditions that require treatment to restore the form and function of an inmate's oral tissue: Some conditions are to be seen within 90 days of HNR submission; other conditions are to be scheduled as follow up care to complete or initiate treatment.
- 3.1. Caries
- 3.2. Mild to Severe Gingivitis
- 3.3. Mild to Severe/Advanced Periodontitis
- 3.4. Routine Prophylaxis
- 3.5. Full Mouth Debridement

3.6. Scaling and Root Planing (SRP)
3.7. Periodic Comprehensive Oral Examinations
3.8. Periodontal Maintenance
3.9. Periodontal Re-evaluations
3.10. Non-restorable teeth
3.11. Edentulous and partially edentulous patients requiring replacements
    3.11.1. For the standard criteria for the provision of prostheses refer to the Clinical Practice Guidelines Manual.
3.12. Broken or non-functional prosthetic appliance if the patient qualifies
    3.12.1. For the standard criteria for the provision of prostheses refer to the Clinical Practice Guidelines Manual.
3.13. Endodontics
    3.13.1. For the standard criteria for the provision of Endodontic Therapy refer to the Clinical Practice Guidelines Manual.
3.14. Fluoride treatments:
    3.14.1. Each patient has access to the preventive benefits of Fluoride in a form determined by the dentist.
    3.14.2. Fluoride shall be provided at the end of each cleaning procedure such as a Routine Prophylaxis or Full Mouth Debridement or at the end of the final Scaling and Root Planing visit.
3.15. Ridge Augmentations, Vestibular extensions
3.16. Stainless Steel Crowns
3.17. Gingival recession/root sensitivity
3.18. Broken prosthetic appliance that remains functional
3.19. TMJ disorders

4.0. **Exempt Conditions**
4.1. Fixed prosthodontics (including crowns and bridges; cast crowns, all porcelain crowns, porcelain fused to metal crowns).
4.2. Pins or post retained core build-up
4.3. Crown lengthening
4.4. Orthodontics
4.5. Removal of asymptomatic third molars or impactions without pathology
4.6. Treatment for cosmetic defects
4.7. Mucogingival surgery, periodontal grafts
4.8. Implants
4.9. Teeth whitening/bleaching

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care MDSTM P-E-06.01, Oral Care MDSTM P-E-08.01, Nursing Assessment Protocols and Procedures MDSTM P-G-05.02, Appointment or Treatment Refusal NCCHC Standard P-E-07, Nonemergency Healthcare Requests and Services NCCHC Standard O-E-06, Routine Health Care Services
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P-E-07.01 Non-Emergency Healthcare Requests and Services

PURPOSE: To ensure all patients have the opportunity to request healthcare services daily and are 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) to maintain the system and flow of patient's requests for health services. This includes maintaining a system of electronic or written patient self-scheduling of appointments as well as collecting, triaging, distributing, and scheduling appointments requested by written or electronic Health Needs Request (HNR), Form 1101-10ES. The CHP is also responsible for ensuring timeliness of responses to HNRs is sufficient to meet the health needs of the patient population.

PROCEDURES:

1.0. Access to Non-Urgent/Non-Emergent Care

- 1.1. Self-scheduling - Patients shall have the ability to indicate their need to be seen for a medical clinic appointment at the next available clinic by one of the following mechanisms, depending on their living situation, freedom of movement, and access to electronics:
  - 1.1.1. Signing up for an appointment date on an electronic list via tablet or kiosk;
  - 1.1.2. Informing the nurse who conducts daily (or more frequent) welfare checks on that unit;
  - 1.1.3. Health Needs Request (HNR), Form 1101-10ES, to be used in the event of temporary nonfunctioning of the electronic system.
- 1.2. If the self-scheduling process is not available at the patient's housing unit, an HNR form or approved electronic equivalent shall be submitted by the patient to request a visit for non-urgent health care needs.
- 1.3. Patients shall utilize the above process and procedure to access non-urgent care and should be reminded to notify a staff member of an urgent or emergent need.
  - 1.3.1. A reminder or alert shall be incorporated into the request for non-urgent care, whether paper or electronic, that redirects patients to the correct process for requesting urgent or emergent care.
- 1.4. Patients will utilize the HNR process either electronically or by submitting the paper form for all dental health care needs.
- 1.5. Patients who are designated as MH-3 or above shall request mental health care via the HNR process, as outlined in the Mental Health Technical Manual (MHTM).
- 1.6. Patients who are designated as MH-1 or MH-2 shall request mental health care through the process for seeking medical care.

1.6.1. These patients shall be directed to a medical provider, ideally the PCP if available, to evaluate for organic or medical causes to reported symptoms prior to being referred to a qualified mental health professional or they may be referred to the medical professional and mental health professional simultaneously.

1.6.1.1. Patients may be referred to the medical provider before being referred to a qualified mental health professional or they may be referred to the medical professional and mental health professional simultaneously.

1.7. Patients are encouraged to submit Health Needs Requests (HNR), Form 1101-10ES, for administrative requests that do not require a clinical encounter or a clinical judgment.

1.7.1. If the CHP triaging nurse is able to acquire or provide the information necessary to meet the patient's needs (e.g., medications update, blanket, diet comment, review of lab/x-ray report, or requesting only information), the appropriate response shall be provided without the need to make an appointment.

1.7.2. The following items may be addressed by appropriate health staff without a visit with a provider;

1.7.2.1. Inquiry about the date of an appointment

1.7.2.2. Immunization request, per provider order

1.7.2.3. Eyeglasses request for replacement, or to schedule a non-urgent request with an optometrist.

1.7.2.4. Dental cleaning

1.7.2.5. If asymptomatic, STD testing request

1.7.2.6. Medication time change (i.e., am to pm)

1.7.2.7. Medication refills for non-expired medications

1.7.2.8. Request to view health records

1.7.2.9. Evaluation for extension of extra items (i.e., low bunk slip, meals in the housing unit, etc.) based on clinical necessity if the patient is not due for a provider visit

1.7.2.10. Patient education sheets

1.7.2.11. Mental health materials (i.e., workbook pages, in-cell activities, etc.)

2.0. Non-Emergency HNR

2.1. Form Availability and Utilization

2.1.1. Security is responsible for maintaining a supply of the paper HNR, Form 1101-10ES, and assuring that every patient in all housing areas, including lockdowns, has access to the forms, either in written or electronic format.

2.1.2. Completed paper HNRs are deposited in the appropriately labeled box, and collected by CHP staff daily.

2.1.2.1. Security, in consultation with CHP, will ensure that appropriate weatherproof 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 ensure medical confidentiality. There shall be coordination with the complex Warden, to ensure that an HNR "Drop Box" is available.

2.1.3. HNRs should be handled as confidential correspondence between CHP staff and the patient. Security staff are not authorized to access or read completed HNRs.

2.2. Collection, Sorting, and Triage of HNRs

2.2.1. Daily, seven days per week, CHP health staff will pick up the paper HNRs from the collection boxes in the open yards and monitor patients in a "Lock-down/lockup" status to ensure that access to health care is not obstructed.

2.2.2. CHP staff will access the HNRs submitted electronically daily through the inmate tablet program.

2.2.3. The date and time the HNR was collected will be indicated on the top right corner of the form.

2.2.3.1. Electronically submitted forms are automatically time-stamped.

2.2.4. On the same day the HNR form is received either paper or electronic, nursing staff shall sort and triage the HNRs to determine the proper discipline.
2.2.4.1. Following the collection of all of the HNRs nursing will sort them into disciplines, such as dental, mental health, nursing, provider, and administrative request.
2.2.4.2. CHP Registered Nurses (RN) with training in the HNR process shall be assigned to triage medical and dental requests.
2.2.4.3. The Primary Therapist or designee shall be assigned to triage all mental health and psychiatry requests.
2.2.4.4. The Patient-Centered Care Model shall be implemented, with the incorporation of daily team huddles including, but not limited to, the primary care provider or designee, nurse, and mental health. Security should only be involved to the extent needed for transport, movement, planning. The purpose of the huddle is to review the clinical delivery of care and to determine assignments of the clinical visit, as determined by the primary care provider or designee.
2.2.4.4.1. Initial care for non-urgent/non-emergent medical needs requested by the patient shall be completed by the patient's primary medical care provider on a specific date if one was specified by the patient or at a reasonable and clinically appropriate time.
2.2.4.4.2. The CHP RN may provide initial care, under the direction of a provider when clinically appropriate for a limited number of conditions. After review and approval by a provider, the care provided by an RN shall be for a limited number of conditions that are simple, rarely serious, rarely confused with serious conditions, and appropriately treatable with self-care and/or over-the-counter medications. See the Medical and Dental Services Technical Manual (MDSTM) P-E-08.01, Nursing Assessment Protocols and Procedures for additional information.
2.2.4.4.3. Non-emergency dental requests shall be provided by the dentist or designee within 24 hours of the face-to-face encounter by the RN.
2.2.4.4.4. Non-emergency mental health requests shall be triaged and addressed by the Primary Therapist or designee within 24 hours of receipt.
2.2.4.5. Patients shall report *urgent* or *emergent* conditions to a staff member immediately. However, when a HNR is received that documents or indicates a patient may be suffering from an *urgent* or *emergent* medical, mental health, or dental condition, those patients shall be seen immediately for a face-to-face evaluation.
2.2.4.5.1. The CHP RN will immediately initiate a referral to the appropriate discipline if clinically indicated.
2.2.4.5.2. The RN is the initial point of contact in an urgent/emergent scenario.
2.2.4.5.2.1. A RN shall triage the patient immediately, either by seeing the patient, or talking to the patient directly over the phone.
2.2.4.5.2.2. Based on the triage results, the RN shall discuss the patient with a medical practitioner (i.e., physician, nurse practitioner, or physician assistant) or mental health professional in a clinically appropriate timeframe, not to exceed four hours. In this context, the mental health professional shall be a psych associate, psychologist, or psychiatric prescriber.

2.3. Documentation of HNRs
2.3.1. Documentation of all HNR responses or visits pertaining to HNR submissions shall be entered into the patient's health record by a qualified healthcare professional.
2.3.2. Patients shall have access to a dated copy of their electronic HNR submissions and responses.
2.3.3. Electronically submitted HNR documentation shall be exported from the HNR tablet program and entered into the electronic health record.

3.0. Healthcare Requests

3.1. CHP nursing staff shall confirm the self-scheduling of a patient visit face-to-face at the patient's housing unit, within 24 hours of a patient signing up for their visit.

3.2. If the self-scheduling module is temporarily non-functional, patients shall be seen as clinically indicated within 24 hours of receipt of an HNR. For medical complaints, the provider shall triage the HNR and determine who sees the patient and the timing of the visit as outlined above.

3.3. A face-to-face encounter for a health care request (medical, mental health, or dental) made by a patient shall be conducted in a clinical setting.

3.3.1. A health care request may include non-urgent requests for a face-to-face visit with a medical provider, mental health provider, or dentist.

3.3.1.1. Requests for dental cleaning qualify as healthcare requests if the patient has a clinical complaint.

3.3.2. Face-to-face medical and dental encounters, including telehealth visits, require that vital signs be obtained and documented in the health record.

3.3.2.1. Vital signs include temperature, blood pressure, pulse, respirations, pulse oximetry, and current weight.

3.4. Urgent Care

3.4.1. Any patient with an urgent need shall be triaged by the RN immediately and have the triage results discussed with a medical practitioner (i.e., physician, nurse practitioner, physician assistant) or mental health professional (i.e., psych associate, psychologist, or psychiatrist) in a clinically appropriate timeframe not to exceed four hours.

3.4.2. Immediate nurse referrals to a medical or mental health provider shall be seen by a provider, or discussed with a provider, as clinically appropriate, and treated the same day. Any further evaluation and treatment will be scheduled if necessary in a clinically appropriate timeframe.

3.4.2.1. If a patient requests an urgent care visit, but it is determined that the healthcare need is not urgent and that a reasonable patient would not have considered the healthcare need to be urgent, treatment may be deferred and the patient shall be instructed to access non-urgent/non-emergent care for treatment.

3.4.3. Further information regarding urgent and emergent dental nee ds may be found in the MDSTM P-E-06.01, Oral Care.

3.5. Scheduling and Recording of Routine Appointments

3.5.1. All appointments shall be scheduled using the electronic health record appointment system where applicable.

3.5.1.1. Information required shall include the following:

3.5.1.1.1. Time the appointment was entered

3.5.1.1.2. Date and time of scheduled appointment

3.5.1.1.3. The appointment location

3.5.1.1.4. The appointing discipline (e.g., nurse, provider, lab, mental health)

3.5.1.1.5. The reason for the appointment

3.5.2. Nurses' visits for initial care of non-urgent/non-emergent clinical complaints shall occur as directed by a physician or advanced practice provider.

3.5.2.1. If the nurse is directed by a physician or advanced practice provider to see a patient for initial care of a clinical complaint, then this should be annotated in the progress note.

3.5.3. Routine appointments scheduled to be seen by a nurse 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.

4.0. Patient Centered Care Model

4.1. Initial patient care shall be provided by the PCP, or another health professional as directed by a physician or advanced practice provider, as clinically appropriate.

4.1.1. The initial care provider shall be the patient's primary care medical provider unless that provider is not on the premises nor conducting telehealth visits at the time.

4.1.2. If the initial patient care is not conducted by the patient's primary care medical provider, then this shall be annotated in the progress note.

4.2. A daily huddle shall take place with the CHP nurse and provider for the assigned the patient panel, and include mental health staff if needed.

4.2.1. Daily huddles are 15-20 minute sessions, in which the entire care team prepares together for the day. These huddles shall focus on a discussion of overnight events involving patients on the panel, consolidation of appointments, reassigning patients to the most appropriate staff. Additionally, structured discussion topics may include the following:

4.2.1.1. Which patients are coming in today and how can we be best prepared for their visits?

4.2.1.2. Are there lab results to gather?

4.2.1.3. Are there ER/hospital reports?

4.2.1.4. Who refused or missed medications or appointments yesterday?

4.2.1.5. Who went off-site for care since yesterday's clinic?

4.2.1.6. Who came back from off-site care?

4.2.1.7. Which patients are new to our clinic? What patients are leaving?

4.2.1.8. Which of us have time off scheduled?

4.2.1.9. Who has something to share or celebrate?

4.2.2. Preparation for daily huddles shall include:

4.2.2.1. Combining any duplicate appointments for the same patient.

4.2.2.2. Identification of any additional patient care issues such as medication refusals, medications that need to be refilled, status of consults, etc.

4.2.2.3. Coordination with other disciplines to maximize staff efficiency and minimize bottlenecks in the delivery of clinical services.

4.3. Close collaboration shall take place between the CHP nurse and provider during the workday, to ensure that patients are seen by the QHCP with the appropriate level of licensure for the patient's clinical status.

4.4. For chronic conditions, a team-based approach shall occur between the CHP nurse and PCP.

4.4.1. Nursing responsibilities may include:

4.4.1.1. Identification of any medications that will expire before the next chronic care visit

4.4.1.2. Determination of preventive care measures that are due, including immunizations and cancer screening tests

4.4.1.3. Providing patient education about their medical condition

4.4.1.4. Ensuring that diagnostic testing and follow up visits are ordered based on the CHP provider's plan

4.4.2. Provider responsibilities include

4.4.2.1. Changing medication therapy, as indicated

4.4.2.2. Renewing medications that will expire prior to the next chronic care visit

4.4.2.3. Reviewing diagnostic test results with the patient

4.4.2.4. Ordering follow up diagnostic testing

4.4.2.4.1. This may be done by nursing for stable chronic care patients where a protocol is in place.

4.4.2.5. Ordering follow up visits

4.4.2.5.1. This may be done by nursing for stable chronic care patients where a protocol is in place.

5.0. Patient Refusal

5.1. If on the scheduled appointment day, the patient refuses to go to the appointment or refuses to be seen, an informed refusal will take place as listed below.

5.1.1. Patient-initiated. Cancellation of a patient-initiated visit has fewer requirements as it carries a lower risk: Must be done by the patient themselves via phone, video, in-person, or tablet, and can be done by any healthcare staff.

5.1.2. Provider-initiated. Refusal of a provider-initiated visit requires the following: Must be informed, conducted via phone, video, or in-person, and, must be done by an RN or provider.

5.1.3. Off-site health visits. All refusals of off-site health visits are made by telephone, video, or face-to-face with an RN or higher at the time of the appointment. If a patient will not voluntarily displace, healthcare staff shall go to the prisoner's location.

5.1.4. The patient will sign the Refusal to Submit to Treatment (Form 1101-4) or approved electronic equivalent in accordance with the MDSTM P-G-05.02, Appointment or Treatment Refusal.

6.0. Missed Appointments

6.1. If the CHP personnel are unable to see all of the patients on a day's appointment list, which should be a rare event due to an emergency situation. Any patient that was not seen shall be noted as incomplete, and be rescheduled (with input from the PCP) and seen as early as possible at the next available appointment time. Patients shall be seen in a clinically appropriate timeframe.

6.2. If security is unable to release the patient from the housing area or escort the patient, as previously scheduled, CHP staff shall make immediate notification to the Warden or designee.

6.2.1. If after notification, health services is still unable to see the patient due to an inability to transport, an Information Report, Form 105-2, shall be written and sent to the Deputy Warden of the respective yard.

6.3. If appointments with qualified healthcare professionals are canceled for security reasons, then the PCP or designated alternative provider, will immediately review all the scheduled visits. 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) that day.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-E-08, Nursing Assessment Protocols and Procedures NCCHC Standard O-E-08, Nursing Assessment Protocols
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-08.01 Nursing Assessment Protocols and Procedures

PURPOSE: To provide the Contract Healthcare Provider (CHP) nursing staff with protocols and procedures based on the nursing statutes and regulations to deliver quality nursing care within their scope of practice.

RESPONSIBILITY: It is the responsibility of the CHP to ensure that all nurses are trained and competent in the use of nursing Emergency Response Orders (EROs) and Nursing Assessment Protocols (NAPs).

PROCEDURES:

1.0. All health units will have the EROs and NAPs manual available to all nursing staff.
- 1.1. Original manual or electronic equivalent shall be kept in the CHP Facility Health Administrator's (FHA) office.

2.0. The NAPs provide the nurse a step-by-step guideline in the management and treatment of a patient's condition, which may include recommended over-the-counter medications.
- 2.1. NAPs include protocols for assessment to be used by RN while treating the patient or to report findings to a practitioner.
  - 2.1.1. The RN may provide initial care for a limited number of conditions that are simple, rarely serious, rarely confused with serious conditions, and appropriately treatable with self-care and/or over-the-counter medications under the direction of the provider when clinically appropriate, provided that the RN operates under clinically appropriate protocols and/or provider orders.

3.0. The Emergency Response Orders (EROs) are step-by-step written instructions from the practitioner to advise the nurse of protocols to use while providing emergency acute care to a patient during a life-threatening event.
- 3.1. The ERO assists the nurse with nursing assessment or triage to stabilize the patient until Emergency Medical Services (EMS) have arrived on the scene and/or the 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.
- 3.4. All nurses must document the use of EROs in the patient's health record.
  - 3.4.1. If an electronic copy of the ERO is not available during the care delivery, then a paper copy of the ERO should be utilized and shall be timely scanned into the patient's electronic health record.

4.0. When new or revised EROs or NAPs are introduced, it is the responsibility of the CHP to introduce them and evaluate competency.

5.0. The content of the EROs or NAPs shall be reviewed, updated as necessary, and approved annually by the ADCRR Medical Director or designee, the CHP Regional Medical Director or designee, and the CHP Regional Nursing Director or designee.

5.1. For facilities without electronic EROs or NAPs a binder of the approved protocols shall be maintained by the FHA, kept in the FHA's office, and reflect an annual review and include an updated signature sheet.

6.0. Training requirements of EROs and NAPs:

6.1. CHP Director of Nursing (DON) and FHA are responsible for ensuring all nurses receive training upon hire and annually applicable to their scope of practice on EROs and NAPs.

6.2. Demonstration of skills, competency, and knowledge regarding EROs and NAPs shall be performed upon hire and annually by all nurses with documentation kept in the CHP employee's personnel file.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-A-01.01, Inmate Access to Healthcare MDSTM P-D-04.01, On-Site Diagnostic Laboratory Procedures MDSTM P-D-04.02, On-Site Diagnostic Radiological Imaging Procedure MDSTM P-D-08.01, Hospital and Specialty Care NCCHC Standard P-E-09, Continuity, Coordination, and Quality of Care During Incarceration NCCHC Standard O-E-09, Continuity and Coordination of Care During Incarceration
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 health care 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 health care to the patient 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 the Medical and Dental Services Technical Manual (MDSTM) P-A-01.01, Access to Healthcare.

2.0. Patients requiring regular follow-up shall be seen in clinically appropriate timeframes and services may be provided via telehealth medicine when clinically appropriate.

2.1. CHP health staff shall ensure the patient has a signed Consent for Telemedicine Services, Form 1101-8, or approved electronic equivalent in the patient's health record prior to being seen on telehealth.

3.0. Provider orders shall be implemented as stated in P-D-0-040.1, On Site Diagnostic Services.

4.0. If deviations from evidence-based practices are indicated, the practitioner shall document clinical justification for the alternative treatment plan in the patient's health record.

5.0. Diagnostic test results shall be reviewed by the practitioner in a clinically appropriate time frame as stated in MDSTM P-D-04.01, On-Site Diagnostic Laboratory Procedures and MDSTM P-D-04.02, On-Site Diagnostic Radiological Imaging Procedure.

6.0. Treatment plans shall be modified by the provider in the electronic health record as clinically indicated by the results of diagnostic tests and response to previous treatment.

7.0. Practitioners shall share treatment plans and test results with patients as appropriate and in a timely manner.

7.1. For specific diagnostic test results timeframes, refer to MDSTM P-D-04.01, On-Site Diagnostic Laboratory Procedures and P-D-04.02, On-Site Diagnostic Procedures.

8.0. Patients shall be seen by a qualified healthcare professional upon return from an urgent care or emergency department visit, hospitalization, or specialty care appointment and shall have recommendations from those visits reviewed for appropriateness, and acted upon in a timely manner in accordance with MDSTM P-D-08.01, Hospital and Specialty Care.

8.1. If the reviewing staff member does not follow the recommendations, then the reason should be documented in the patient's health record.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1001, Inmate Release Systems MDSTM P-F-04.02, Treatment of Substance Use Disorder MDSTM P-F-04.04, Medication Assisted Treatment (MAT) Program Pharmaceutical Operations MHTM Chapter 3, Section 16.0 Release Planning NCCHC Standard P-E-10, Discharge Planning NCCHC Standard O-E-10, Discharge Planning Mental Health Technical Manual (MHTM)
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-E-10.01 Discharge Planning/Transition to the Community

PURPOSE: To provide guidance in ways the Contract Healthcare Provider (CHP) staff can support patients as they approach the end of their incarceration.

RESPONSIBILITY: It is the responsibility of the CHP Discharge Planner and the CHP Facility Health Administrator (FHA) to ensure that all patients are provided support, planning, and assistance as their release becomes imminent.

PROCEDURE:

1.0. Department Order #1001, Inmate Release Systems provides guidance in the notification process for CHP release planning staff of the patient's upcoming release.

1.1. The CHP staff will review the patient's health record and provide release planning services including, but not limited to:

1.1.1. Arranging for necessary durable medical equipment, medication, and medication delivery supplies (e.g., insulin needles/syringes).

1.1.2. Coordinating transfer of health records with a patient's consent to a releasing patient's provider in the community to ensure continuity of care upon release.

1.1.2.1. Release planning may include housing, transportation, scheduling of community appointments, and in-reach services. This is not limited to patients in the MAT program and includes patients with medical and mental health continuity of care needs.

1.1.2.2. Records to include, at a minimum:

1.1.2.2.1. Problem list

1.1.2.2.2. List of active medications

1.1.2.2.3. Current symptoms

1.1.2.2.4. Functional impairments

1.1.2.2.5. Summary of relevant care provided during incarceration

1.1.2.2.6. Necessary care or follow-up care

1.1.2.2.7. Point of contact for the community provider to receive additional information if needed

1.1.2.2.8. For patients with a history of mental illness, the name and contact information of the patient's primary therapist, an aftercare plan that reflects progress in treatment, and a current treatment plan

1.1.2.2.8.1. All patient designated as MH-3 and above shall have release planning completed in accordance with MHTM Chapter 3, Section 15.0.

1.1.2.3. The CHP shall document in the patient's health record to whom and when the above information was provided.

1.1.3. Discharge planning from medication assisted treatment (MAT) program services care is provided for patients who are leaving the program in the correctional facility and includes arrangements for continuing treatment in the community.

1.1.3.1. For further guidance in patient education and discharge planning refer to the Medical and Dental Services Technical Manual (MDSTM) P-F-04.02, Treatment of Substance Use Disorder.

1.1.4. Assisting releasing patients undergoing ongoing or lifelong treatment such as dialysis with locating facilities in the community to continue care, including getting patients accepted, enrolled, and scheduled.

1.1.5. Assisting the patient in applying for Arizona Healthcare Cost Containment System (AHCCCS) applications.

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 admitted to the hospital at the time of release will be coordinated by the CHP Discharge/Release Planner, CHP Utilization Management or designee, and the treating hospital.

2.0. Release Medications:

2.1. A patient pending discharge from ADCRR custody shall have release medication orders sent to the CHP Pharmacy by a licensed healthcare professional at least one week prior (but no sooner than two weeks prior) to discharge for the medication to be filled by the CHP Pharmacy.

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

2.1.1.1. If the licensed healthcare professional needs clarification during reconciliation, they shall notify the provider.

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

2.2. The CHP staff shall provide patients releasing to the community a 30-day supply of all active medication, (including as-needed medication) pursuant to a new prescription, excluding MAT medications, as clinically appropriate as determined by the PCP.

2.2.1. Patients shall be provided medication for a sufficient length of time (in some cases, greater than 30 days) to allow the patient to attend an appointment with their community practitioner or to complete the course of therapy.

2.2.2. Prescriptions for release medications shall comply with all State and Federal laws and be accompanied by printed drug information sheets for all medications received.

2.2.3. Details regarding MAT program release medications, including the provision of naloxone may be found in MDSTM P-F-04.04, Medication Assisted Treatment (MAT) Program Pharmaceutical Operations.

2.2.4. Birth control pills may be prescribed and dispensed to female patients one month prior to release, with a supply that is sufficient to allow the patient time to obtain a new supply in the community.

2.2.5. To assist releasing patients in preparation 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 provider's written order.

2.3. Release medications shall be brown bagged and have chain of custody maintained by the signing of an acknowledgment sheet by the CHP staff and security.

2.4. 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.

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

2.4.2. Documentation of released medications in the electronic health record shall include the date and time of delivery, medication name, strength, and quantity and include the authorized signature of the individual issuing the release medication(s).

3.0. For additional information regarding mental health services release planning refer to the Mental Health Technical Manual (MHTM), Chapter 3, Section 16.0, Release Planning.

4.0. All aspects of discharge planning shall be documented in the patient's health record.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care MDSTM P-E-07.01, Non-Emergency Healthcare Requests and Services MHTM Chapter 3, Section 5 Levels of Mental Health Services Delivery NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-01.01 Medical Classification and Chronic Disease Management

PURPOSE: To provide criteria for the Contract Healthcare Provider (CHP) to use while assigning medical scores that correspond to the patient's health condition, inform housing of medical needs, identify patients receiving ongoing multidisciplinary care, and provide guidance in the management of chronic disease.

RESPONSIBILITY: It is the responsibility of the CHP practitioner to evaluate and assign an appropriate medical score corresponding to 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 (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 a 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 diseases include but are not limited to the following:

2.2.1. Blood Diseases including anticoagulant therapy

2.2.2. Cancer

2.2.3. Cardiac/Heart Disease (if hypertension, see 2.2.10)
2.2.4. Coccidioidomycosis (Valley Fever)
2.2.5. Diabetes Mellitus
2.2.6. End-stage Liver Disease (compensated or decompensated cirrhosis)
2.2.7. Hepatitis C (active infections)
2.2.8. HIV/AIDS
2.2.9. Hyperlipidemia
2.2.10. Hypertension
2.2.11. Hyperthyroidism and hypothyroidism
2.2.12. Inflammatory Bowel Disease
2.2.13. Untreated Latent Tuberculosis Infection
2.2.14. Neurological Disorders (Parkinson's, Multiple Sclerosis, Myasthenia Gravis)
2.2.15. Renal Diseases
2.2.16. Respiratory Disease (COPD, Asthma, Cystic Fibrosis)
2.2.17. Rheumatological Disorders (Lupus, Rheumatoid Arthritis)
2.2.18. Seizure Disorder
2.2.19. Sickle Cell Disease
2.2.20. Substance Use Disorder (SUD)
2.2.21. Patients who are on a medication for longer than 90 days with more than one renewal.

2.3. All patients with chronic conditions (including conditions not listed above) shall receive routine visits conducted by their assigned primary care provider or a nurse as specified in the patient's treatment plan at least every 90 days unless a documented reason exists for a longer timeframe to be implemented.
2.3.1. Patients shall be assigned to the caseload of a physician or an advanced practice practitioner (APP) in a clinically appropriate manner.
2.3.1.1. Patients with multiple or complex medical conditions who are "acutely complex" shall only be assigned to a physician caseload. Once they are stabilized, they can be transferred back to an APP caseload, as clinically appropriate.
2.3.2. For chronic conditions appointments, a team-based approach shall occur between the CHP nurse and primary care practitioner as outlined in the Medical and Dental Services Technical Manual (MDSTM) P-E-07.01, Non-Emergency Healthcare Requests and Services, in the section on the PCCM.

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.
2.4.1. The problem list included in the patient's health record shall be accurate, complete, and contain the date of onset or resolution of each condition with historical or resolved diagnoses kept separate from current conditions.
2.4.1.1. The problem list ideally should also allow for notation of prior diagnostic testing, monitoring that was done, or an ongoing treatment plan.
2.4.2. Similar or identical diagnoses of current conditions shall only be listed once.

3.0. Treatment Plans

3.1. The ADCRR Healthcare Services Division (HSD) has 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 preclude compliance with the treatment plan, the practitioner must clearly document the justification for deviation and outline the proposed treatment plan in the patient's health record.
3.1.1.1.1. The Practitioner shall submit the case for review to the Site Medical Director or designee prior to initiation of the proposed treatment plan.
3.1.2. A treatment plan shall be developed and documented in the health record by a PCP 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 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 providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:
    4.1.1. A relevant history and physical exam.
    4.1.2. The rationale of the assessment and which history, exam findings, or other relevant data led to that conclusion
    4.1.3. Documentation about what is being implemented above and beyond order entry.
    4.1.4. Determining the frequency of follow up for medical evaluation based on disease control
    4.1.5. 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
    4.1.6. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication)
    4.1.7. Documenting patient education (e.g. diet, exercise, medication)
    4.1.8. Clinically justifying any deviation from the protocol

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #108, Americans with Disabilities Act (ADA) Compliance Department Order #926, Management of Inmates with Disabilities Department Order #705, Inmate Transportation Department Order #909, Inmate Property MDSTM P-B-07.02 Americans With Disabilities Act (ADA) Accommodations MDSTM P-D-03.02 Clinical Space, Equipment, and Supplies NCCHC Standard P-F-01, Patients with Chronic Disease and Other Special Needs
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-01.02 Special Needs Management

PURPOSE: To ensure the removal of barriers to programs, services, and processes for patients with qualifying disabilities and to ensure reasonable accommodations are made. To provide guidance in the use of assistive devices 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 limitations of patients and to share pertinent information with correctional staff. It is the responsibility of the CHP to develop and monitor systems to support provisions of medically necessary supplies and devices.

PROCEDURES

1.0. Auxiliary Aids and Services

1.1. Please refer to the Medical and Dental Services Technical Manual (MDSTM) P-B-07.02, Americans with Disabilities ACT (ADA) Accommodations.

2.0. Special Needs Consideration and Orders

2.1. Patients identified with special needs will have their needs listed on an accurate, complete, and easily usable problem list maintained in the patient's health record.

2.2. To maintain patient safety, CHP staff shall consider the patient's health care needs in decisions regarding housing, work assignment, and programming.

2.2.1. These decisions should be made in a manner that is consistent with the requirement that the need for reasonable accommodations and the provision of reasonable accommodations be considered in all aspects of ADCRR programming, services, and activities.

2.3. Correctional and Classification staff shall be advised of a patient's special needs that may affect housing, work, and program assignments; disciplinary measures; and transfers via a Special Needs Order, Form 1101-60, or approved electronic equivalent that does not compromise the confidentiality of health information.

2.4. When alternative methods of restraint are clinically necessary, then collaboration shall occur between health staff and custody to ensure that the patient's condition is not at risk for worsening and to ensure that medically necessary care can be provided. For further guidance refer to Department Order #705, Inmate Transportation.

2.5. Patients with either a pacemaker or Implantable Cardioverter Defibrillator (ICD) will be provided with a Special Needs Order, Form 1101-60, or approved electronic equivalent indicating such:

2.5.1. Use of a hand-wand or other alternative to walking through a metal detector should be utilized if available.

2.5.2. The duration of this special needs order (SNO) can be written "for the duration" or "indefinite."

3.0. Medical Supplies, Orthotic Devices, and Aids (this list is not inclusive of all reasonable accommodations required by the ADA)

3.1. Patients shall be evaluated by a provider to determine if a medical device or aid is clinically necessary.

3.2. Security clearance for necessary medical property is completed in accordance with Department Order #909, Inmate Property.

3.3. Intravenous (IV) catheters: Patients with a temporary IV catheter, including a dialysis port and PICC lines, shall be housed in a Special Needs Unit (SNU) or Inpatient Component (IPC).

3.3.1. When permanent intravascular access is established then housing in a SNU or IPC is no longer required.

3.4. 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 an SNU or the IPC.

3.4.1. Oxygen concentrators are allowed for patients with as needed supplemental oxygen in any housing unit.

3.4.2. A continuous positive airway pressure (C-PAP) may be issued and utilized by patients in any housing unit.

3.5. Self-Catheterization and Colostomy: Patients shall be provided adequate medical and hygiene supplies to meet specific needs such as but not limited to self-catheterization or colostomy supplies, including the need for special housing, as ordered by the CHP practitioner.

3.6. 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.

3.6.1. Assistive medical devices issued for patients for long-term use shall be added to the patient's personal property.

3.6.2. Maintenance, repair, and replacement shall be timely completed as necessary by the CHP.

3.7. Prosthetics: Patients should have timely referrals to a specialist when clinically indicated.

3.8. Footwear: Patients with medical disorders, that may require special foot care, shall be scheduled with a CHP practitioner for evaluation of the medical problem.

3.8.1. Medical shoes as prescribed treatment shall be provided to patients with the following conditions:

3.8.1.1. 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.

3.8.1.2. Diagnosed peripheral vascular disease.

3.8.1.3. Patients with prescribed orthotic inserts that require tennis shoes or other accommodating footwear that cannot be appropriately utilized in a deck shoe.

3.8.2. A CHP practitioner order for specialty shoes must be supported in the progress notes including diagnosis and treatment plan according to the criteria above.

3.8.3. After authorization, the order for modified or specialty shoes will be implemented by the CHP Facility Health Administrator (FHA) or designee and sent to the appropriate purchasing agent.

3.8.4. Requests for specialty athletic shoes are not a medical issue and should not be scheduled for practitioner examination.

3.8.5. 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.

3.9. 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.

3.9.1. Eyeglasses become the patient's real property and are handled according to the procedure outlined by Department Order #909, Inmate Property.

3.9.2. Willful destruction or mistreatment of glasses will be responded to in accordance with Department guidance regarding the destruction of state provided or state owned property.

3.9.2.1. If glasses are broken through no willful fault of the patient, they should not be charged for replacement.

3.9.3. Eyeglass frames will be provided in accordance with the styles and materials described by the individual optician contract.
3.9.3.1. Patients may not choose different styles of frames beyond that offered by the optician.
3.9.4. Specialty optical aids, such as photo gray glasses, sunglasses, or contact lenses are not considered medically necessary unless ordered by an optometrist or ophthalmologist as part of a medical treatment plan or if approved by the CHP Regional Medical Director.

3.10. Hearing aids, based on the results of audiology testing.

3.11. Any medical or dental assistive device or aid to impairment is generally issued for a chronic problem, used long-term, and therefore becomes the personal property of the patient.
3.11.1. The CHP shall provide timely maintenance, including battery replacement, and/or repair of any approved assistive or orthotic device or aid.

3.12. Medical aids issued by the 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.

3.13. The following guidance is provided in consideration of bed wedges:
3.13.1. Bed wedges may be prescribed for documented, current, symptomatic congestive heart failure with orthopnea or severe symptomatic Chronic Obstructive Pulmonary Disease (COPD).
3.13.2. CHP practitioners will not prescribe a bed wedge via the SNO process or renew a SNO for a bed wedge for the treatment of GERD without the authorization of the CHP Regional Medical Director or designee.
3.13.3. 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.

3.14. Any prescribed therapeutic treatments with risk to the institution or patient safety (e.g. physical therapy or occupational therapy devices) shall be made available for use by the patient at their assigned health unit (i.e., the medical clinic where health services are delivered for a specific housing location).

3.15. 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.

P-F-01.03 Management of Transgender, Intersex, and Non-Binary Individuals

PURPOSE: To provide guidance in coordinating the needs of transgender, intersex, and non-binary inmates entering the ADCRR system.

RESPONSIBILITIES: It is the responsibility of the Contract Healthcare Provider (CHP) to identify, assess, monitor, and treat appropriately, incarcerated individuals who identify as transgender, intersex, or non-binary.

PROCEDURES

1.0. Patients identified at intake, during a clinical encounter, or those who request any form of consideration or accommodation for gender dysphoria (GD), shall be referred to mental health staff as outlined in the Mental Health Technical Manual (MHTM), Chapter 3, Section 12.0, Mental Health Service Delivery for Transgender, Intersex, and Gender Non-Conforming Individuals.

1.1. Patient's needs shall be addressed by a multi-disciplinary team (the Transgender Committee), defined in Department Order #810, Management of LGBTI Inmates.

1.1.1. The Transgender Committee shall convene and perform services in accordance with the procedures outlined in Department Order #810, Management of LGBTI Inmates.

2.0. Hormone Treatment

2.1. A patient who is receiving hormonal medication at the time of intake into ADCRR shall be continued on hormonal medications provided the following conditions are met:

2.1.1. The hormonal medication is part of an established treatment that has been prescribed under the supervision of a qualified prescriber.

2.1.2. CHP staff is able to obtain written records or other necessary documentation of the patient's previous treatment.

2.1.3. Hormone treatment shall be continued while awaiting outside records to avoid interruptions in treatment or until an on-site provider deems them medically necessary.

2.1.4. CHP staff determines that the hormones are medically necessary and not contraindicated.

2.1.5. Hormonal therapy shall be managed by the practitioner and outside consultation will be obtained when necessary.

2.2. A patient who is not receiving hormonal medication at the time of ADCRR intake shall receive treatment if clinically indicated.

3.0. Diagnosed GD

3.1. Patients diagnosed with GD shall have access to:

3.1.1. Appropriate psychiatric and psychological treatment in accordance with MHTM.

3.1.2. Hormonal treatment, as clinically indicated.

3.1.3. Other treatment and accommodations, determined to be appropriate or necessary.

3.2. Patients who have completed gender-affirming surgery prior to incarceration shall be housed in a correctional facility determined appropriate by the Transgender Committee.

4.0. Apparel and Hygiene Accommodations

4.1. ADCRR shall provide state-issued undergarments according to their gender identity, as requested by the individual.

4.2. Patients may order undergarments and other items from the commissary that correspond to their gender identity, in accordance with Department Order #810, Management of LGBTI Inmates.

	Medical and Dental 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: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-01.04 Hunger Strike and Clinical Support

PURPOSE: To outline the process and procedures to follow when an incarcerated individual refuses nutrition as a hunger strike.

RESPONSIBILITY: It is the responsibility of the ADCRR in conjunction with the Contract Healthcare Provider (CHP) to monitor the health and welfare of a patient engaged in the hunger strike and ensure legal and medical procedures are pursued to preserve the patient's right to autonomy.

PROCEDURES

1.0. Evaluation and Documentation:

1.1. According to Department Order #1101, Inmate Access to Healthcare, a patient is to be considered to be on a hunger strike when:

1.1.1. Patient communicates to staff that they are on a hunger strike, and/or have been observed by staff to be refraining from caloric intake for a period in excess of 72 hours.

1.1.1.1. For patients who are refusing food and water/liquids, the timeframe should be 24 hours.

1.1.2. When a patient is on a hunger strike, a notification will be sent 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.

1.1.2.1. Upon verification of a hunger strike, and after discussion with a PCP or other medical provider, the FHA or designee shall notify the Regional Medical Director or designee, ADCRR Assistant Director for Healthcare Services, ADCRR Medical Director or designee, and ADCRR Healthcare Coordinator.

1.2. Upon referral to CHP staff, the following initial assessment procedures shall be completed:

1.2.1. General physical exam by a practitioner within 24 hours for evaluation, including height, weight, and vital signs.

1.2.2. Patient education on the risks of fasting and refeeding syndrome.

1.2.3. Dipstick urinalysis.

1.2.4. Complete blood count and chemistry profile.

1.2.5. Serum pregnancy test on any patient with the capacity to become pregnant.

1.2.6. Psychiatric or psychological assessment by the primary therapist or prescribing psychiatric provider, if assigned. If not assigned or unavailable, then they shall be assessed by a licensed psych associate, psychologist, or psychiatric provider to determine the patient's capacity to make the decision to go on a hunger strike.

1.2.6.1. For patients found by mental health clinicians 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 housing needs and property limitations 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 meeting to discuss the patient (to include security operational staff and CHP mental health staff) shall be convened within 24 hours of notification to discuss the patient's purpose for the hunger strike.

2.1.1. Results of the meeting to discuss the patient shall be communicated in writing to the CHP Regional Medical Director and ADCRR Assistant Director for Healthcare 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, as clinically appropriate, and documented in the patient's health record.

2.3. Counseling of the patient should take place on the risks of a hunger strike, the health benefits of ending the hunger strike and accepting treatment, and the evaluation if it is possible to meet the desired wishes of the patient based on the reasons stated for the hunger strike.

2.4. Regularly scheduled meal delivery and an adequate supply of water should continue to take place.

2.5. Water intake is to be documented at least once every 24 hours.

2.5.1. Lab testing (e.g., urine specific gravity) may be utilized to assess a patient's hydration status.

2.5.2. If a patient is not drinking any water/liquids, closer monitoring shall occur.

2.6. Other medical procedures, including mental health assessments shall be repeated as clinically indicated, ideally by the same healthcare professionals for continuity of care.

2.7. The 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, the supervising physician or designee shall ensure the patient is sent to an acute care facility for observation and/or treatment.

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 for a sufficient period of time as determined by the practitioner.

4.1.1. Only a medical practitioner may order that a patient be released from a hunger strike evaluation and treatment.

4.1.2. The practitioner order must be documented in writing in the patient's health record.

4.1.3. The patient should be evaluated by a provider to determine if precautions need to be taken when reintroducing food to the patient.

	Medical and Dental Services Technical Manual
	REFERENCES: NCCHC Standard P-F-02, Infirmary-Level Care
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-02.01 Infirmary Operations

PURPOSE: To define the scope of care provided on-site to patients whose medical conditions warrant a higher level of care than can be provided in the general housing areas.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) is responsible for providing continuity of care and ongoing clinical support for patients' healthcare services within the designated facilities. Patient admission into the Infirmary and assigned level of care is the responsibility of the CHP IPC Medical Provider or designee and is based on the acuity and complexity of the patient's condition and the type of services and resources needed including medical, nursing, and mental health.

PROCEDURES:

1.0. General Infirmary Information
- 1.1. The following housing options are available to patients who require a higher level of care than general housing:
  - 1.1.1. Inpatient Component (IPC), which may also be referred to as the Infirmary.
  - 1.1.2. Sheltered housing status for patients who meet criteria for the Special Needs Unit (SNU) but are located in an IPC.
- 1.2. Overall bed management and movement in and out of the IPCs is a collaborative process between ADCRR and CHP Clinical Leadership.
- 1.3. Admission and discharge of IPC patients is performed by the CHP provider and is based on a patient's medical condition.
- 1.4. IPCs are NOT to be used for detention or other security purposes.

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. Registered Nurses (RN) will be responsible for supervising the activities of the nursing staff on the unit, which operates 24/7.
  - 2.1.2. Licensed Practical Nurses (LPN) may be assigned to augment the activities of the RNs.
    - 2.1.2.1. LPNs shall NOT be the supervising caregiver in an IPC.
  - 2.1.3. Other healthcare staff including but not limited to Certified Nursing Assistants (CNA), Medical Assistants (MA), and Emergency Medical Technicians (EMT) may be utilized to provide assistance with activities of daily living and routine care such as monitoring vital signs.
  - 2.1.4. Advanced practice providers may deliver care in the IPC under the supervision of a physician.
    - 2.1.4.1. However, level 1 patients shall receive care from a physician.

3.0. Admission/Discharge: An IPC admission note will be documented on every new admission to the IPC.
- 3.1. <u>Admissions from another complex, intake, general population, or mental health unit:</u>
  - 3.1.1. A provider shall place an order to transfer a patient to an IPC.

3.1.2. Communication shall take place between the sending and receiving facilities.
3.1.3. The request for patient movement shall be forwarded by CHP personnel at the sending facility to ADCRR Central Classification.
3.1.4. Clinic nurse tasks from sending facility:
3.1.4.1. Calls Infirmary to notify staff of pending admission and gives report to IPC RN.
3.1.4.1.1. Advises receiving facility RN of patient specific needs to ensure availability of medical equipment.
3.1.4.2. Notifies security to transport the patient to Infirmary, if applicable.
3.1.4.3. Forwards patient-specific medication (DOT and KOP), via a correctional officer, to the IPC in a secured bag.
3.1.4.4. Arranges for health records to be transferred to the receiving IPC by the sending facility, if applicable.
3.1.5. IPC nurse tasks from the receiving facility:
3.1.5.1. Admits patient to Infirmary Level 1 and carries out admission orders.
3.1.5.1.1. If there is no on-site medical provider, the RN 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 Infirmary medical provider or designee.
3.2.2. IPC medical provider or designee:
3.2.2.1. Completes reconciliation of medication between what was being given at the hospital, what was recommend upon discharge, and what the patient was on prior to going to the hospital to figure out what medications the patient should receive upon return to the facility.
3.2.2.2. Reviews hospital discharge summary to determine if the patient is appropriate for admission to Infirmary.
3.2.2.3. Reviews and reconciles all clinical recommendations made upon discharge.
3.2.2.4. Admits patient to Infirmary Level 1 and enters admission orders.
3.2.3. IPC nurse:
3.2.3.1. Obtains verbal report from sending hospital nurse.
3.2.3.2. When there is no on-site medical provider available, the nurse admits the patient to Infirmary Level 1 and carries out admission orders, through telephone or verbal order.
3.2.3.3. Notifies security and ADCRR Central Classification that the patient will be admitted to the Infirmary upon release from the hospital.

3.3. Discharge from an IPC
3.3.1. A discharge from an IPC requires a medical provider's order.
3.3.1.1. The medical provider will complete a discharge summary when the patient is discharged from the IPC.

4.0. Clinical Responsibilities:
4.1. CHP Medical Provider:
4.1.1. The IPC provider temporarily takes over the primary care of the patient for the duration of their stay in the IPC and any chronic conditions.
4.1.2. All medications need to be reviewed and managed appropriately while housed in the IPC in addition to any acute issues that resulted in the admission.
4.1.3. Care can be in consultation with the PCP as appropriate.
4.1.4. The medical provider shall collaborate on the creation of the care plan immediately upon a patient being admitted to the IPC.
4.1.5. On weekends/holidays after normal duty hours, the medical provider designated on the urgent notification roster will be called for orders when needed.

4.1.5.1. The medical provider will review and confirm the orders on the next business day.

4.1.6. Patients admitted to the IPC will have a history and physical completed by the medical provider within one (1) calendar day of admission, including weekends and holidays.

4.1.6.1. Patients admitted to the IPC and discharged < 1 calendar day after admission, must be seen by a provider prior to discharge. If it is after hours and a provider is not on-site, then the patient should not be discharged until they can be evaluated by a provider.

4.1.6.2. Ongoing care is provided based on the patient's acuity level (level 1, level 2, or level 3) and is assigned by the provider.

4.2. Infirmary RN:

4.2.1. Admission assessment is completed and documented immediately upon arrival of the patient but no greater than one (1) hour after arrival.

4.2.2. Ensures patient's inmate identification card is present.

4.2.3. Collects any keep-on-person (KOP) medications that may have arrived with the patient upon admission.

4.2.4. Ensures all DOT medications were sent with the patient.

4.2.5. Ensures infirmary staff educates patients on infirmary processes including expectations of clinical care, call light usage, bed controls, use of side rails, and documents all education provided in the patient's health record.

4.2.6. Verifies/obtains orders that include diagnosis, allergies, medications, diet, activity/restriction, diagnostics required, and special needs.

4.2.7. Ensures all medications are administered by direct observed therapy (DOT) or as ordered by the medical provider.

4.2.8. Completes clinically appropriate patient assessments at a frequency determined by the IPC level of care ordered by the CHP IPC Medical Provider.

4.3. At least daily, a supervising RN, as assigned by the Director of Nursing, ensures that care is being provided according to the medical provider order.

5.0. Level and Scope of Care in the IPC: The frequency of medical provider and nursing rounds for patients admitted to the infirmary are specified based on clinical acuity and the categories of care provided.

5.1. Infirmary-level 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. Patients admitted to the infirmary are always within sight or hearing of a facility staff member, and a qualified healthcare professional that can respond in a timely manner.

5.3. All IPC patients shall have a properly working call button or light upon admission.

5.3.1. All call lights or buttons shall be checked for functionality a minimum of once per month.

5.3.2. If call buttons or lights are not functional, CHP staff shall perform and document 30-minute patient welfare checks.

5.4. The level of care is ordered by the CHP IPC Medical Provider, is clinically appropriate, and is clearly documented in the patient's health record.

5.4.1. As the patient's clinical status changes, the level of care is updated by the IPC Medical Provider:

5.4.1.1. Level 1: (IPC status)

5.4.1.1.1. New admissions to the infirmary are Level 1 until evaluated by a practitioner.

5.4.1.1.2. Medical provider rounds daily, Monday through Friday (excluding holidays).

5.4.1.1.3. Nursing assessments every – shift (more frequently if ordered by the provider).

5.4.1.1.4. Vital Signs every – shift (more frequently if ordered by the provider).

5.4.1.2. Level 2: (IPC status)
5.4.1.2.1. Medical provider rounds once per week or more often, as clinically indicated.
5.4.1.2.2. Nursing assessment daily
5.4.1.2.3. Vital signs daily
5.4.1.3. Level 3: (Sheltered Housing status)
5.4.1.3.1. Medical Provider rounds once per month or more often, as clinically indicated.
5.4.1.3.2. Nursing assessments once per week
5.4.1.3.3. Vital signs once per week
5.4.1.3.4. Access to non-emergent healthcare services via a Health Needs Request (HNR) shall be made available.

6.0. Observation: Patients may not be placed in observation status in an IPC setting.

7.0. Sheltered Housing: Physical locations for infirmary level care may also be used to provide sheltered housing for a patient who is 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 month or more often, as clinically 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 shall receive appropriate MH services while admitted to an IPC.
8.2. Infirmary RN or provider notifies Infirmary-assigned MH staff of any admitted patient's MH service needs whenever necessary.
8.3. If the patient is on psychotropic medications at the time of admission to the Infirmary, the practitioner reviews orders and the health record to initiate new orders for psychiatric medications, as appropriate.
8.4. MH staff assigned to the infirmary shall conduct a MH assessment, schedule psychiatric evaluations as needed, and initiate appropriate interventions if the patient 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. Reason for infirmary admission, history of present illness, full physical exam, review of any studies/labs, review of meds, all the acute and chronic conditions, and an assessment and plan for each one.
9.1.2. Admission order with diagnosis, rationale for ordered infirmary level of care, treatment goals, and monitoring plan.
9.1.2.1. Admission orders shall include at a minimum: the level of care required, medication, diet, activity restrictions, diagnostic tests, and any necessary treatments.
9.1.2.2. All new medications and all old medications should be noted individually if they are to be continued or stopped while in IPC.
9.1.3. Resuscitation status.
9.1.4. Completed Durable Health Care Power of Attorney form 1101-97 or approved electronic equivalent to include contact information for the patient's Power of Attorney if applicable.
9.1.5. All face-to-face encounters shall be documented in the appropriate format in the patient's health record (e.g., S.O.A.P.E. notes, Nursing Assessment Protocols, Emergency Response Orders).
9.1.6. Electronic Medication Administration Record.
9.1.7. Discharge plan and discharge notes.

10.0. Weekly Interdisciplinary Meeting

10.1. A weekly interdisciplinary meeting, with documentation of meeting minutes, shall take place for all sites with an IPC that determines clinical treatment plans for each patient.

10.2. This is a very important function to ensure that patient-specific goals are identified and patients are being provided treatment based on these goals.

10.3. Some patients have an end-point of transitioning care to a SNU or back to general population. When these goals are met, then patients should be discharged to a lower level of care.

P-F-02.02 Special Needs Unit (SNU)

PURPOSE: To define the scope of medical, psychiatric, and nursing care provided on-site to patients whose medical conditions warrant a higher level of nursing care than can be provided in the general housing areas but do not warrant infirmary-level care.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to provide an appropriate level of care for patients with health-related issues that do not require infirmary-level care but have needs greater than what can be met in general housing units.

PROCEDURES:

1.0. Patients admitted to SNU housing may be those who are elderly, physically disabled, have dementia, and/or are developmentally disabled, but do not have acute health care needs requiring admission to an Inpatient Component (IPC).
- 1.1. The SNU provides care to patients with an illness or diagnosis that may require monitoring, medication administration, and/or therapy less frequently than in an IPC setting, or those patients who may require assistance with activities of daily living (ADL) or may require cueing for some activities.
  - 1.1.1. The SNU allows for the provision of care to patients whose health needs require a protective environment greater than what is available in the general population housing areas.

2.0. Admissions of patients into the SNU shall be coordinated through the complex Medical Director or designee of the facility where the SNU is located.
- 2.1. Admission and discharge of SNU patients is done under the order of a medical practitioner guided by the health/functional/physical needs criteria established by the Arizona Healthcare Cost Containment System (AHCCCS) for individuals to receive Elderly and Physically Disabled services as defined in Arizona Administrative Code R9-28-304, the Pre-Admission Screening Tool.
- 2.2. To determine a patient's need for a SNU admission, a functional assessment shall be performed and documented in the health record.
- 2.3. Upon admission the provider shall ensure the patient's health record reflects an updated problem list and medical score according to functional assessment criteria.

3.0. Clinical Requirements
- 3.1. Upon admission to the SNU, the provider takes over as the primary provider (unlike the IPC, it may be permanent) for the patient and therefore is responsible for all acute and chronic care issues that the patient has and each issue should have an assessment and plan in place that is tracked over time.
- 3.2. Practitioner rounds shall be completed once per month or more often, as indicated.
- 3.3. All new medications and all old medications should be noted individually if they are to be continued or stopped while in IPC.
- 3.4. Nursing staff shall be onsite at all times.

3.4.1. A weekly documented nursing assessment shall be performed.
3.4.1.1. All assessments shall include complete vital signs and weight with documentation.

4.0. 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.
4.1. A Registered Nurse (RN) shall be assigned to monitor the care provided in the unit 24/7.
4.2. A Licensed Practical Nurse may be assigned to provide the nursing care in the unit with an RN on-site for consultation when needed.
4.3. Certified Nursing Assistant may assist patient with personal care and ADLs as needed.
4.4. Mid-level practitioners may be assigned as the primary care provider to patients in the SNU unless a patient's clinical complexity warrants that a physician manage the patient.

5.0. Mental Health (MH) Services for SNU patients
5.1. Patients shall receive confidential MH services in accordance with their level of care and clinical needs while admitted to a SNU.
5.2. Nursing staff or a provider notifies MH staff of any admitted patients' MH service needs whenever necessary.
5.3. If the patient is on psychotropic medications at the time of admission to SNU, the psychiatric provider reviews orders and health record to continue or initiate new orders, as appropriate.
5.4. CHP MH staff shall conduct a MH assessment, schedule psychiatric evaluations as needed, and initiate appropriate interventions if the patient is a danger to self or others.
5.5. Patients shall not be admitted to SNU for mental health watches.

6.0. Health records for patients who need SNU-level care include:
6.1. Complete documentation of the care and treatment given that includes:
6.1.1. Reason for SNU admission, history of present illness, full physical exam, review of any studies/labs, review of meds, all the acute and chronic conditions, and an assessment and plan for each one.
6.1.2. Admission order with diagnosis, rationale for ordered SNU-level of care, treatment goals, and monitoring plan.
6.1.2.1. Admission orders shall include at a minimum: the level of care required, medication, diet, activity restrictions, diagnostic tests, and any necessary treatments.
6.1.3. Resuscitation status and advanced directives.
6.1.4. Contact information for the patient's Power of Attorney. [Completed Power of Attorney, Form 1101-97]
6.1.5. All face-to-face encounters shall be documented in the appropriate format in the patient's health record (e.g., S.O.A.P.E. notes, Nursing Assessment Protocols, Emergency Response Orders).
6.1.6. Electronic Medication Administration Record.
6.1.7. Discharge plan and discharge notes.

7.0. Monthly Interdisciplinary Meeting
7.1. A monthly interdisciplinary meeting, with documentation of meeting minutes, shall take place for all sites with a SNU to ensure clinical treatment plans are in place for each patient.
7.2. This is a very important function to ensure that patient-specific goals are identified and patients are being provided treatment based on these goals.
7.3. Some patients have an end-point of transitioning care to general population. When these goals are met, then patients should be discharged to a lower level of care.
7.4. Some patients may need to transition care to an IPC. Appropriate action should be taken when this need is identified.

	Medical and Dental Services Technical Manual
	REFERENCES: Mental Health Technical Manual NCCHC Standard P-F-03, Mental Health Services
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 as clinically indicated.

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.

3.0. Patients in inpatient mental health treatment units have 24/7 access to medical care by speaking with a nurse.

4.0. Staff shall ensure all healthcare services are appropriately integrated and appointments are coordinated to ensure all patient healthcare needs are met.

	Medical and Dental Services Technical Manual
	REFERENCES: MSDTM P-F-04.02 Treatment of Substance Use Disorder NCCHC Standard P-F-04, Medically Supervised Withdrawal and Treatment NCCHC Standard P-F-05, Counseling and Care of the Pregnant Inmate NCCHC Standard O-E-05, Medically Supervised Withdrawal
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-04.01 Medically Supervised Withdrawal and Treatment

PURPOSE: To provide guidance to the Contract Healthcare Provider (CHP) staff on the appropriate treatment of patients who are intoxicated or withdrawing from alcohol or drugs and to provide guidance in educating and counseling the patient population on drug and alcohol intoxication and abuse.

RESPONSIBILITY: It is the responsibility of CHP staff to evaluate and complete an appropriate clinical physical assessment to determine intoxication and/or withdrawal symptoms in patients and provide treatment for the physiological results of disorders associated with alcohol and other drugs as required.

PROCEDURE:

1.0. The CHP staff shall obtain drug and alcohol use history from each new patient at intake and evaluate for indication of drug or alcohol intoxication.

1.1. If clinically indicated, the patient shall be referred to the practitioner for evaluation, monitoring, or treatment in accordance with national guidelines.

1.2. Patients arriving on opiates or actively withdrawing from opiates, shall be assessed for MOUD induction and started on treatment immediately, if clinically indicated based on acute presenting clinical signs and symptoms.

1.3. Patients with a documented history of opioid overdose or who upon assessment are determined to be at imminent risk of opioid overdose shall be referred to the medication-assisted treatment (MAT) program provider and offered medication for opioid use disorder (MOUD) in accordance with the Medical and Dental Services Technical Manual (MDSTM) P-F-04.02, Treatment of Substance Use Disorder and the Clinical Practice Guidelines, Treatment of Substance Use Disorder.

1.4. Patients identified with disorders associated with alcohol and other drugs (e.g., HIV, liver disease) shall be recognized and treated in accordance with approved chronic care treatment guidelines.

2.0. CHP staff shall respond to any indication of drug or alcohol intoxication or withdrawal symptoms by documenting observations in the health record and contacting a practitioner immediately.

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.

2.1.1. Protocols shall be consistent with nationally accepted treatment guidelines and reviewed annually by the ADCRR Medical Director or designee.

2.2. Patients experiencing severe or progressive intoxication (overdose), severe withdrawal symptoms, or are found to have internalized unopened packages of a drug are transferred immediately to the hospital for treatment.

2.3. Any medically supervised withdrawal is done under provider supervision.

REFERENCES:
MDSTM P-E-02.01 Receiving Screening
MDSTM P-F-05.01 Counseling and Care of the Pregnant Inmate
NCCHC Standard P-F-04, Medically Supervised Withdrawal and Treatment
NCCHC Standard P-F-05, Counseling and Care of the Pregnant Inmate
NCCHC Standard O-A-01, Access to OTP Services
NCCHC Standard O-A-05, Policies and Procedures
NCCHC Standard O-A-08, Communication on Patients' Health Needs
NCCHC Standard O-A-09, Privacy of Care
NCCHC Standard O-A-04, Administrative Meetings and Reports
NCCHC Standard O-C-02, Staffing
NCCHC Standard O-C-03, Professional Development
NCCHC Standard O-D-02, Medication Services
NCCHC Standard O-D-03, Clinical Space, Equipment, and Supplies
NCCHC Standard O-D-04, Diagnostic Services
NCCHC Standard O-E-01, OTP Admission Process
NCCHC Standard O-E-02, Health Assessments
NCCHC Standard O-E-04, Treatment Plans
NCCHC Standard O-E-10, Discharge Planning
NCCHC Standard O-F-01, Healthy Lifestyle Promotion
NCCHC Standard O-H-01, OTP Record Format and Contents
NCCHC Standard O-I-02, Informed Consent and Right to Refuse
https://www.ncchc.org/position-statements/opioid-use-disorder-treatment-in-correctional-settings-2021/

Effective Date: 10/01/2024
Supersedes only as it relates to State Prisons: N/A

P-F-04.02 Treatment of Substance Use Disorder

PURPOSE: To provide guidance to the Contract Healthcare Provider (CHP) staff on the appropriate treatment of patients with substance use disorder (SUD).

RESPONSIBILITY: It is the responsibility of the CHP staff to evaluate and complete assessments as clinically indicated of patients with SUD and to provide appropriate services, including medications for SUD, counseling, and reentry planning.

PROCEDURE:

1.0. All newly admitted patients shall be screened for, and if indicated then evaluated for SUD.
  1.1. Screening shall include an assessment of the patient's history of opioid overdose.

2.0. Any patient entering the facility on medications for SUD shall be offered to have their medication continued.
  2.1. CHP staff shall ensure that continuity of care occurs at the receiving facility.
  2.2. CHP staff shall document that a good faith effort has been made to determine whether the patient is taking medications for SUD outside of the correctional facility.

3.0. Patients evaluated and clinically approved for opioid treatment shall be offered services to address their addiction despite housing requirements by their security status or changes in their behavior, health, or mental health status subsequent to their enrollment.

3.1. Medication assisted treatment (MAT) services shall include one or more of the following, as clinically indicated:
   3.1.1. Maintenance treatment
   3.1.2. Medically supervised withdrawal, under the guidance and supervision of regional clinical leadership
   3.1.3. Medication induction
3.2. MAT clinicians will be notified when patients are restrained or placed in seclusion for security or clinical reasons.
3.3. Patients with special needs related to MAT that may affect housing, work, program assignments, disciplinary measures, and admission to or transfer between facilities shall have those needs communicated with correctional staff and health services staff as necessary.

4.0. Patients with SUD shall be provided with psychosocial assessments, including evaluation for mental health conditions and social needs, as well as appropriate mental health treatment, psychosocial counseling, and referral.
4.1. All MAT clinical encounters are conducted in a private manner with interview space for both individual assessment and group treatment, as well as desks and chairs to encourage the patient's subsequent use of clinical services.

5.0. For all pregnant and post-partum patients diagnosed with Opioid Use Disorder ("OUD"), please refer to the Medical and Dental Services Technical Manual (MDSTM) P-E-02.01, Receiving Screening and P-F-05.01, Counseling and Care of the Pregnant Inmate.

6.0. Patients with a history of overdose or who are at imminent risk for opioid overdose shall be offered medication for opioid use disorder (MOUD).
6.1. Opioid medication will not be used to reinforce or punish behavior.

7.0. Patients who are offered treatment for hepatitis C shall be evaluated for OUD and if found to have OUD, shall be offered MOUD.

8.0. Patients who the meet criteria for alcohol use disorder will be offered medication and counseling if clinically indicated.

9.0. If a fee-for-service program is in place, indigent patients clinically appropriate for MAT program services shall receive care regardless of their ability to pay.

10.0. All MAT encounters shall include documented individual health education and instruction on self-care related to the patient's addiction.
10.1. Patient education will include the following:
   10.1.1. Appropriate counseling about SUD,
   10.1.2. Patient management and recovery groups,
   10.1.3. Counseling and education to promote adherence to the medication regimen,
   10.1.4. Risks associated with stopping medications and how continued treatment with medications for SUD can save lives,
   10.1.5. Discharge planning and continuation of treatment in the community, and
   10.1.6. Use of naloxone.
10.2. Information on how to prevent HIV and hepatitis C exposure and treatment options for those infected will be provided to each patient admitted or readmitted to the MAT program.

11.0. CHP shall ensure that adolescents with SUD have access to providers with experience in medications for SUD, as well as developmentally appropriate psychosocial interventions, and shall take into consideration relevant concerns about confidentiality, consent, and include family whenever possible.

12.0. Where applicable, opioid treatment program (OTP) licensure will be obtained through the Substance Abuse and Mental Health Services Administration (SAMHSA).
- 12.1. A requirement of OTP certification includes accreditation by an independent, SAMHSA-approved accrediting body (e.g., the National Commission on Correctional Health Care).

13.0. Staff understanding and buy-in of the MAT program are essential to the success of the program.
- 13.1. The following topics shall be considered for incorporation into the training of custody and health staff:
  - 13.1.1. Science of SUD, including OUD
  - 13.1.2. Science of opioid withdrawal
  - 13.1.3. Recovery-oriented principles and approaches
  - 13.1.4. Trauma-informed principles and approaches
  - 13.1.5. Science of medications for SUD, including different forms of medications
  - 13.1.6. Benefits and effectiveness of medications for SUD
  - 13.1.7. Medication diversion control techniques
  - 13.1.8. Security issues related to medications for MOUD, including staff concerns about safety and security during program implementation
  - 13.1.9. Federal, state, local, and accreditation bodies' rules and regulations related to storage, mixing, administration, disposal, and ordering of MOUD
  - 13.1.10. Culture change around the treatment of people with SUD
- 13.2. All staff members shall receive initial and annual training on the appropriate use of naloxone for overdose.

14.0. MAT Admission Process
- 14.1. Procedures shall be in place that allow:
  - 14.1.1. Self-referral of the patient to the MAT program.
  - 14.1.2. Referral by facility health/mental health clinicians for MAT services.
- 14.2. Sufficient written information on MAT services shall be made available for patients to facilitate self-referral.
- 14.3. Admission decision shall be based solely on clinical criteria according to federal regulations.
- 14.4. Each patient accepted into the program shall receive information that outlines policies, patient rights and responsibilities while participating in the program, and the treatment offered.
- 14.5. Patients not accepted into the program shall be referred to other appropriate treatment alternatives as necessary.
- 14.6. The provider admitting the patient to the MAT program shall determine, using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), that:
  - 14.6.1. The patient currently meets DSM-5 criteria for opioid dependence.
- 14.7. All patients shall receive an initial health assessment prior to initiating treatment.
- 14.8. Policies and procedures require written documentation of informed consent for patient participation in the MAT program.
  - 14.8.1. Patients may be required to sign a voluntary participation contract, agreement, or release of information that authorizes the treating staff to provide progress reports to the court or other correctional or parole authorities.
- 14.9. CHP staff shall educate the patient that any health evaluation or treatment may be refused but is required to be documented in writing.
- 14.10. CHP staff shall provide the patient with an explanation of all relevant facts including the use of opioid drugs, and any informational materials that may outline the rights and responsibilities of patients participating in the MAT program.

15.0. MAT Treatment Plans

15.1. The health services in the treatment plan may be provided by MAT program staff or by other providers or agencies with which the program has arrangements.

15.2. Individual treatment plans shall be developed by a physician or other qualified clinician at the time of the patient's admission to the program and updated when warranted.

15.2.1. Depending on the length of anticipated incarceration and current status in the criminal justice system, objectives in the educational, vocational, and residential areas may need to be addressed, most frequently by participation in facility-based programs or classes.

15.3. Plans for patients with significant medical and/or mental health problems shall reflect multidisciplinary input, monitoring, and appropriate linkage to treatment either on-site or through referral.

15.4. Treatment objectives for maintenance therapy shall include:

15.4.1. Preventing the onset of signs or opioid abstinence for at least 24 hours.

15.4.2. Reducing or eliminating drug craving.

15.4.3. Blocking the effects of illicitly acquired or self-administered opiates.

15.5. The treatment plan shall include, at a minimum:

15.5.1. The patient's short-term goals and tasks associated with achieving the goals.

15.5.2. The frequency of follow-up for MAT.

15.5.3. A schedule for drug therapy.

15.5.4. The option of individual and/or group therapy or counseling.

15.5.5. The type and frequency of diagnostic testing.

15.6. Diagnostic testing shall be available to confirm or rule out the presence of a variety of drugs including opioids with results available in a timely fashion.

15.6.1. For patients in maintenance treatment, eight random (unpredictable, not scheduled) drug screens a year.

15.6.2. For patients in short-term medically supervised withdrawal treatment, at least one initial test.

15.6.3. For patients receiving long-term medically supervised withdrawal (which should not exceed 180 days, according to federal standards), one initial test and monthly random test.

15.6.4. Whenever clinically indicated by patient's behavior.

15.7. Treatment modifications may be necessary under certain circumstances and shall be made as clinically indicated.

15.7.1. Patient suspected of medication diversion shall be referred to medical provider with MAT Program experience in accordance with Clinical Practice Guidelines, Treatment of Substance Use Disorder.

16.0. CHP Regional Leadership shall provide statistical reports of all MAT services to ADCRR Healthcare Services Division (HSD) on a monthly basis or upon request.

17.0. Patient Education and Discharge Planning

17.1. Adequate substance abuse counseling shall be provided directly from the MAT program or qualified counselor, in an individual or group format, and shall be available to each patient as clinically necessary to contribute to the treatment plan and monitor patient progress.

17.2. Information on how to prevent HIV and hepatitis C exposure and treatment options for those infected shall be provided to each patient admitted or readmitted to the MAT program.

17.3. Reentry planning shall occur for patients on medications for SUD as they return to the community including receiving medication prescriptions when clinically appropriate and appointments with community treatment providers, along with backup plans if appointments are canceled or delayed.

17.3.1. For planned discharges to the community, staff shall arrange for enrollment in a community-based program.

17.3.1.1. Close coordination between discharging and receiving entities shall occur.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-B-02.01, Infectious Disease Prevention and Control MDSTM P-B-08.01, Patient Safety Through Reporting of All Significant Health Care Events NCCHC Standard O-A-02, Program Sponsor NCCHC Standard O-A-06, Continuous Quality Improvement Program NCCHC Standard O-B-01, Infection Prevention and Control Program NCCHC Standard O-G-01, Suicide Prevention Program
	Effective Date: 10/01/2024 Supersedes only as it relates to State Prisons: N/A

P-F-04.03 Medication Assisted Treatment (MAT) Program Sponsor

PURPOSE: To provide guidance to the Contract Healthcare Provider (CHP) on the appointment of a designated program sponsor responsible for the MAT program.

RESPONSIBILITY: It is the responsibility of CHP to appoint a designated MAT program sponsor who is responsible for arranging for all levels of MAT services in a high quality, timely manner, that are accessible to all patients. The MAT program sponsor is the responsible health authority assigned to a complex, most commonly referred to as the Facility Health Administrator (FHA) or Health Services Administrator (HSA), their designee, or an outside agency.

PROCEDURE:

1.0 The MAT program sponsor shall agree on behalf of the clinic to adhere to the federal regulations for Opioid Treatment Program (OTP), if applicable, as set forth in 42 CFR 8.12 (Certification of Opioid Treatment Programs, Federal Opioid Treatment Standards).

2.0 The sponsor's responsibilities shall be documented in a written agreement, contract, or job description.

3.0 The program sponsor shall ensure that:
- 3.1. Infection control procedures are followed in accordance with the information found in the Medical and Dental Services Technical Manual (MDSTM) P-B-02.01, Infectious Disease Prevention and Control.
- 3.2. Staff reporting on adverse or near-miss events is conducted in accordance with MDSTM P-B-08.01, Patient Safety Through Reporting of All Significant Health Care Events.
- 3.3. There is an approved suicide prevention plan; training curriculum for staff, including development for intake screening for suicide potential and referral protocols; and training for staff conducting the suicide screening at intake.
- 3.4. MAT program policies and procedures are site-specific.
  - 3.4.1. Each policy and procedure related to the MAT program is reviewed at least annually and revised as necessary.
  - 3.4.2. No other policy conflicts with MAT program policies.

4.0 The program sponsor is the Facility Health Administrator (FHA), Health Services Administrator (HAS), their designee, or an outside agency.
- 4.1. Where the agency acting as a program sponsor is a state, regional, corporate, or national entity, there shall also be a designated individual at the local level to ensure that policies are carried out.

5.0 Clinical judgments shall be made by a single, designated, licensed, responsible physician.

5.1. The responsible physician, the Site Medical Director or their designee is responsible for providing oversight of all medical services performed by the MAT program.

5.2. The responsible physician shall ensure that the MAT program is in compliance with applicable federal, state, and local laws and regulations.

5.3. The responsible physician shall be involved in the Continuous Quality Improvement (CQI) Committee.

6.0 The program sponsor shall establish appropriate links to the facility's health/mental health services so that patients' health care is appropriately coordinated.

7.0 The program sponsor shall ensure the decision to admit or discharge an individual from the MAT program is based on clinical information.

7.1. A patient's possible discharge from the MAT program due to medication noncompliance, diversion, or other issues that may affect patient safety, shall be coordinated through the Regional Medical Director or designee.

8.0 There will be a designated mental health clinician if required according to the program organizational structure.

	Medical and Dental Services Technical Manual
	REFERENCES: MDSTM P-D-01.01, Pharmaceutical Operations NCCHC Standard O-D-01, Pharmaceutical Operations NCCHC Standard O-D-02, Medication Services
	Effective Date: 10/01/2024 Supersedes only as it relates to State Prisons: N/A

P-F-04.04 Medication Assisted Treatment (MAT) Program Pharmaceutical Operations

PURPOSE: To provide guidance in the pharmaceutical operations procedures required by a MAT program.

RESPONSIBILITY: It is the responsibility of CHP staff to ensure that the MAT program complies with all applicable state and federal regulations regarding prescribing, dispensing, distributing, administering, procuring, accounting, and disposing of pharmaceuticals.

PROCEDURE:

1.0 CHP MAT program staff shall ensure a diversion control plan is in place and contains measures to reduce the possibility of diversion of controlled substances from legitimate treatment use.

2.0 CHP MAT program staff in collaboration with the ADCRR Pharmacy and Therapeutics (P&T) Committee shall maintain a formulary.

3.0 CHP MAT program staff shall maintain procedures for the timely prescribing, procurement, dispensing, distribution, administration, accounting, and disposal of pharmaceuticals.

3.1. CHP MAT program staff shall document in the patients' health record any significant deviations regarding dose, frequency, or the conditions of use described in the approved label of the medication being prescribed.

4.0 CHP MAT program staff shall maintain records as necessary to ensure adequate control and accountability of all medications.

4.1. Tracking and accountability of MAT program medications shall take place as outlined in the Medical and Dental Services Technical Manual (MDSTM) P-D-01.01, Pharmaceutical Operations.

4.2. Where there is no staff pharmacist, a consulting pharmacist shall be used for documented inspections and consultation as outlined in MDSTM P-D-01.01, Pharmaceutical Operations.

5.0 CHP MAT program staff shall maintain maximum security storage of and accountability for Drug Enforcement Agency (DEA) controlled substances.

5.1. Medications shall be kept under the control of appropriate staff members.

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

5.3. All medications shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

6.0 Methadone shall be administered or dispensed only by a practitioner licensed and registered under appropriate state and federal laws or by an agent of such a practitioner, supervised by and under the order of the licensed practitioner.

6.1. The agent is required to be a pharmacist, registered nurse, licensed practical nurse, or any other professional authorized by federal and state law to administer or dispense opioid drugs.

7.0 Release Medication – Patients releasing while enrolled in a comprehensive maintenance treatment program will be issued a minimum of a 7-day supply of medications or enough to ensure they have enough to last until their scheduled appointment with a community provider. If the patient is on methadone, a shorter supply of take home medication shall be provided to the patient, if needed, based on their individualized treatment plan in coordination with their community provider.

7.1. Documentation for any self-medication protocol shall be approved by the responsible physician.

7.2. Release medication shall be packaged according to federal regulations (child-resistant packaging).

7.3. Patients enrolled in short-term medically supervised withdrawal treatment or interim maintenance treatment will not be given drugs for unsupervised use.

8.0 An adequate and proper supply of naloxone and corresponding equipment for either injection or intranasal use and other emergency medications, as well as related information, shall be readily available to all staff.

8.1. Naloxone shall be kept in every living unit or with every AED.

9.0 For discharge planning purposes, harm reduction methods shall be undertaken through the provision of nasal naloxone (Narcan) for overdose prevention, along with patient education.

10.0 The poison control telephone number shall be posted in areas where overdose emergencies are possible.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #705, Inmate Transportation MDSTM P-A-03.01, Medical Autonomy NCCHC Standard P-F-05, Counseling and Care of the Pregnant Inmate NCCHC Standard P-F-04, Medically Supervised Withdrawal and Treatment NCCHC Standard O-E-05, Medically Supervised Withdrawal NCCHC Standard O-G-02, Counseling and Care of the Pregnant Inmate
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-05.01 Counseling and Care of the Pregnant Patient

PURPOSE: To address the healthcare needs of patients throughout their pregnancy and postpartum stages in a manner that aligns with best practices, identifies risks, and improves patient outcomes.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) to ensure that pregnant patients receive care and counseling that align with best practices throughout their pregnancy and postpartum timeframe, and are consistent with Arizona statutes pertaining to women's health.

PROCEDURES:

1.0. Intake Evaluation, Counseling, and Education for Pregnant Patients

1.1. Individuals new to ADCRR or those returning to custody from parole, with a verified pregnancy, shall be provided counseling on the day of arrival by the CHP medical staff.

1.2. All counseling/education provided by the CHP medical staff related to pregnancy shall be documented in the patient's health record.

1.3. All pregnant or post-partum patients with diagnosed Opioid Use Disorder ("OUD") shall be offered to have current medications for opioid use disorder (MOUD) continued, or if not currently on MOUD, shall be offered to initiate treatment.

1.3.1. Priority admission to the medication assisted treatment (MAT) program is given to pregnant patients.

1.3.2. If the patient is taking MOUD during pregnancy, the patient shall receive education from the CHP OB/GYN or medical provider about treatment during and after pregnancy.

1.3.3. Prenatal care includes access to information regarding neonatal abstinence syndrome and its management.

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, including clinically indicated levels of activity, nutrition, medications, housing, and safety precautions, shall be documented in the patient's health record.

2.1.3. Counseling and education shall be provided in accordance with the pregnant patient's expressed desires regarding her pregnancy and shall include keeping the child, the use of adoptive services, or termination if allowed by state law.

2.1.4. The patient shall be provided an opportunity to ask questions about her pregnancy and questions shall be answered by CHP staff as comprehensively as possible.

2.1.5. In accordance with the Medical and Dental Services Technical Manual (MDSTM) P-A-03.01, Medical Autonomy, healthcare decisions are made by qualified healthcare professionals for clinical purposes. A shared decision-making approach, which includes the patient's desires and treatment goals regarding the pregnancy and delivery, shall be utilized.

2.1.5.1. If an induction of labor is recommended by the treating OB/GYN for the safety of the patient and/or her baby, then clear documentation of the indications, risks, and benefits shall be placed in the patient's health record.

3.0. The mother and newborn baby may be transferred to an off-site facility for bonding purposes following hospital discharge prior to returning to the prison complex.

3.1. Coordination of care with the off-site facility shall take place as clinically necessary and prior to the patient returning to the prison complex.

4.0. Routine off-site follow-up protocols shall be followed upon the patient's return to the 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.

5.1. Patients shall be provided free of charge all necessary post-delivery supplies (continence briefs, pads, creams, etc.).

6.0. The Facility Health Administrator (FHA) of any ADCRR prison complex where pregnant patients are housed shall have Doppler fetal heart tone monitors available as well as emergency OB delivery kit(s) within the facility.

6.1. For a list of the minimum requirements for an emergency OB delivery kit refer to MDSTM Attachments P-F-05.01A, Emergency OB Delivery Kit Minimum Requirements.

6.1.1. One emergency OB delivery kit shall be available in the health unit of every populated complex unit.

6.2. Inventory of the emergency OB delivery kit shall be conducted a minimum of once per month and shall reflect the amount(s) of each item/medication with a record of expiration dates (if applicable).

7.0. The CHP staff shall advise complex security of the current status of any pregnant patient requiring care so security may apply exceptions to the use of restraints and provide transportation services in accordance with Department Order #705, Inmate Transportation.

8.0. CHP staff are responsible for maintaining a list of all pregnancies and their outcomes and discuss as applicable during Continuous Quality improvement (CQI) meetings.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #125, Sexual Offense Reporting NCCHC Standard P-F-06, Response to Sexual Abuse NCCHC Standard O-B-04, Federal Sexual Abuse Regulations
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-06.01 Response to Sexual Abuse

PURPOSE: To ensure patients who report or seek health care services as a result of sexual assault receive prompt attention, treatment, and evidence gathering as required. ADCRR encourages victims of sexual assault to report the assault as soon as possible and encourages cooperation in its investigation. 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 the Prison Rape Elimination Act (PREA) education to all staff, report any findings or patient complaints of sexual assault or abuse, provide supportive care to the patient, and ensure appropriate intervention and treatment is received.

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. A 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 custody or healthcare staff leave the patient alone until evaluated by mental health staff.

3.0. The patient shall be transported to the hospital emergency room for the collection of forensic evidence and medical treatment if determined necessary by the medical or mental health provider.

4.0. CHP staff shall not conduct forensic examinations. If a forensic examination is determined necessary, the patient shall be taken to a hospital emergency room for 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 patients, as appropriate.
  - 6.1.1. Emergency contraception is timely available to female patients who are victims of sexual assault as allowed by state law.
- 6.2. Evaluation by qualified mental health professional for crisis intervention counseling and follow-up as clinically indicated.

	Medical and Dental 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 the Terminally Ill Arizona Revised Statute 36-3231. Surrogate decision makers; priorities; limitations Arizona Revised Statute 36-3221. Health care power of attorney; scope; requirements; limitations; fiduciaries
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-F-07.01 Care for the Terminally Ill

PURPOSE: To establish guidelines that address the needs of terminally ill 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 patients of 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: During the intake/orientation, ordering the patient's correctional healthcare plan, the Correctional Officer III (CO III) shall inquire whether the patient has an existing Durable Healthcare Power of Attorney and Living Will (End of Life Care) in accordance with Department Order #1101, Inmate Access to Healthcare.

1.1. If a DPOA or Living Will previously exist, the CO III shall make efforts to obtain a copy. If they do not exist and/or if the patient would like to fill out a new one, the CO III shall notify a licensed healthcare professional.

1.2. Forms included are listed below and copies can be found in the Legal/Administrative section of the patient's health record:

1.2.1. Durable Healthcare Power of Attorney, Form 1101-97

1.2.2. Living Will (End of Life Care), Form 1101-98

1.2.3. Inmate Acknowledgement of Rights, Form 1101-99

1.3. Any request to change or modify medical directives by the patient is done by submission of an Inmate Letter, Form 916-1, in accordance with Department Order #1101, Inmate Access to Healthcare.

1.4. Request to revoke medical care directives by the patient is done by submission of Inmate Letter, Form 916-1, 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: A patient DNR request will be honored in accordance with Department Order #1101, Inmate Access to Healthcare.

2.1. DNR orders may be written by a medical provider in consultation with the patient.

3.0. DNR orders are not in any way associated with expediting the death of a patient.

3.1. Upon the patient's request to be DNR status, the practitioner shall complete the 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 Inpatient Component (IPC) or Special Need Unit (SNU) where the patient is housed.

3.1.1. Prehospital Medical Care Directive (Do Not Resuscitate or DNR) Form, must be printed on paper with an orange background.

3.1.1.1. Refer to the Medical and Dental Services Technical Manual (MDSTM) Attachments P-F-07.01A, Prehospital Medical Care Directive (Do Not Resuscitate or DNR) Form for form resources.

3.1.2. Any DNR orders written by a hospital, hospice, or other medical provider not directly employed by the CHP shall be honored.

3.1.2.1. DNR forms filled out elsewhere should be verified that it is still the patient's wishes when the paperwork is received.

3.1.2.2. A DNR Order completed in an emergency situation outside of a facility should not just be honored once the emergency situation resolves and the patient returns.

3.1.3. 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 paperwork shall be placed in the legal section of the patient's health record and be duly annotated as withdrawn.

3.1.3.1. The patient may reinstate the DNR directive by requesting a new declaration.

3.2. A DNR is for use only by outside healthcare providers, hospitals, and/or hospice facility, or for use by medical staff only while the patient is housed in the IPC or SNU.

3.3. 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.

4.0. Surrogate

4.1. 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.

4.1.1. If the patient has a health care Power of Attorney that meets the requirements of A.R.S. 36-3221, the patient's designated agent shall act as the patient's surrogate.

4.2. In the absence 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:

4.2.1. If the court appoints a guardian for the express purpose of making healthcare treatment decisions, that guardian shall act as the patient's surrogate.

5.0. Hospice Services: Hospice care will be provided to ADCRR patients as appropriate.

5.1. Patients become eligible for hospice care when they are diagnosed with a terminal illness and a prognosis of six months or less to live.

5.1.1. The practitioner shall inform the patient of the prognosis and treatment options, which include palliative care upon admission to hospice.

5.1.1.1. The hospice care plan/program shall include pain management, mental health care needs, and the DNR process.

5.1.1.2. Patients who meet the criteria for hospice do NOT need to choose hospice and may choose to continue full care with a curative intent if possible and appropriate.

5.1.2. Upon placement of the patient in the hospice care program the treating practitioner shall notify the CHP Facility Health Administrator (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.

5.2. A multidisciplinary team shall be developed which may include direct care CHP health services staff, religious services, mental health personnel, off-site consulting practitioners, and other members as deemed necessary by the FHA and security staff designated by the Warden.

5.3. CHP medical personnel trained in the delivery of palliative/hospice care will provide direct physical care and medication administration as clinically appropriate to any patient receiving hospice care.
5.3.1. Volunteers may be used for spiritual and emotional support.
5.3.1.1. Adequately trained, screened, and supervised inmates may be used as volunteers.

6.0. Clemency/Compassionate Release: The 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 and Dental 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 MHTM Chapter 5, Sec. 2.0, Progressive Mental Health Restraints NCCHC Standard P-G-01, Restraint and Seclusion
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 for ensuring 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, Chapter 5, Section 2.0, Progressive Mental Health Restraints.

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 and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care MHTM Chapter 3, Section 10.0, Mental Health Service Delivery in Restrictive Housing NCCHC Standard P-G-02, Segregated Inmate
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-G-02.01 Segregation of Individuals Who Are Incarcerated

PURPOSE: To provide guidance in the delivery of healthcare for all patients who are housed in 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 the patient's healthcare needs are met, regardless of housing location.

PROCEDURE:

1.0. Nursing staff will be notified by security when a patient is placed in segregation, including type of segregation/degree of isolation, within one hour of patient placement.

1.1. Upon notification of a patient's transfer to segregation a 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 housing status.

1.1.1. SMI patients shall not be placed in detention, maximum custody, restrictive housing or enhanced housing.

1.1.2. Any concerns, including SMI status, that do exist should be immediately discussed with the respective PCP or PT.

1.1.3. When the notification includes information that the patient is injured or appears to be ill, nursing staff shall conduct an immediate hands-on assessment.

1.1.4. Documentation of chart review and/or any assessment findings shall be made in the patient's health record.

1.1.5. Keep-on-person (KOP) medications will be allowed to continue to be in the possession of the patient provided there are no contraindications.

1.2. Before going to segregation, a Registered Nurse (RN) shall complete an initial assessment to include vital signs and weight, and any patient concerns or physical abnormalities, including bruises or abrasions.

1.2.1. Any suicide/self-harm ideation shall be brought to the attention of the mental health staff or the practitioner immediately, and the patient shall be continuously observed until assessed by a QHCP.

2.0. Rounding Requirements:

2.1. For those who don't have tablets.

2.2. Segregation Housing - All patients (regardless of mental health score) housed in Restrictive Housing, Maximum Custody, or Detention shall receive segregation rounds a minimum of three (3) times a week by mental health or medical staff (not to include LPNs, CNA's, MH clerks) in accordance with the Mental Health Technical Manual, Chapter 3, Section 10.0, Mental Health Service Delivery in Restrictive Housing.

2.2.1. All rounds shall be documented in the patient's health record and on ADCRR approved rosters or count sheets obtained for each scheduled date.
2.2.2. 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.
2.2.3. There will be no healthcare fee for the segregation rounds as the visit was initiated by the CHP staff.

2.3. Any patient found to be physically or psychologically deteriorating shall be promptly identified and reported to custody staff, who shall facilitate movement for proper evaluation.

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. Clinical encounters shall be conducted by the assigned PCP and PT while the patient is in segregation.
3.3. All clinical encounters must occur in an appropriate clinical setting and not take place cell side, unless there is a clinical or legitimate and substantial safety and security concern that is documented.
3.3.1. This requires coordination between the FHA and the Warden.

4.0. The FHA is responsible for ensuring that segregation round records are maintained in a complete form and are available for auditing.

	Medical and Dental Services Technical Manual
	REFERENCES: MHTM Chapter 4, Sec. 7.0, Procedures for Involuntary Use of Psychotropic Medication NCCHC Standard P-G-03, Emergency Psychotropic Medication
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 nursing staff to administer emergency psychotropic medications to patients when clinically indicated while following policies developed for their use.

PROCEDURE:

1.0 The policies on authorized use of emergency forced psychotropic medication can be found in the MHTM, Chapter 4, Sec. 7.0, Procedures for Involuntary Use of Psychotropic Medications.

2.0 The nursing staff administering emergency forced psychotropic medication must ensure follow-up documentation is made at least once within the first 15 minutes after administration, then every 30 minutes until transferred to an inpatient setting or the patient no longer requires monitoring.

3.0 All documentation is made in the patient's health record.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #125, Sexual Offense Reporting MDSTM P-F-06.01, Sexual Assault NCCHC Standard P-G-04, Therapeutic Relationship, Forensic Information, and Disciplinary Actions NCCHC Standard O-I-01, Forensic Information
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

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 the collection of or participation in the 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: The CHP Facility Health Administrator (FHA) is responsible for ensuring that CHP staff assigned under their management does not participate in the 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. It is an examination being done for medical purposes and under the orders of a physician, including body cavity searches or body fluid testing; or
- 1.3. Conducting court-ordered examinations with the consent of the patient and it is medically indicated.

2.0. As outlined in the Medical and Dental Services Technical Manual (MDSTM) 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 practitioner determines a 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 this should occur, then the patient should ideally be sent off-site for removal.
- 3.2. If the CIU supervisor determines the item to be of an evidentiary nature, they will witness the removal of the item and advise in its preservation.
- 3.3. If an item is removed as a result of an unplanned discovery, CHP staff shall preserve the item and contact CIU for advice and direction.

4.0. CHP 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 and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care NCCHC Standard P-G-05, Informed Consent and Right to Refuse NCCHC Standard O-I-02, Informed Consent and Right to Refuse
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-G-05.01 Informed Consent

PURPOSE: To advise the 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 provide patients with information regarding recommended examinations, treatments, and procedures so the patient is able to make informed decisions regarding their healthcare.

PROCEDURE:

1.0. The 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 practitioner shall explain the benefits, risks, and possible side effects of the recommended treatment.
- 1.3. The practitioner shall explain any potential alternative treatment.

2.0. The practitioner shall document in the health record exactly what was explained to the patient regarding the recommended treatment.

3.0. CHP staff shall request the patient sign a completed Consent to Treat Form in a language they understand, when applicable (e.g., upcoming examination, treatment, or procedure) and scan it into the patient's health record.

4.0. For Dental Treatment
- 4.1. The dental practitioner shall inform the patient of the proposed dental treatment recommendations as indicated on the Dental Treatment Plan, Form 1101-1.
  - 4.1.1. Patient shall sign and date Dental Treatment Plan, Form 1101-1, prior to receiving treatment.
    - 4.1.1.1. The dental staff shall scan the completed form into the patient's health record.
- 4.2. For additional dental procedures such as Endodontic Treatment and Oral Surgery, the dental practitioner shall inform the patient of possible risks/consequences of the proposed dental procedure prior to the patient giving consent.
  - 4.2.1. Consent form related to the specific proposed dental procedure (e.g., Informed Consent for Oral Surgery, Form 1101-36 and/or Informed Consent for Endodontic Treatment, Form 1101-100) shall be completed, signed by the patient, and witnessed.

5.0. Enrollment in the Medication Assisted Treatment (MAT) Program
- 5.1. The treatment provider shall inform the patient of all relevant facts related to the MAT program and may require the patient to sign a voluntary participation contract or agreement.

6.0. 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 and Dental Services Technical Manual
	REFERENCES: Department Order #1101, Inmate Access to Health Care NCCHC Standard P-G-05, Informed Consent and Right to Refuse NCCHC Standard O-I-02, Informed Consent and Right to Refuse
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-G-05.02 Appointment or Treatment Informed Refusal

PURPOSE: To outline the process for documentation of a patient's refusal to attend an appointment or accept a recommended treatment for a 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 for informing 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 for educating the patient on the potential risks and consequences of a refusal.

PROCEDURE:

1.0. Cancellations of patient-initiated health visits can be by tablet, in writing, telephone, video, or face-to-face with any healthcare staff.

2.0. CHP staff initiated refusals. A patient has the right to refuse any health evaluation and/or proposed treatment.
- 2.1. Refusals of provider-initiated on-site and off-site health visits shall be made by telephone, video, or face-to-face with an RN or provider at the time of the appointment.
- 2.2. If the patient will not voluntarily displace for a provider-initiated visit, healthcare staff shall go to the patient's location to obtain the informed refusal.

3.0. A patient who refuses a dental examination treatment or procedure that is part of a treatment plan shall be seen by the dental provider who shall explain the risks of refusal to the patient.
- 3.1. The dental provider may determine if further treatment cannot proceed due to the deleterious effect on the overall outcome.
- 3.2. A completed and signed refusal form for dental services will be included in the patient's dental record.

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 approved electronic equivalent and submitting it to the CHP.
- 4.1. The documentation should follow the specific format below, regardless of the type of refusal and needs to contain all the elements of an informed refusal as noted for an informed consent.
- 4.2. All refusals shall include:
  - 4.2.1. The reason that a health service (e.g., medication, diagnostic test, specialty visit) was offered.
  - 4.2.2. The risks and benefits of the refusal explained in lay language of the patient's preferred language.
  - 4.2.3. The reason that the patient is refusing.
  - 4.2.4. A list of potential alternatives discussed to address any concerns that the patient may have.
  - 4.2.5. The outcome of the discussion.
  - 4.2.6. The patient's signature on the form or electronic signature.

4.2.6.1. The form must be witnessed and signed by one CHP staff member.

4.3. The Refusal to Submit to Treatment, Form 1101-4, shall be scanned into the patient's health record, if not completed electronically within two business days.

5.0. Should a patient refuse to sign a Refusal to Submit to Treatment, Form 1101-4, CHP staff shall, in front of an additional witness:

5.1. The documentation should follow the specific format below, regardless of the type of refusal and needs to contain all the elements of an informed refusal as noted for an informed consent.

5.2. All refusals shall include:

5.2.1. The reason that a health service (e.g., medication, diagnostic test, specialty visit) was offered.

5.2.2. The risks and benefits of the refusal explained in lay language of the patient's preferred language.

5.2.3. The reason that the patient is refusing.

5.2.4. A list of potential alternatives discussed to address any concerns that the patient may have.

5.2.5. The outcome of the discussion.

5.2.6. The patient's signature on the form or electronic signature.

5.2.6.1. The form must be witnessed and signed by one CHP staff member.

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 the 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 the patient changes their mind, they may seek and be provided treatment if still clinically indicated.

	Medical and Dental 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 NCCHC Standard O-I-03, Medical and Other Research
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-G-06.01 Participation in Medical, Clinical, or Other Research

PURPOSE: To provide guidance in requesting, authorizing, and the 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 for Healthcare 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 of obtaining approval to conduct research.

2.0. Confidential communicable disease information may be disclosed for epidemiological purposes in accordance with the 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 practitioner, and be asked for contact information of the research group.

- 3.1. The practitioner shall contact the research group to determine if the researcher's institutional review board (IRB) approval extends to incarcerated individuals.
  - 3.1.1. If it does, there is no ethical reason to remove the patient from the protocol.
  - 3.1.2. Written verification that the removal of the patient from the protocol will not cause harm to the patient must be received by the practitioner or FHA and documented in the patient's health record.
  - 3.1.3. If an adverse reaction may result from the patient's removal from the protocol, the practitioner shall immediately contact the CHP Regional Medical Director or designee for approval and coordinate via electronic notification with the ADCRR Assistant Director for Healthcare Services or designee, to allow the patient to continue in the protocol.

4.0. Removal from a research project or not should have more to do with whether the researchers IRB approval extends behind bars. If it does, there is no ethical reason to remove the patient from the protocol.

4.1. 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 the ADCRR Assistant Director of Healthcare Services or designee for consideration, action, and direction.

	Medical and Dental Services Technical Manual
	REFERENCES: Department Order #710, Execution Procedures NCCHC Standard P-G-07, Executions
	Effective Date: 10/01/2024 Supersedes only as it relates to State prisons: 10/01/2022

P-G-07.01 Executions

PURPOSE: To provide guidance to ADCRR Healthcare Services Division (HSD) and the Contract Healthcare Provider (CHP) staff regarding executions in the State of Arizona.

RESPONSIBILITY: Any real or perceived assistance in the execution of incarcerated persons 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 incarcerated person.

PROCEDURE:

1.0. The ADCRR Assistant Director for Healthcare Services and the CHP shall ensure all necessary healthcare services are available to all patients while they remain in custody. Medical care, including specialty care, shall not be denied on the basis that a patient is condemned.

2.0. Mental health services will be provided as necessary, regardless of the patient's mental health score. This will not include competency determination. Competency determinations will be provided by contracted professionals and not by the CHP.

3.0. CHP staff shall not assist in directly causing the death of an incarcerated individual.
- 3.1. CHP staff shall not supervise an activity that causes the death of an incarcerated individual or pronounce death in an execution.
- 3.2. CHP staff shall not contribute to another individual's ability to cause the death of an incarcerated person.

4.0. In no event shall an execution be performed in an area designated as a health unit.

Glossary

PURPOSE: This document is the official listing and definitions of terms used in the Healthcare Services Technical Manual. The ADCRR Healthcare Services Division (HSD) 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 hsdtechnicalmanuals@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.

ALCOHOL USE DISORDER (AUD): A problematic pattern of alcohol use leading to clinically significant impairment or distress, which may include consumption in larger amounts, inability to cut down, craving, tolerance, and withdrawal.

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 MORTALITY REVIEW COMMITTEE: A committee consisting of Facility Health Administrator, Site Medical Director, Director of Nursing, Mental Health staff (if appropriate), ADCRR Healthcare Coordinator, 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.

DELIVERY: 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.

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.

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.

HEALTHCARE COORDINATOR: An ADCRR employee who reports to the ADCRR Healthcare Services Division (HSD) and is tasked with ensuring compliance with the health services contract. Previously known as Contract Monitor.

HEALTH NEEDS REQUEST (HNR) FORM: The form either electronic or paper the patient uses to request nonemergency health services.

HEALTH RECORD: Any information regarding an inmate-patient's health including medical, dental, and mental health history and treatment. (May also be referred to as medical record.)

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.

HOSPICE: Hospice care provides medical care and support services to a patient with a terminal illness as well as to their family and other caregivers. The focus is on quality of life rather than cure or life prolongation. The hospice philosophy aims to help patients achieve comfort and quality of life until death; the care and treatment provided are based on the patient and family/loved ones' goals and values. The hospice model is one of comprehensive interdisciplinary team care that addresses the physical, psychological, social, and spiritual aspects of suffering.

HUMAN IMMUNODEFICIENCY 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 (KOP) MEDICATION: 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: Facilities within ADCRR that are licensed as Level 1 Behavioral Health Treatment Facilities 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 Healthcare Coordinator, 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 RECORD: Refer to definition of health record. (May also be referred to as health record.)

MEDICAL RESTRICTION: Is a permanent restriction to a unit, facility(ies) because of medical or psychiatric limitations or disorders.

MEDICATION ASSISTED TREATMENT (MAT): US Food and Drug Administration (FDA)-approved medications for the treatment of substance use disorder, typically used in combination with clinically indicated behavioral or cognitive-behavioral counseling and other indicated services.

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.

MEDICATIONS FOR OPIOID USE DISORDER (MOUD): The use of medications approved by the Food and Drug Administration to treat Opioid Use Disorder. These medications include buprenorphine, methadone, and naltrexone.

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.

Includes qualified mental health professionals (QMHPs), as well as administrative and support staff (e.g., behavioral health technicians, mental health clerks, and nursing and medical assistants).

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 ASSESSMENT PROTOCOLS (NAPs): A specific set of guidelines developed to be used by Contract Healthcare Provider nursing staff when treating specified illness/complaints. Previously known as Nursing Encounter Tools (NETs).

- 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.

OPIOID USE DISORDER (OUD): Opioid Use Disorder (OUD) – A problematic pattern of opioid use leading to clinically significant impairment or distress, which may include consumption in larger amounts, inability to cut down, craving, tolerance, and withdrawal.

- P -

PALLIATIVE CARE: Palliative care focuses on improving quality of life for patients with serious illness and their families. This approach may include providing relief from pain and/or other distressing symptoms, integrating psychological and spiritual aspects of care, assisting with difficult decision-making, and supporting patients and families. Palliative care can be provided alongside therapies intended to treat the underlying disease or prolong life (for example, chemotherapy), and it is appropriate at any age or stage of serious illness. A percentage of patients receiving palliative care may transition to hospice care, in which case the focus of their care plan is exclusively on palliation.

PAROLEE: An adult offender who has been granted a parole and is under community supervision.

PATIENT CENTERED CARE MODEL (PCCM): is a patient-centered and team-based approach that has been associated with effective chronic disease management, improved patient outcomes, reduced use of emergency and inpatient care, and increased patient and provider satisfaction.

The model emphasizes a focus on the whole patient, as opposed to individual tasks, services, and needs. With the introduction of the self-scheduling process, patients will be given an opportunity to be seen for a medical clinic appointment at the next available clinic, for non-urgent/non-emergent.

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 Healthcare Services Division and Contracted Healthcare providers, 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.

REFERRAL: Refer to definition of specialty referral. (May also be referred to as specialty referral.)

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.

SPECIALTY REFERRAL: Includes any request for a consultation, intervention, tests, provision of materials, or other service that is performed or fulfilled by someone other than CHP employees or persons filling a CHP position (e.g., registry staff). (May also be referred to as referral.)

SUBSTANCE USE DISORDER (SUD): A problematic pattern of use leading to clinically significant impairment or distress, which may include consumption in larger amounts, inability to cut down, craving, tolerance, and withdrawal.

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 off-site (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 –