Arizona Department of Corrections, Rehabilitation & Reentry

Medical Services Division

Medical Services Technical Manual

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INTRODUCTION

PURPOSE: This Medical Services Contract Monitoring Bureau (MSCMB) Technical Manual was created to provide technical and professional guidance for the delivery of quality health care within the Arizona Department of Corrections Rehabilitation & Reentry facilities or their supporting non-ADCRR organizations.

RESPONSIBILITY: It is the responsibility of the ADCRR Health Services Contract Vendor, with oversight monitoring by MSCMB, to ensure that adequate Dental, Medical, Mental Health, Nursing, Pharmaceutical, Medical Records, Laboratory, and X-ray services are available to the inmate population incarcerated within the Arizona Department of Corrections Rehabilitation & Reentry.

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Chapter 1, Sec. 1.0 Guiding Doctrines and Philosophies

REFERENCES: NCCHC STANDARD P-A-01
NCCHC STANDARD P-A-03

PURPOSE: To provide grounding guidance for Medical Services Contract Monitoring Bureau and Health Services Contract Vendor staff to ensure access to, and provision of, high quality and well organized Health Services to inmates that are incarcerated in facilities that are under the medical auspices of the Arizona Department of Corrections Rehabilitation & Reentry.

RESPONSIBILITY: It is the responsibility of the ADCRR Health Services Contract Vendor Regional VP/Administrator, and Vendor Facility Health Administrators (with oversight monitoring by ADCRR Medical Services Contract Monitoring Bureau) to ensure that the communications regarding activities affecting the delivery of health care services are accurate, complete, and timely. Each is to be responsive to the other. It is every Vendor staff member's responsibility to ensure that inmate patients can be seen by a clinician and receive professional clinical judgments regarding their health status and also receive pertinent clinically necessary care that is ordered by authorized clinicians.

PROCEDURES:

1.0 Guiding Doctrines and Philosophies Department of Corrections Mission: The Arizona Department of Corrections Rehabilitation & Reentry and its Contract Partners recognize that a well-trained, professional work force serves and protects our communities and its crime victims by effectively employing the field's best security practices and proven pre-release programming support to prepare for the release and reintegration ex-offenders as civil, productive citizens.

1.1 MSCMB Mission: Through full programming of ADCRR offenders the Programs Division intends to contribute to a significant decrease in Arizona's relapse, revocation, and recidivism. A strategic and integrated approach to offender programming that combines the strengths of Health, Religious Services, Workforce Development, Work-based Education (Vocational Training), Mental Health Symptom Management, Alcohol and Drug, and Sex Offender Treatment delivers that promise. Targeted for change are those risk factors that drive offender criminality. This approach strengthens prison security and supports programs that normalize and reinforce responsible offender behavior through a philosophy. This is a system of "Change for Success by Design".

1.2 MSCMB: Our strategy, through our Contracted Partners, is to provide evidenced-based programming opportunities and services that sound social science research identifies as risk reducing activities. We will use proven techniques embedded in social learning theory, behavioral repetition that supports personal accountability, followed by positive reinforcement. With the funding provided by Arizona citizens, Programs will require offenders to practice on the inside the behaviors that produce civil and productive citizens on the outside. A business-like approach is our strategic goal to offender programming.

2.0 Mission: To provide constitutionally mandated health care to the offenders of the Arizona Department of Corrections Rehabilitation & Reentry, while protecting the health of its employees. To accomplish this, Health Care has several program and specialty areas for the employee and offender needs. The Arizona Department of Corrections Rehabilitation & Reentry provides inmates reasons for living healthy lifestyles and through its Contracted Partners, appropriate access to medical and dental health care at reasonable fees. Appropriate and uninterrupted health care be provided to inmates with chronic health conditions. ADCRR Medical Services Contract Monitoring Bureau provides oversight to ensure that all inmates are provided access to scheduled and emergency (as needed) health care, and are not refused health care treatment due to inability to pay. Consistent with community standards, to monitor the provision of quality medical care and services responsive to the inmate population to include: medical services, dental care, primary nursing care, and quality pharmacy care. Keeping inmates healthy is the basic platform from which the inmate is launched to successfully complete basic education, workforce development, and alcohol and drug treatment sessions essential to building good citizenship and self-sufficiency. The Correctional Public Health program assists in reducing the incidence and spread of communicable diseases, making the prison system a healthy and productive environment for both staff and inmates.

3.0 The Contract Vendor Health Staff hold to the basic tenets of the modern Hippocratic Oath (*L. Lasagna*, 1964) as guiding principles of daily activity.

> I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
>
> I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism.
>
> I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
>
> I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
>
> I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
>
> I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
>
> I will prevent disease whenever I can, for prevention is preferable to cure.
>
> I will remember that I remain a member of society, with special obligations to all my fellow human beings, those of sound mind and body as well as the infirm.

Chapter 1, Sec. 2.0 Authority and Accountability

REFERENCES: DEPARTMENT ORDER 105
DEPARTMENT ORDER 509
DEPARTMENT ORDER 512
DEPARTMENT ORDER 703
DEPARTMENT ORDER 706
DEPARTMENT ORDER 712
NCCHC STANDARD P-A-02
NCCHC STANDARD P-D-01
NCCHC STANDARD P-G-04

PURPOSE: To establish general authority for the provision of clinical services by the ADCRR Contract Vendor at each complex.

RESPONSIBILITY: Beginning July 1, 2012, all aspects of ADCRR Health Services were privatized. The Assistant Director, Medical Services Contract Monitoring Bureau (MSCMB) provides guidance to MSCMB Staff in order to meet the mission of the MSCMB and Department of Corrections Rehabilitation & Reentry, as well as ensure, through a joint effort with ADCRR Contract Vendor, the provision of constitutionally-mandated medical care to inmates in the custody of the Arizona Department of Corrections Rehabilitation & Reentry. The process of monitoring medical care provided by the Contract Vendor will be accomplished with an audit tool employed by ADCRR MSCMB.

PROCEDURES:

1.0 Medical Services Contract Monitoring Bureau

1.1 ADCRR Contract Vendor is responsible to ensure that all inmates are provided access to scheduled and emergency (as needed) health care, and are not refused health care treatment due to financial reasons. The Contract Vendor shall ensure that health care is delivered through a joint effort of the Vendor Health Services and security operations. The ADCRR Contract Vendor monitors the health care staff to ensure compliance with the same security regulations as other Department employees. The Medical Services Contract Monitoring Bureau Monitors shall ensure compliance with the Contract. Health Services Monitoring Bureau in conjunction with the Contract Vendor shall ensure that clinical decisions and actions regarding health care services provided to inmates remain the sole responsibility of qualified health care professionals. The Assistant Director accomplishes this through the Medical Services Contract Monitoring Bureau Monitoring Team.

1.2 MS Contract Monitoring Bureau Medical Program Administrator shares responsibility with the MS Program Evaluation Administrators in ensuring that clinical decisions and actions regarding health care services provided to inmates remain the sole responsibility of qualified health care professionals. The Medical Program Administrator serves as the senior Health Services Contract Monitoring clinician for

the Department. The ADCRR Contract Vendor sets, monitors, and adjusts standards of professionalism for their staff. The MS Contract Vendor shall develop medical staff by-laws.

2.0 Complex Responsibilities:

2.1. General Administration.

2.1.1 The Contract Vendor FHA is responsible for developing, reviewing, creating, publishing, and updating complex-specific post orders in support of Department Orders, Director's Instructions, the Medical Services Technical Manual and Institutional Orders.

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

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

2.2. Personnel:

2.2.1 Position Authority: The Vendor Facility Health Administrator at each complex is designated as the Responsible Health Authority. His or her responsibilities are delineated by the Contract Vendor's job description, Position Description Questionnaire, Medical Services Technical Manual and the Contract.

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

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

2.3 Staffing Patterns:

2.3.1 The MS Contract Vendor shall establish a standard staffing schedule, to include unit assignment, to ensure that adequate levels of staff are available to meet the requirements of the ADCRR Contract standards of care.

2.3.2 The Vendor FHA shall ensure that there is a current urgent notification (after hours) schedule for all pertinent disciplines as set forth by this Manual and Department Order 512.

2.4 Personnel Requirements:

2.4.1 As per the Contract, the Vendor is responsible for staffing needs, establish new positions, recruit staff, and document staff training.

2.4.2 The Contract Vendor is responsible for the acquisition of contracted Providers and other health care services.

2.4.3 The Vendor is responsible for ensuring all employed and contracted professional and technical staff are required to meet their licensure and certification requirements.

2.4.4 The Vendor is responsible for developing systems ensuring that all facility health staff meets the annual training requirements.

2.4.5 The Vendor is responsible for ensuring that each new employee receives New Employee Orientation within sixty days of hiring in accordance with ADCRR Department Order 509.

2.4.6 The Contract Vendor shall be responsible for ensuring that all documentation regarding misconduct and letters of discipline are forwarded through the on-site Contract Monitor to the Program Evaluation Administrator.

3.0 Physical Plant:

3.0.1 The Vendor is responsible for ensuring the acquisition of equipment, and supplies for routine and emergency services.

3.0.2 The Vendor is responsible for ensuring all requirements for Department, State, and uniform building and safety codes are satisfied and documented.

3.0.3 The Vendor is responsible for ordering all equipment, supplies, and forms.

3.0.4 The Vendor shall ensure that all radiology equipment is properly and regularly inspected and registered with Arizona Radiology Regulatory Commission. Refer to Department Orders 703 and 712.

3.0.5 The Vendor is the overall property manager for the assigned facility and shall ensure that all inventorial and non-inventorial equipment under their responsibility is accounted for and controlled at all times. The list of budgeted equipment and capital and non-capital will be provided by the MS Contract Monitoring Bureau personnel.

3.1. Safety and Security:

3.1.1 The Vendor is responsible to coordinate all routine, emergent, and advance planning with the complex Warden and designated staff as well as inform the MSCMB Program Evaluation Administrator and on-site Monitor on the resulting agreements and procedures.

3.1.2 The Vendor is responsible for the safe and secure operation of the Health Unit.

3.1.3 The Vendor is responsible for ensuring that their facility health staff complies with ADCRR Department Orders and complex Post Orders.

3.1.4 The Vendor has the responsibility to coordinate security coverage for the Health Units during normal business hours and after hour's emergencies with the Warden or his/her designee.

3.1.5 The Vendor is responsible for ensuring that all Health Services contracted or other visits to the facility are cleared by security prior to the visit. (Refer to Department Order 202).

3.1.6 The Vendor's FHA or designee is responsible to notify the Regional VP/Administrator and the MS Monitoring Bureau Assistant Director or designee when significant events occur.

3.1.7 The Vendor shall, in conjunction with Occupational Health Unit, establish an infection control plan in order to comply with all OSHA & HAZMAT regulations.

3.1.8 The Vendor shall, in conjunction with complex Fire and Safety Liaison and the Occupational Health Unit, monitor and advise the Warden regarding creation and management of biomedical waste.

3.2. Access to Care:

3.2.1 The Contract Vendor is responsible for ensuring the development and implementation of program establishment and procedures that have been directed by the MS Contract.

3.2.2 The Vendor shall ensure the establishment and publication of clinical procedures for each of the clinical areas; Medical, Nursing, Dental, and Medical Records.

3.2.3 The Vendor retains responsibility to create systems that provide for (that at the time of admission and throughout their stay) all inmates are informed verbally, with written instructional handouts, and other necessary means, a description of the process to access health care services.

3.2.4 The Vendor is responsible to develop systems to ensure that sufficient and suitable space, equipment, and supplies are made available for providing an adequate health care delivery system in the complex.

3.2.5 The Vendor will ensure that all newly arrived inmates are provided with required up-to-date orientation information and/or literature.

3.2.6 The Vendor shall oversee and ensure development, publication, and distribution of schedules of hours of health care services and services that are provided to inmates assigned to the complex.

3.3. Provision of Care:

3.3.1 The Vendor is responsible for ensuring that any recommendation for care and treatment taken by the medical staff is supported through facility resources.

3.3.2 The Vendor shall ensure that on-site clinics are scheduled in accordance with need and in compliance with the governing contracts and directives.

3.3.2 The Vendor will ensure on-site compliance with governing licensure and treatment statutes.

3.3.3 The Vendor is responsible to establish a process for the delivery of authorized medications, treatments, and diagnostic testing. The systems should include a process for the clinic issue supply reordering and delivery of bulk clinical supplies.

3.4. Special Needs and Special Issues:

3.4.1 The Vendor designated personnel is the convening authority for Clinical Staffing when one is requested by the attending Provider of record to address the inmate who presents with complex issue(s) or series of health issues.

3.4.2 The Vendor shall develop procedures for the delivery of both routine and emergency nursing services to CDU/Lockdown.

3.4.3 The Vendor is responsible for ensuring the development of a schedule for the passing of medications to include CDU and Lockdown and maintenance.

3.4.4 The Vendor is responsible to identify the number of Americans with Disabilities Act (ADA) Beds in the facility and develop a method for identifying and tracking inmates who meet ADA criteria.

3.4.5 The Vendor is responsible to coordinate the management team in developing procedures for facility specific emergency medical services and procedures to include ground and air transportation.

3.4.6 The Vendor shall develop a local plan for IMS in coordination with the Complex Incident Management System plan. (Refer to Department Order 706).

3.4.7 The Vendor, in coordination with their Mental Health staff, shall establish local procedure (to include training protocols and schedules) to provide the necessary health services required to support the health of the inmate being managed under Department Order 804.

3.4.8 The Vendor shall establish an Outside Review Consultation and Referral process in accordance with Department Order 1101.

4.0. Mental Health Services will be provided by the Contract Vendor as per the Contract. The Vendor shall provide treatment for routine, acute, and crisis psychiatric needs.

5.0. This technical manual must be reviewed at least annually and updated as necessary. Annual review will be documented by signing and dating this technical manual by the Vendor's supervisory staff members.

Chapter 1, Sec. 3.0 Communications, Meetings and Reports

REFERENCES:

DEPARTMENT ORDER 102
DEPARTMENT ORDER 105
DEPARTMENT ORDER 112
DEPARTMENT ORDER 117
DEPARTMENT ORDER 201
DEPARTMENT ORDER 513
DEPARTMENT ORDER 706
DEPARTMENT ORDER 711
NCCHC STANDARD P-A-04
NCCHC STANDARD P-A-08
NCCHC STANDARD P-E-08

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

RESPONSIBILITY: It is the responsibility of the Contract Vendor personnel and Medical Services Contract Monitoring Bureau to ensure that the communications regarding activities affecting the delivery of health care services are accurate, complete and timely; each is to be responsive to the other.

PROCEDURES:

1.0. Leadership Team Meetings: The Contract Vendor FHA shall attend a weekly meeting of their facility management team consisting of the FHA, Medical Services Contract Monitor, complex Warden and other invited guests as deemed necessary, Minutes of these meetings shall be prepared and distributed to the MS Contract Monitoring Bureau Program Evaluation Administrator (through the Contract site Monitor), the facility Warden and the Vendor's Supervisory staff.

1.1. The Vendor FHA shall convene a monthly Complex Continuous Quality Improvement Committee. The meeting will serve to describe ongoing quality improvement studies and activities. Minutes of the meeting shall be prepared and a copy forwarded to the MS Contract Monitoring Bureau Program Administrator, through the site Contract Monitor. The CQI minutes should include but not limited to guidelines outlined in the National Commission on Correctional Health Care (NCCHC) Standards PA-06.

1.2. Medical Services Contract Monitoring Bureau Staff shall meet monthly using Teleconferencing technology as needed.

1.3. Pharmacy and Therapeutics Committee: The ADCRR Contract Vendor and selected MS Contract Monitoring Bureau staff (Pharmacy monitor, Medical Program Administrator, Medical Program Evaluation Administrator, the Assistant Director or designee and other MS Contract monitors as deemed necessary) shall conduct Quarterly Pharmacy and Therapeutics Committee meetings. Minutes of the meetings shall be made available to all members of the committee and to the Vendor's clinical staff (Practitioners and Nursing).

2.0. Communication between MS Contract Monitoring Bureau and the MS Contract Vendor: All communication, written or verbal, shall be transmitted in the most direct, concise, timely and clear manner in order to facilitate issue resolution.

2.0.1 Written communication includes, but is not limited to: Department Orders, Technical Manuals, Technical/Clinical Notices, Standard Operating Procedures, Meeting Minutes, Personnel Actions, Addendums, Letters and Memorandums.

2.0.2 Verbal communication includes, but is not limited to: conference calls, information requests, and inmate status inquiries.

2.1. All communication via telephone or face to face will be conducted in a professional and courteous manner. Significant verbal decisions and/or directions given or received by the initiator shall be followed up by written memorandum to the other party.

3.0. Emergency Notifications to the Vendor Regional VP/Administrator.

3.1. The Vendor FHA or designee shall notify the Vendor Regional VP/Director or designee and ADCRR MS Assistant Director or designee immediately (day or night) when any of the following significant events occur:

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

3.1.2 Major disturbances, e.g., riots.

3.1.3 Death of Vendor's Health Services employee.

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

3.1.5 Suspected cases of TB, chicken pox, Hepatitis A, mumps, Rubella (German measles), and Rubella (measles); or any other communicable disease. (Refer to Department Order 1102, Communicable Disease Reporting Requirements.)

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

3.2. The Vendor FHA or designee shall forward a written information report, to the Vendor Regional VP/Administrator and ADCRR MS Assistant Director detailing the circumstances by the close of business on the next business day following the occurrence.

3.3. During an emergency (while under ICS), the Vendor FHA, in coordination with the Logistics Section Commander, will determine who will be issued radios and coordinate the communication methodologies to be followed during the ICS.

4.0. Emergency Notifications to Warden: The Contract Vendor FHA or designee shall notify the Warden, or designee, of all serious illness, injury, communicable disease outbreak, or potential disease outbreak. The Warden shall be notified of an inmate's health status when, as determined by health staff:

4.0.1 An illness is life threatening.

4.0.2 Any incident involving reported potential safety hazard.

4.0.3 The Warden shall be notified of the death of an inmate. Notification to next of kin will be carried out by Security Operations and/or the chaplain service according to established policy at the local prison complex and as described in Department Order 711. All attempts and/or completion of notification shall be documented on an incident report and forwarded in accordance with DO 711. When referred to the FHA, every effort should be made to answer any related questions or inquiries by the family within the confines of confidentiality policies. Any questions or information of concern should be discussed with the Contract Vendor Regional VP/Administrator or designee.

5.0. Information Reports: Incident report formatting and submission of such reports are to be in compliance with Department Orders 105 and 706. This document and the references describe proper notification and reporting of significant incidents. Staff shall complete an Information Report, Form 105-2pf on all major or minor incidents.

6.0. Emergency Notifications to Facility Professional Management Staff: As a general rule, inmates will not be transported off-complex to outside hospitals without the acknowledgment and/or direction of a medical provider employed by ADCRR Contractor. The Vendor FHA or designee will be contacted by either the nursing staff or the Vendor Provider of any "send outs" to the hospital or emergency facilities. After hours, following the departure of an inmate by emergency medical transportation, the attending nurse will contact the staff and offices identified by local post order and leave a voice or e-mail message informing the recipient of the transport. The Facility Health Administrator or designee will be immediately contacted by the on–site Nurse if any unplanned conditions occur related to an emergency medical transport. All errors relating to an inter-facility transfer must be communicated to the FHA or designee and ADCRR site monitor at the time the error (inappropriate placement, inability for receiving complex to provide adequate care of the inmate's needs, etc.) has been identified.

7.0. Outside Communications: Oral communication regarding inmate health status will be responded to by ADCRR Contract Vendor in accordance with the guidance contained in this Manual. Inquiries relating to an inmate's health condition shall be referred to the Vendor FHA or their designee. Authorization for release of information must be obtained from the inmate prior to releasing any information. If a Vendor health staff member receives a Governor's inquiry, Legislature inquiry, an inquiry from any elected official or a media inquiry, the MSCMB Assistant Director or designee and the Vendor Regional VP/Administrator or designee must be notified IMMEDIATELY. If contacted by the Media for information refer to Department Order 201.

8.0 All public speaking presentations by ADCRR Contract Vendor on behalf of ADCRR, must receive approval by MS Assistant Director or designee.

Chapter 1, Sec. 4.0 Policy Administration (Policy and Procedures)

REFERENCES: Department Order 512
NCCHC STANDARD P-A-05

PURPOSE: To provide policy formats for standard publications.

RESPONSIBILITY: It is the responsibility of ADCRR Medical Services Contract Monitoring Bureau to provide current Policy guidance to the Contract Vendor. It is the responsibility of all Contract Vendor staff to ensure standardized policies that are published, are adhered to, in accordance with sound medical and security practices.

PROCEDURES:

1.0 The Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau maintains a Medical Services Technical Manual (MSTM) that serves as an adjunct to Department Order manual.

1.1. The MSTM shall contain only those policies that are approved by the Health Services Assistant Director.

1.2. The policy statements define the official position on particular issues, and procedures describe how the policies are carried out.

2.0. The Vendor's Facility Health Administrators, Vendor's complex Directors of Nursing (DONS) and Vendor's site Medical Directors retain responsibility to annually review the MSTM as well as Facility Post Orders to ensure accuracy and effectiveness.

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

4.0. Each MSTM policy and each Post Order will be cross-referenced with the appropriate NCCHC Standard(s), ADCRR Department Orders, ADCRR Director's Instructions, if applicable, and any other appropriate official document(s).

5.0. All policies published for inclusion in the MSTM will be published under a POLICY TRANSMITTAL COVER SHEET.

5.1. The coversheet will describe the policy number, title, a short description of the reason for the policy, where the policy should be filed. The Coversheet is not to be published without the signature of the Health Services Assistant Director or his policy designee.

5.2. The Contract Vendor FHA or designee is responsible to copy and distribute the new policy to all unit Technical Manuals under his/her supervision. Upon completion of the entries into the unit MSTM, the

transmittal should be dated and initialed by the FHA or his administrative designee and filed with the FHA's Master MSTM (maintained under the control of the FHA and located in the FHA's office).

5.3. The cover sheet of the FHA's Master MSTM must indicate (by dated signature) an annual review of the MSTM by all the facility's Vendor site Medical Directors, Vendor Site Directors of Nursing (DONS) and the Vendor FHA.

6.0. The verbiage contained in this manual is provided to assist the Contract Vendor personnel. The guidance contained in this Manual is designed to clarify State and Federal regulations. It is also designed to intertwine with professional standards and common sense.

6.1. Many of the words and abbreviations in common use will be found in Appendix G. However, not all words are defined due to the common sense nature of many health service expressions. For example;

6.1.1 "Document" generally means to write information in a permanent and officially sanctioned form.

6.1.2 "Notify" generally means to contact an individual through immediate one-on-one means without relying on voice mail or unverifiable intermediary methods.

6.1.3 "Observe" generally means to visualize with one's own eyes without relying on reports from others.

7.0. All policies are provided as guidance in administration by Medical Services Contract Monitoring Bureau. The Contract Vendor is responsible to ensure compliance.

7.1. Should a Vendor perceive a need for a change to policy or a waiver of policy, as it affects the specific complex health facility, the Vendor shall produce a letter to the ADCRR Health Services Assistant Director or designee that:

7.1.1 Identifies the particular policy element that presents a problem.

7.1.2 Identifies what is requested to be waived.

7.1.3 Describes any recommended changes to policy.

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

7.2. The letter must receive a comment and endorsement by the appropriate Vendor Regional VP/Administrator or designee, prior to decision by the ADCRR Assistant Director or designee.

7.3. The original policy shall be complied with until and unless the waiver is authorized and approved by the MSCMB Assistant Director or designee.

Chapter 1, Sec. 5.0 Quality Improvement of Health Services

REFERENCES: DEPARTMENT ORDER 1101
NCCHC STANDARD P-A-06

PURPOSE: To provide guidance for a Continuous Quality Improvement (CQI) philosophy for the MS Contract Vendor. To establish a structure that develops and utilizes quality resources and promotes the implementation of Continuous Quality Improvement. A continuous quality improvement (CQI) program monitors and improves healthcare delivery in the facility. Implementation of CQI will be accomplished by the instruction of quality tools and team facilitation skills. The quality of the delivery of health care in the Arizona Department of Corrections Rehabilitation & Reentry will be monitored through Continuous Improvement activities, which will include program review, inquiries regarding customer satisfaction, assessment of health care outcomes, assessment of the relationship of Health Services to other areas of inmate management, and educational activities. The ADCRR Medical Services Contract Monitoring Bureau has embarked on a process of results oriented quality documentation to achieve the desired outcomes.

RESPONSIBILITY: It is the responsibility of the ADCRR Medical Services Contract Monitoring Bureau Assistant Director or designee, the Contract Vendor Vice President of Operations or designee, Vendor Medical Directors or designee, Vendor Facility Health Administrators or designee and key contact staff/Vendor Supervisory staff to ensure program compliance. It is the responsibility of all Contract Vendor staff to implement and utilize quality tools and concepts. This is to include but not limited to: Attending quality and team training, identifying opportunities for improvements, management by fact, and focusing on processes. The Vendor Quality Improvement Director or designee is responsible for ensuring that the daily operations of the Quality Improvement Program are in compliance with the ADCRR System of Written Instruction, Department Orders, National Commission on Correction Health Care (NCCHC) guidance and Medical Services Contract Monitoring Bureau (MSCMB) Technical Manuals.

PROCEDURES:

1.0. Complex CQI Committee responsibilities: The Health Services Contractor is responsible to ensure the establishment of the complex CQI committee. The quality improvement committee should consist of, representatives from all disciplines practicing at the complex. The Site Medical Director (responsible physician) must be involved in the CQI process. This group will meet monthly, and minutes of committee meetings will be prepared utilizing an approved agenda format. CQI minutes should provide sufficient detail to guide future discussions. The committee:

a. Identifies health care aspects to be monitored and establishes thresholds.
b. Designs quality improvement monitoring activities.

c. Analyzes the results of monitoring activities, for factors that may have contributed to not reaching the desired threshold.

d. Develops and implements improvement strategies to improve/correct the identified health care problem.

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

1.1. The CQI committee will assure that the following areas to be reviewed at least annually include (but are not limited to); access to care, admission screening and evaluations, nursing and provider lines, chronic disease services, health assessments, continuity of care, hospitalizations, infirmary care, pharmacy services, diagnostic services, dental services, adverse patient occurrences and all deaths. Further review will include man down drills, disaster drills, environmental inspection reports, inmate grievances and infection control practices.

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

2.1. The focus of these reviews is clinical aspects of the outpatient health care delivery system. Criteria for a quality assurance chart review are included on the Quality Assurance Chart Audit form.

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

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

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

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

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

3.0 CQI Studies (Outcome- or Process-study) will be reported in the following formats:

3.0.1 How topic was selected

3.0.2 Methodology used to study the topic

3.0.3 Findings of the group

3.0.4 Plan for improvement based on evidence

3.0.5 Implementation plan

3.0.6 Outcome following monitoring of 3, 6, or 9 months to assess effectiveness of corrective action plan.

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

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

5.0 The Health Service's Contractor will forward a copy of each complex CQI monthly meeting minutes to the MSMB as required by the contract. The CQI meeting minutes must include an up-date on any ongoing CQI process and/or outcome studies in process, as well as review of grievances, infection control, review of emergency transports, medication errors, overview of chart reviews, environmental inspections, and any health care delivery concerns or improvements addressed by the committee.

6.0 In order to reduce risks and prevent harm to patients, the Health Services Contract Vendor shall institute a system to review adverse and near miss clinical events. An <u>adverse clinical event</u> is defined as a potential or actual injury or death caused by medical management rather than by the patients disease or condition. A <u>near miss clinical event</u> is an error in clinical activity without consequential adverse patient outcome, i.e., wrong drug dispensed but not administered to the patient.

The Vendor designated staff member should analyze each adverse clinical or near miss event. These events shall be discussed as part of the Continuous Quality Improvement Program.

The key to instilling a culture of patient safety is to understand that there is no one way to reduce errors and there are no infallible systems that prevent medical errors. Supervisors, therefore, should employ a range of activities that communicate to staff that a culture of patient safety is largely a matter of attentiveness and therefore encourage staff to openly address problems without reprisal, and also to offer solutions.

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

8.0 Health staff responsible for guiding the CQI program should be given training opportunities to enhance their skills and the program's effectiveness.

9.0 Process for cross-divisional staff participation: Processes in need of improvement may cross divisional lines. In such cases, the chartering sponsor may request participation from the supervisor(s) and Deputy or Assistant Director of the other division or Warden of employees who would be beneficial to the team and show interest in participating.

ARIZONA DEPARTMENT OF CORRECTIONS REHABILITATION & REENTRY

Monthly CQCR Report and Action Plan

Institution/Unit:

[ ]Jan [ ]Feb [ ]Mar [ ]Apr [ ]May [ ]Jun
[ ]Jul [ ]Aug [ ]Sep [ ]Oct [ ]Nov [ ]Dec
Year: _____

CHART REVIEWS

Total Number of Charts Reviewed	Discussion of Noncompliant Items	Action Taken	Person(s) Responsible	Time Lines

Overall conclusion of chart findings:

Infection Control Reviews and Findings:

July:	Aug:
PPD's	PPD's
HEP-C	HEP – C
MRSA	MRSA
Syphilis	Syphilis
HIV	HIV

Environmental Inspection Report Findings:
Fire & Safety Reports:
Kitchen Inspections:

Additional Reviews and Findings:
[ ] Prescription Errors [ ] Inmate Grievances [ ] Psychotropic Med Review
[ ] Emergency Drill (1) [ ] MRC (Non Routine)
[ ] MRC Committee [ ] Death and Mortality Reviews

Comments: (Narrative Detail)

Emergency Drills:
Inmate Grievances:
Prescription Errors:
Death and Mortality Review:

IN ATTENDANCE

Administration:	Dental:	Medical :
Medical Records:	Nursing:	Mental Health:
Pharmacy	Psychiatry	Other

Submitted By: _____ Date: _____

ACTION PLAN

Significant Problems (follow-up on previous meetings, and present findings)	Units	Corrective Action and Time Line	Responsible Person(s) and Status
Comments:			

FOCUS STUDIES IDENTIFIED

Describe Problem	Discuss Method Evaluation Method	Responsible Person(s) and Status
PROCESS STUDY:	See attached narrative report	
Comments:		

Health Services Administrator Signature Date	

1105-7
1/18/05

QUALITY ASSURANCE CHART AUDIT

Audit Completed by: _____

Date: _____ Institution: _____

AUDIT CRITERIA		ADCRR #
1. Dates of service reviewed in chart.		
2. Name of staff whose documentation was reviewed.		
3. Was the exam appropriate to the patient's complaint?	Yes/No Not Applicable	
4. Were on site lab tests, EKGs, Vital Signs appropriate?	Yes/No Not Applicable	
5. Were appropriate lab tests, diagnostic studies, and/or consults ordered?	Yes/No Not Applicable	
6. Were lab tests, diagnostic studies, and/or consults completed in a timely manner?	Yes/No Not Applicable	
7. Were abnormal lab or other diagnostic test results acknowledged and acted upon?	Yes/No Not Applicable	
8. Was the assessment consistent with the subjective and objective notes?	Yes/No Not Applicable	
9. If medication was prescribed was it consistent with the diagnosis?	Yes/No Not Applicable	
10. Were follow up instructions noted as given?	Yes/No Not Applicable	
11. Where changes in housing or work assignment documented if needed?	Yes/No Not Applicable	
12. Was patient education documented if needed?	Yes/No Not Applicable	
Comments:		

GRIEVANCE WORK SHEET

Facility				
UNIT				
SEX	Male Female			
AGE		HepC	YES NO	
CATEGORY	Medication issue – related to receipt of medication			
		Pharmacy related		Nursing related
		Intake Related		
	Dental access issue-imperfection in provision of dental care			
	Dental Treatment issue-disagrees with dental care plan			
	Professional inter-relations RN-addresses specific RN			
	Professional inter-relations provider-addresses specific provider			
	Prosthetic devices –dental			
	Prosthetic devices-glasses (exam relation below)			
	Prosthetic devices-ortho			
	Prosthetic devices-misc			
	Medical treatment disagreement-disagrees with prescribed plan of medical care. Nursing, provider, timelines, medications, discrimination, plan of care, miscellaneous.			
	Living assignment issues-relates to living accessories and/or assignment			
	Medical access-imperfection in provision of medical care			
	Diets-related to receipt of or provision of therapeutic diets			
	IPC issues-relates to provision of inpatient care			
	Miscellaneous-responded to by health services, doesn't fit above categories and may or may not be medically related			
	Medical Records-related to receipt. Provision of medical records			
	Access to eye exam-unable to obtain eye exam			
	Charging-inmate disagrees with co-pay for visit			
COMPONENTS	For reviewing quality of responses			
	Appropriate-does it place blame, does it assume responsibility			
	Informational-does it address concern of patient			
	Professional-does it acknowledge the importance of the concern or consider the patient, or is it argumentative, defensive and lacking in professional ethics			
	Directed to the patient			

Chapter 1, Sec. 5.1 Peer Review of Professional Activities

REFERENCES: DEPARTMENT ORDER 1105
NCCHC STANDARD P-C-02

PURPOSE: A clinical performance enhancement process evaluates the appropriateness of primary care clinicians' services delivered by all direct care clinicians, and RNs and LPNs.

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

GENERAL PROCEDURE:

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

1.1 Clinical performance enhancement reviews are kept confidential and incorporate at least the following elements:

a. Name of the individual being reviewed
b. Date of the review
c. Name and credentials of the reviewer
d. Confirmation that the review was shared with the clinician
e. Summary of the findings
f. Corrective action, if any

1.2 A log or other written record providing the names of the individuals and dates of their most recent reviews is to be made available to the MSCMB. This documentation may be shared for verification.

1.3 The responsible health authority (RHA) implements an independent review when there is serious concern about a health care clinician's competence.

1.4 The RHA implements procedures to improve an individual's competence when such action is necessary.

1.5 The clinical performance enhancement process for practitioners is part of the Health Services Contractor Credentialing Process and shall be conducted at the corporate level.

1.6 The clinical performance enhancement for Qualified Mental Health Professionals, RN's and LPN's shall be conducted at the site level.

2.0. First Level--Local Review: The Contract Vendor complex Medical Director or designee shall review the health record activity entries of all medical care Providers at the complex. The Contract Vendor complex Dental Director or designee shall review the dental activity records of all dental care Providers at the complex. The Contract Vendor complex Director of Nursing or designee shall review the health record

activity entries of all nursing staff (RNs and LPN/LVNs) at the complex. The records of the site Medical Director shall be reviewed by the Contract Vendor Regional Medical Director or his designee according to the following peer review procedures. The records of the site Dental Director shall be reviewed by the Contract Vendor Regional Dental Director or his designee according to the following peer review procedures. The records of the site Director of Nursing shall be reviewed by the Contract Vendor Regional Director of Nursing or their designee according to the following peer review procedures. Copies of the health record sections do not need to be made for this local review.

2.1. 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 Vendor site Medical Directors and site Dental Directors in conjunction with the Vendor Facility Health Administrators (FHA) are to retain all copies of review reports for 1 year following the review.

3.0. First Level--Formal Peer/Case Review: A formal peer review or case review may be requested relative to inmate health care by the MSCMB Assistant Director, MS Contract Vendor, ADCRR Medical Program Administrator, or the Health Services Program Evaluation Administrator.

3.1. Within ten working days of the written request for a Formal Peer review, the Contract Vendor shall convene a committee to conduct the initial review. The committee shall include (as appropriate): Vendor Facility Health Administrator; Vendor Medical Provider(s); Vendor Dental Provider, Vendor Mental Health Provider; Vendor Director of Nursing; and others as needed.

3.2. The Vendor representative shall obtain copies of the complete health record(s) of the case prompting the Peer Review, including both those from within ADCRR and those from offsite providers of care for the focus inmate. The Contract Vendor representative may also acquire and provide to the committee, any health records of other inmates relevant to the case being reviewed.

3.3. Upon completion of the peer review, a complete copy of the inmate health record; committee findings, summary statement along with a cover letter must be forwarded through the appropriate MSCMB Monitor to MSCMB Program Evaluation Administrator within ten working days following completion of the review.

4.0. Second Level Health Services Program Evaluation Administrator/Medical Program Administrator Review:

4.1. Upon receipt by the Health Services Program Evaluation Administrator of the items produced by the first level peer review, a second level peer committee may be convened by the MSCMB Program Evaluation Administrator or designee within ten working days to review in a comprehensive manner all relevant materials, documents, and initial peer review findings.

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

4.3. Upon completion of the second level peer review, a summary of findings shall be prepared by the Medical Program Administrator or designee and submitted to the Medical Services Contract Monitoring Bureau Assistant Director within ten working days.

Chapter 1 Sec. 6.0 Incident Command System (ICS)

REFERENCES: Department Order 706
Department Order 804
Department Order 1101
NCCHC STANDARD P-A-06
NCCHC STANDARD P-A-07

PURPOSE: The following procedure describes and explains Health Services' emergency response roles and responsibilities in the event of a man-made disaster, natural disaster, internal disaster and/or an external disaster. This procedure applies to ICS responses, as defined by NCCHC STANDARD P-A-07 in which Prison Operations has determined a need for health staff involvement. This procedure also outlines training and documentation requirements necessary to help staff prepare for a large scale emergency. Proper training will yield an efficient response in the event of an actual emergency. An ICS drill is to be practiced, documented, and critiqued at least annually on all shifts, and at all units where medical staff are routinely assigned. This procedure is designed to provide the greatest amount of good for the greatest number of people in the event of an emergency.

RESPONSIBILITY: It is the responsibility of the MS Contract Vendor Regional VP/Administrator or designee to coordinate the Emergency Plan with the Warden and designed staff as well as inform all Vendor Health staff of the defined procedures below. All Vendor Health staff, including professional and technically trained experts, are expected to respond appropriately to all medical emergencies.

PROCEDURES:

1.0. General Organization Response Requirements.

1.1. While the primary focus of the ADCRR Health Services Contract Vendor is to provide routine and emergency services to inmates, all Vendor staff must also be prepared to (and must) respond to medical emergencies involving security staff and visitors. In general, the emergency support provided by Vendor Health staff, may include such things as advice in contacting emergency first responders; application of basic first aid and CPR while waiting for emergency response personnel to arrive; or serving as on-scene medical managers of acute situations.

1.2. As the most likely profession to be called upon to respond to emergencies, Vendor nursing staff are reminded that they should not provide care outside the scope of the Nurse Practice Act or in areas beyond the limits of their training. Additionally, staff are reminded that, within the directives of the senior security officer on scene, care is to proceed regardless of the availability or non-availability of a camera to record the event.

1.3. It is the responsibility of the Contract Vendor to keep up-to-date emergency phone numbers and distribute this phone list to their supervisory staff. Phone lists should include the approximate time it would take an employee to get to the facility in the event of an emergency.

1.4. Vital health services necessary for the preservation of life or function should be maintained at involved as well as uninvolved units, but only when it is safe and reasonable to do so. The Vendor representative, under direction of the Incident Commander, should instruct and direct Vendor Health staff at other units.

1.5. Wardens and MS Contract Vendor are expected to coordinate emergency response exercise scenarios that require emergency response within the time frame and response described in ADCRR Directives into existing emergency exercise plans. Post orders must reflect procedures to support the THREE MINUTE response required by Directive and to reduce the response time of Medical Staff to the minimum time possible.

2.0. ICS organization:

2.1. The Vendor FHA or designee will be notified of an ICS by the Warden or designee. The FHA or designee must be available by cell phone at all times in case of an emergency.

2.2. In the event of an ICS, Vendor health staff fall under the administrative coordination of the Logistics Section of the ICS Control organization. This group is called OPAL (Operations, Planning, Administration, and Logistics).

2.3. Any ICS response requires notification of the Vendor Regional VP/Administrator or designee by the Vendor FHA or designee. See MSTM Chapter 1 Section 3.0.

2.4. It is the intent of this policy that a complex specific system be created by the Vendor Facility Health Administrator or designee and the Warden that ensures that the personnel arriving and/or responding to a medical emergency contact the most appropriate level of medical support. That is, Security Staff may be the staff who makes the call to 911 to acquire an ambulance. This will typically be at the direction of the attending medical staff. However, if awaiting medical staff's arrival will endanger the life of an inmate, security staff may make the call.

3.0. Simulations and Plan Evaluation: The Emergency Plan developed in coordination with the Warden must be practiced, documented and critiqued at least annually by security and Vendor Medical Staff.

3.1. Wardens and Vendor Facility Health Administrators are expected to conduct exercises and drills that test staff response time to these situations. "Man-Down" drills must simulate an emergency affecting one individual and must be practiced once per year per shift per unit where medical staffs are regularly assigned; and "Mass disaster" drills must involve staff on all shifts and must be practiced so that over a 3-year period each shift has participated; and the simulations must be level "B" ICS or higher that involves medical personnel. Prior to the simulation, the Vendor FHA is to appoint 1-3 people to serve as evaluators of the ICS simulation. One evaluator shall be a representative from Prison Operations. The evaluators are to fill out the ICS critique and submit it to the FHA. The results of the critique shall be disseminated to involved Vendor health staff and incorporated into future ICS training sessions. The FHA will forward a copy of the Critique to the Vendor Regional VP/Administrator and ADCRR site Monitor. In the event of an actual ICS, the FHA or designee is responsible for the completion of the ICS critique within five business days. A copy of this critique will be sent to the Vendor Regional VP/Administrator and ADCRR site monitor by the end of the 5th business day. The Comprehensive Quality Review Committee must review the written evaluation in accordance with the NCCHC Standard P-A-06.

4.0. General Medical Response Requirements: In the event of an ICS (level "C" and above), the Vendor FHA or designee will assume command of Vendor health staff in coordination with the Logistic Section Leader at the Command Post. The location of the Command Post is determined by the Incident Commander. The FHA or designee will act in coordination with the Logistics Section to expand the ICS as needed. This may include obtaining backup staff. If back up health staff is required, the FHA should first contact Vendor on-call staff, followed by facility site Medical Director and site Director of Nursing (DON). Vendor Supervisory staff will then notify additional staff at the FHA or designee directions. All vendor Health staff should assess scene safety before entering an area to provide treatment or triage.

5.0. Emergency Supplies: At least one "man-down" bag will be kept in a readily accessible area, to be used in the event of an ICS. The contents of the "man-down" bag should be monitored routinely in accordance with the inventory listed in MSTM Chapter 1 Section 6.2. Additional "man-down" bags and supplies can be obtained from units not affected by the ICS. A robust set of medical supplies will be located at a place identified by the Vendor FHA or designee and Warden and will be maintained and acquired for use in Mass casualty situations as directed by the FHA.

6.0 Multiple Inmate Events:

6.1. Triage: The Logistics Section Leader will determine where triage will occur. When possible, staff members will be triaged in separate areas from inmates. The Primary Triage Officer is the person with the most appropriate health care skill and experience on the scene. The Primary Triage Officer is subject to change as more experienced medical personnel arrive on the scene. Upon changing Primary Triage Officers, a status briefing should be given by the initial triage officer to the new person assuming this responsibility. Triage tags will be used to triage victims of an emergency. The triage tags need to identify treatment and transportation needs of victims based on a four level classification scheme such as the following:

Priority 1 patients needing immediate care that have a high likelihood of survival. Examples include patients with airway obstruction and early signs of hemorrhagic shock.

Priority 2 patients whose transport and treatment can be delayed for a few hours. Examples include patients with fractures or sprains and soft tissue injuries.

Priority 3 patients whose injuries do not threaten life or functions.

Priority 0 patients who are dead or whose injuries are so severe that prognosis is poor. The following guidelines can be used to triage victims:

6.2. Treatment Location: When possible, treatment areas should be kept separate from triage areas. Separate treatment areas will be established for injured inmates and staff. A log should be kept indicating disposition of victims in an emergency. A separate form is to be used for staff and for inmates. This log shall be utilized after ICS to document treatment in an inmate's health records. (Refer to Appendix Staff/Inmate Disposition Log). The Vendor FHA or designee shall designate personnel responsible for completion of this log. The Logistics Section Leader is responsible to determine who will accompany inmates transferred to off-site medical resources.

6.3. 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. If possible, separate holding areas should be established for staff and inmate bodies.

6.4. Medication Administration in a Disturbance. The Vendor Facility Health Administrators or designee will develop a local response for each incident with the input of the Vendor site Medical Director, Vendor DON, other supporting personnel and Vendor Medical Records Librarian. The plan must generally include the following elements:

6.4.1 Methods for identification of inmates in varying need of medications or treatment.

6.4.2 Methods of delivery of medication and treatment in highly controlled <u>or</u> unsecured areas.

6.4.3 Coordination of communication under ICS restrictions.

6.4.4 Methods of control and monitoring of staff safety.

6.4.5 Personnel relief plans should the ICS overlap shifts.

7.0. Individual inmate emergencies: It is the standard of the Arizona Department of Corrections Rehabilitation & Reentry to assess and render aid to all medical emergencies, including suicide attempts, within THREE MINUTES of becoming aware of a non-responsive inmate or an inmate in medical crisis. In the event that an inmate is found non-responsive, in a state of medical emergency, or in the act of attempting suicide, staff shall assess the situation and render aid within three minutes of becoming aware. In the instance where an inmate is secured in a cell, a minimum of two staff (including non-security staff) may access a cell to respond and initiate aid. Where an inmate is in a single cell, one staff member may access the cell to respond and initiate aid. Assembling a team to remove an inmate from a cell is not

required. It is not required that a supervisor be present prior to cell access or before initiating aid to an inmate.

8.0. For all emergency responses, staff should assess the situation and proceed as follows within the THREE MINUTE time frame: Activate Incident Control System (ICS). Inherent in the ICS is the notification to supervisory staff and medical responders as required.

8.1. In the case of a non-responsive inmate, issue two loud orders for the inmate to respond.

8.1.1 Conduct a visual sweep of the area to determine that no weapons are present or accessible.

8.1.2 If an inmate's hands cannot be seen and he/she is non-responsive, an immediate judgment must be made by a first responder to determine whether the inmate's condition outweighs the potential risk involved in entering the cell/living area.

8.1.3 Remove other inmates from the cell/living area.

8.1.4 While ideally all situations of this type should be videotaped whenever possible, the availability or arrival of a video camera should never delay entry into a cell/living area or the initiation of aid to an inmate.

Chapter 1, Sec. 6.1 Urgent Notification List

REFERENCES: Arizona Administrative Code R4-23-672
DEPARTMENT ORDER 512
NCCHC STANDARD P-A-07

PURPOSE: To provide current contact information to the Vendor medical and ADCRR security staff in the event of a medical emergency, providing capability to address emergent medical needs on a twenty-four hour basis by the Vendor medical staff in the event that a Vendor medical Provider is not on site.

RESPONSIBILITY: It is the responsibility of MS Contract Vendor to provide a current On Call / Urgent Notification List (UNL) to Vendor Medical and ADCRR Operations staff upon receipt from the below authors. This list is to be used in providing after hours clinical support.

PROCEDURES:

1.0. Urgent Notification List Authors: The UNL will be provided for Vendor Medical, Dental, Nursing and Mental Health staff.

1.1 Creation and publication of the Medical Providers UNL is the responsibility of the Vendor.

1.2 Creation and publication of the Dental Providers UNL is the responsibility of the Vendor.

2.0 UNL Development Process: The UNL will be created identifying Vendor staff that will be responsible for coverage of assigned complexes. The UNL will identify both a Primary and a Secondary staff member with current contact numbers including cell number, home phone number. The UNL will include contact numbers for the Vendor Medical Director, Vendor Facility Health Administrator, Vendor Mental Health Director, Vendor DON, Vendor Dental Director, Vendor Pharmacy Director Vendor Regional VP/Administrator, and Vendor Director of Operations.

2.1. The UNL will identify the dates that each staff member is providing coverage.

- 2.1.1 Coverage will be identified for each calendar month.
- 2.1.2 The UNL will be provided to all Vendor Health staff.
- 2.1.3 Any changes to a published UNL will require notification to all Vendor Health staff to prevent any lapse in coverage.

3.0. Calls to Vendor UNL staff members are to be documented in the health record for any patient indicating the time the call was placed, and the time of the response.

Chapter 1, Sec. 6.2 Emergency Medical Supplies

PURPOSE: To assure that adequate supplies are in place to provide for continuity of emergency medical care during a disturbance, emergency or other interruption of routine care.

RESPONSIBILITY: The Vendor Facility Health Administrator or designee bears the responsibility in conjunction with the Vendor site Medical Director and Vendor Complex Director of Nursing (DON) to design and manage adequate supplies in preparation for a potential loss of access to a medical unit or in preparation for a small (single patient) event requiring man-portable emergency supplies. The Vendor Complex DON or designee is accountable for assuring that nursing staff are knowledgeable in use of emergency supplies and provision of emergency medical care and triage/assessment techniques.

PROCEDURES:

1.0. The purpose of the "Man-Down" bag is for individual response during emergency situations.

2.0. A stock of supplies (to be determined by the Complex DON and site Medical Director and approved for purchase by the Vendor) must be created and maintained in a readily accessible area of the unsecure perimeter in an event that access to a yard is lost. The approved listing of stock supplies must take into account the needs of either multiple individual events or single site mass casualties.

3.0. Medical Equipment: All efforts should be taken by the Vendor's nurse to retain equipment that is the property of ADCRR. This includes full and half-back boards, wheelchairs, stretchers and any other equipment that could be utilized by emergency transport services. In the event such equipment is taken, the nurse will complete an Incident Report noting the agency that took the equipment, and submit to the Vendor Facility Health Administrator or designee.

4.0. "Man-Down Bag/Box": The purpose of the man-down bag/box is to provide immediate first aid to a patient in the field until he/she can be transferred to the triage room or the EMS personal arrives. The following list describes the minimal equipment required. The Complex DON may add more equipment based on consultation with the providers, nursing staff, the FHAs and approved by MSCMB.

5.0 A minimum of monthly inventory of man down bag/box to be conducted reflecting amount(s) of each item/medication on the following list.

Medication Requirements	**IV Set-up**
Aspirin 325 mg Bottle of #36 pills	18 gauge needle x 2
Diazepam Rectal Gel 15 mg and 20 mg/injectable	20 gauge needles x2
Diphenhydramine 50 mg IM one syringe	1 inch role of non-allergenic tape x2
Epipen x2	Alcohol Prep and Opsite IV dressings x5
Glucose Gel x3	Betadine scrub and ointment 2 packages.
Glucose Tablets 1 Box	IV tubing
Glucagon Emergency Kit	1000 cc of each D5W, and 0.9% Normal Saline or 500 cc
Narcan 2mg syringe x4	Latex Free Gloves- size per staff S, M, L 8 pair of each
Nitroglycerine ointment	Tourniquet
Nitroglycerin .4 mg SL btl. of # 25 pills	
Prefilled D50 syringe	

Assessment/Equipment kit	**Injury kit**	**Dressing kit**
Stethoscope	Clavicle splint x2	Eye wash
Blood Pressure cuff	Cervical Collar x2	ABD Dressing x 10
Airways of all different sizes	Extremity splints x2	Kerlex 6 inch x 4 rolls
Ambu Bag	ACE Wrap 4 inch x2	Scissors and tape
Portable O2 and tubing/mask		
Pen Light		
Clip Board with Soap Notes, refusal form, and a pen.		
Personal Protective Equipment		
Small sharps container		
Hand disinfectant		
Pulse Oximeter		

6.0 Automated External Defibrillators (AEDs) shall be maintained and readily accessible to health care staff. Daily checks of the equipment shall be done with documentation in the daily log.

Chapter 1, Sec. 7.0 Confidentiality

REFERENCES: DEPARTMENT ORDER 201
NCCHC STANDARD P-A-09
NCCHC STANDARD P-H-02

PURPOSE: To educate the Vendor Health staff regarding the importance of confidentiality. To provide an environment where there is an assurance on behalf of the patient that health care encounters remain private and that the patient's dignity is protected. By doing so, the fostering of necessary and candid dialog between the patient and the Practitioner/Provider can occur.

RESPONSIBILITY: It is the responsibility of the Vendor FHA or designee to ensure that all clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of health services. The Vendor Health staff at each facility faces challenges to this obligation to keep all information between Practitioner/Provider and the inmate private. Dental staff, nursing, laboratory, radiology, health records, and support staff is required to respect the patient's privacy by restricting access of others to that information.

REQUIREMENTS:

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

2.0. The Arizona Department of Corrections Rehabilitation & Reentry is a non-covered entity and not subject to the privacy requirement of HIPAA.

2.1. Specifically, HIPAA addresses correctional institutions and other law enforcement custodial situations. It allows Permitted Disclosures.

2.2. 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:

3.1. Clinical encounters are conducted in private, without being observed or overheard by security personnel. Privacy is made more difficult when triaging health complaints at the inmate's cell, in segregated housing, or in a lockdown setting. When triage is required to be conducted at the inmate's cell, health services staff will take extra precautions to promote private communication between health staff and the patient.

3.2. When safety is a concern and full visual privacy cannot be afforded, alternative strategies for partial privacy, such as a privacy screen, will be utilized. Security personnel are present only if the patient poses a probable risk to the safety of the health care Practitioner (Provider) or others.

3.3. The Vendor Medical staff will provide timely instruction to security staff that observe or hear health encounters regarding maintaining confidentiality.

Chapter 1, Sec. 8.0. Medical Grievance System

REFERENCES: DEPARTMENT ORDER 802
DEPARTMENT ORDER 1101
NCCHC STANDARD P-A-11

PURPOSE: The outcome of the delivery of health care in the Arizona Department of Corrections Rehabilitation & Reentry will receive a significant amount of monitoring and feedback through the Inmate Grievance program.

PROCEDURE:

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

2.0. Medical Grievances:

2.1. Filing the Grievance: The inmate shall attempt to resolve the complaint informally, prior to filing a formal grievance, in accordance with the procedure outlined in Department Order 802. In attempting to resolve the complaint, the inmate's assigned CO III has authority to correspond or speak with the appropriate medical staff to develop a response.

2.2 In the event an inmate is unable to resolve their complaint through informal means, he/she may submit an informal Complaint on an Inmate Informal complaint Resolution form to the Correctional Officer (CO) II in their respective unit. The informal complaint must be submitted within ten workdays from the date of the action that caused the complaint. The inmate shall attach copies of all documentation to support his/her complaint.

2.2.1 The Contract Facility Director of Nursing shall respond to the Informal complaint within 15 workdays using the Inmate Informal Complaint Response for.

2.2.2 Inmates may file a Formal Grievance if they are dissatisfied with the Inmate Informal Complaint Response or if the time frames for the response have been exceeded.

2.3 FORMAL GRIEVANCE PROCESS (MEDICAL)

2.3.1 An inmate may file a Formal Grievance should he/she be unable to resolve their complaint informally. The inmate has five workdays from receipt of the response from the Contract Director of Nursing to submit a Formal Grievance to the unit CO IV Grievance Coordinator, using the Inmate Grievance form. Upon receipt of any Medical Grievance, the unit CO IV Grievance Coordinator shall immediately forward the Formal

Grievance form to the Contract Facility Health Administrator. Within 15 workdays of receipt, the Contract Facility Health Administrator shall:

2.3.2 Investigate the complaint.

2.3.3 Prepare a written response to the inmate's Formal Grievance. The written response to the inmate shall include:

2.3.3.1 A summarization of the inmate's complaint.

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

2.3.3.3 A summary of findings.

2.3.3.4 The decision and supporting rationale in reaching the decision.

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

2.3.4 Maintain a copy of the inmate's Formal Grievance and return the completed grievance in a sealed envelope to the unit CO IV Grievance Coordinator clearly marked with the inmate's name, Arizona Department of Corrections (ADC) number, housing unit location, and the Grievance number.

2.3.4.1 The unit CO IV Grievance Coordinator shall utilize the Grievance number on the envelope to close out their tracking log and forward the completed Formal Grievance to the inmate in the sealed envelope.

2.3.5 Email copies of the Grievance, Response, and supporting documentation to the ADC Contract Compliance Monitor or designee.

2.4 The decision of the Contract Facility Health Administrator is final and constitutes exhaustion of all remedies within the Department.

Chapter 2, Sec. 1.0. Resource Administration

REFERENCES: DEPARTMENT ORDER 102
DEPARTMENT ORDER 304
DEPARTMENT ORDER 712
DEPARTMENT ORDER 912
NCCHC STANDARD P-F-02
NCCHC STANDARD P-B-02

PURPOSE: To provide guidance for administration of assigned and acquired resources. To maximize resources while protecting taxpayer expenditures. To maximize resources while providing quality care.

RESPONSIBILITY:

1.0. Health Services Contract Vendor Facility Health Administrator's Responsibilities: The Contract Vendor FHA or designee is responsible for ensuring that the daily operations of the health care delivery system are compliant with all administrative directives charged to not only the FHA but all Vendor Supervisory personnel and the adherence by all Vendor staff to ADCRR Department Orders and Medical Services Contract Monitoring Bureau Technical Manuals. It is the responsibility of the Vendor Facility Health Administrator (FHA) or designee to ensure that adequate services are available to the inmate population in the following areas: Dental, Medical, Mental Health, Nursing, Pharmacy, Medical Records, Laboratory, and X-ray.

2.0. Facility Inspections: In accordance with guidance in Department Order 712, the Vendor FHA or designee is responsible for conducting periodic security inspections and submitting a report to the Vendor Regional VP/Administrator. To meet this responsibility, the Vendor FHA or designee will conduct a regular tour through each of the health units on his/her complex (Refer to DO 712.03).

2.1. A documented clinic inspection shall be conducted to ensure a clean and sanitary working environment. Areas inspected should include nurse's stations, storage areas, exam rooms, pharmacy/medication rooms, x-rays, lab, medical records office, and other administrative clinic office areas. Results of inspections shall be documented. Documentation shall be maintained for one year from date of inspection.

3.0. Inventory (Refer to DO 304). http://adcnet/policy/300/0304.pdf

3.1. The Medical Services Contract Monitoring Bureau OPS Business Office Manager shall ensure that all inventorial equipment is assigned an ADCRR equipment tag number and shall affix the assigned tag to the appropriate piece of equipment.

3.2. The Contract Vendor FHA or designee is the overall property manager for the facility and shall ensure that all inventorial and non-inventorial equipment under their responsibility is accounted for at all times. The Vendor FHA or designee may appoint a facility property custodian to assist in accounting for

inventorial and non-inventorial equipment. The FHA shall ensure that a Department Property Inventory list, ADCRR Form 40900058, is completed for each area with equipment and posted for easy review and audit in each area. The Vendor shall ensure that the annual year-end equipment inventory is completed and returned in the specified period of time. The year-end equipment inventory shall be signed by the Contract Vendor's designated staff member conducting the inventory.

4.0. Reporting State Property Losses: The Contract Vendor shall contact the MSCMB OPS Business Office Manager for forms and a Claim Number. The designated Vendor staff shall fill out the Property Loss Report (RM013) and attach an estimate of the repair or replacement if available or practical. The Vendor shall submit the completed RM013 within five working days from the date-of-loss.

5.0. Acquisition/Security of Computer Equipment and Software/Information, Technology Services Division. Hardware and software purchases must meet standards as set forth by the Information Technology and Service Division (Refer to DO 102).

5.1. Movement of any ADCRR tagged equipment from one assigned location to another is not authorized without an ADCRR Form 304-3 first being submitted to the local complex MSCMB inventory liaison for review and approval by the Property Manager.

5.2. All computers which are surpluses must have all information data/program removed.

Chapter 2, Sec. 2.0 Pharmacy Inventory Control

REFERENCES: ARIZONA Administrative Code R4-23-658
ARIZONA Administrative Code R4-23-672
DEPARTMENT ORDER 304
DEPARTMENT ORDER 702
DEPARTMENT ORDER 712
NCCHC STANDARD P-B-02
NCCHC STANDARD P-D-03

PURPOSE: To ensure that all pharmaceuticals and the medication inventory is accounted for and actively managed at each Facility Health Unit at all times.

RESPONSIBILITIES: It is the responsibility of the MS Contract Vendor Regional Pharmacist, and the Vendor Correctional Director of Nursing (DON), to make sure that all procedures are followed to maintain the accountability of controlled substances, legend and OTC medication and needles and syringes.

PROCEDURES:

1.0. Narcotic Inventory: The narcotic Clinic stock is that working stock of Controlled Substances, CII-CV, kept in the medical room for daily use issued via a prescription or medical order. Any Vendor health staff member who receives, delivers, dispenses, returns or administers a controlled substance shall be held responsible for documenting the transaction. All Controlled Clinic stock will be signed for by two receiving Vendor licensed nurses as document of receipt. This includes all manifest accompanying the Controlled Clinic stock. All documentation shall comply with all state and federal regulations.

1.1. Monthly inventory audits shall be conducted for all controlled substances, in addition to the daily shift change audits by the Vendor Nursing staff. Two Vendor's Correctional Nurses shall conduct the inventories. Monthly inventory logs will be maintained by the Vendor Charge Nurse. The completed logs shall be kept on file by the Vendor Nursing Supervisor (DON). All discrepancies shall be reported on a Medication Incident Report, 1101-53P (formerly 70400033), to the Facility Health Administrator for action. The Vendor Facility Health Administrator or designee shall make a written report of all discrepancies and resolutions to the Vendor Pharmacy Director, Complex Director of Nursing (DON) and MSCMB Pharmacy Monitor.

1.2. This stock as well as controlled patient specific medication, will be stored in a double locked wall mounted cabinet or location otherwise authorized by the department. Clinic Stock will be utilized via a written prescription or verbal order incompliance with state and federal regulations. A perpetual use inventory log will be kept for/with each prescription. A record of each dose administered will be recorded. Patient specific orders shall be addressed in the same manner.

1.3. At the beginning and end of each shift a narcotic inventory will be accurately verified by the off-going and on-coming Vendor Charge Nurse responsible for the narcotic inventory and recorded on the Narcotic Log.

1.4 All narcotic clinic stock and patient specific medication administered will be recorded on the inmate's medication record form, and on an internal narcotic perpetual inventory log.

1.5. All controlled substances returned to the Vendor pharmacy will be documented upon return. The Charge Nurse or designee sending the controlled substances and the returned narcotics will account for the doses being returned on the perpetual narcotics use inventory log as per vendor policy, incompliance with the Medical Services Technical Manual, and satisfying all state and federal regulation.

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

1.7. Narcotic inventory logs shall be kept on file in the respective health care units as per vendor guidelines and in compliance with all state and federal regulations (7 years).

2.0. Narcotic clinic stock as well as patient specific controlled medication: will be stored in a secured area and under two locks. Receiving and issuing of Narcotic Stock will be in accordance with State and Federal law. The Perpetual Inventory Log will be maintained with the following information: Drug, Strength, Sub-unit of issue (i.e. tablet, capsule, vial etc.) Date of transaction/administration, Prescription number Quantity received/issued, Balance to date, inmate name, DOC number, ordering provider, name of health care professional accessing/issuing medication, and an accurate total maintained after each administration/receipt/return. Receipt and Transfer of Controlled substances will require the signature of 2 licensed Vendor nurses on the inventory form as well as the manifest substantiating the receipt of medication. The Inventory log will be legible and maintained in chronological order.

2.1 All Controlled Substance logs and invoices will be maintained for a period of seven years.

3.0. Needle and Syringe Inventory is described in MSTM policy Chapter 1 Section 2.3.0 regarding Medical Tools and Sharps and will not be addressed in this policy. MSTM 2-3.0 addresses the requirements for bulk stock of syringes and needles, procurement, and storage for normal clinic operations.

4.0. Yearly Pharmacy Inventory, Quarterly Audits, Monthly Audits, Weekly Inventories of Medication Rooms and CLINIC STOCK STORAGE AREAs (clinic stock): An annual inventory will be conducted of all pharmaceutical supplies, stocked within each Health Unit by the Vendor Pharmacy representative and a copy shall be made available to ADCRR Pharmacy monitor.

4.1. The Vendor Facility Health Administrator or designee shall review and approve the completed inventories to ensure all areas of the inventory forms have been properly completed. Any incomplete inventory received by the MS Pharmacy Monitor will be returned to the unit. This corrective requirement must be completed within seven working days of receipt.

4.2. The Vendor Arizona licensed Pharmacist will conduct and document a <u>quarterly</u> audit of all drug storage areas. This will include the following elements: Inspection for neat, organized, and clean storage and work areas, and evidence of expired or contaminated drugs and to ensure that all medications are kept in clean, dry containers protected from extremes in temperature and damaging light and in compliance with manufacturer's storage instructions. Search for discontinued and outdated drugs; containers with worn, illegible, or missing labels. Found items will be returned to the pharmacy for proper disposition. Food, food products, and laboratory specimens will not be stored in refrigerators designated for storage of drugs and/or sterile laboratory stock. Review of stock levels of drug inventories.

4.3. An Arizona licensed Vendor Pharmacist will be responsible for auditing the health unit quarterly and a copy of the report will be maintained on site by the Vendor Facility Health Administrator or designee, and at the Vendor pharmacy with a copy to ADCRR Pharmacy Monitor. Quarterly audit results are reported to Pharmaceutics and Therapeutics (P&T) Committee for discussion and follow-up by the identified discipline.

5.0. Quality Assurance at Remote Health Care Sites: A Vendor Lead Dentist or designee or Vendor Director of Nursing (DON) (or designee) will be responsible for auditing their respective health unit and CLINIC

STOCK STORAGE AREA clinic stock monthly with the following minimal requirements: Medication storage areas are double locked when not in use; (this includes ALL medications); Keys with Nurse or Lead Dentist or designee; Health Unit, CLINIC STOCK STORAGE AREA, OTC, Clinic Stock, Controlled Substance and Refrigerator Medications within date of expiration; All medications are properly accounted for and discrepancies reported to the Vendor FHA, Pharmacist, Lead Dentist, DON for appropriate follow-up and completion of proof of use sheet or medication incident report and follow-up; Refrigerator temperature between 36º to 44ºF or 2º to 7ºC; Room temperature between 65º to 85ºF or 18º to 29ºC. Documentation of a daily temperature log shall be done in the morning and evening for both refrigerators and room temperature log. If the temperature range exceeds the recommended range, appropriate action stated by the manufacture should be taken and documented.

5.1. Clinic stock is to be inventoried weekly, except when the CLINIC STOCK STORAGE AREA is sealed by a safety seal. It can be inventoried each time the seal is broken by Lead Dentist or nursing staff with all medication properly accounted for and discrepancies reported to the Vendor FHA, the Vendor Regional Pharmacist, Vendor Lead Dentist, Vendor DON, and ADCRR Pharmacist Monitor for appropriate follow-up and completion of proof of use sheet or medication incident report and follow-up.

5.2. A copy of the monthly Health Unit Audit Report is maintained on site by dental staff and nursing staff and a copy is sent to the pharmacy contact monitor upon request. Health Unit Audit results are reported at the next onsite Quality Control Meeting for discussion and follow-up by the identified discipline.

5.3. Multi-Dose Vials: Multi-dose vials will be dated, on the label, when opened and initialed by the user. All opened vials will be good for 30 days unless otherwise stated by manufacture or the expiration date is less than 30 days.

5.3.1 EXCEPTION: All insulin shall expire 28 days once opened and be destroyed or as stated otherwise by the manufacture.

5.3.2 EXCEPTION: Tuberculin expires 30 days after it is opened and should be destroyed. Multi-dose vials will be inspected quarterly by the Vendor pharmacy staff, monthly by nursing staff and/or monthly by dental staff for evidence of deterioration and contamination. Vials with evidence of either will be removed from use. Noncompliance with this procedure will be reported to the Vendor Unit Charge Nurse, DON, and/or the Vendor FHA.

5.4. Disposal of Expired, Contaminated, or Partial Drug Stocks: Non-controlled Substances Medications removed from stock having reached their expiration date will be returned to the Vendor pharmacy and will be maintained in a separate area from current active stock. All documentation as required by the Primary Vendor or authorized return goods vendor will be completed at the earliest convenience and the medication returned to the Prime Vendor or authorized return goods vendor for credit or replacement. Primary disposal will be through a contract vendor for facility medical waste. A log of disposals will be kept on file in the pharmacy. All prefilled syringes (except Controlled Substances) will be disposed of in an approved sharps container without emptying their contents. All live virus vaccine containers, vials & syringes, will 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.

5.5. Disposal of Expired, Contaminated, or Partial Drug Stocks: Controlled Substances, CII-V: Out dated or contaminated Controlled Substances will be removed from active stock and placed in a separate area from current active stock. Adjusting entries will be made in the Controlled Substances log book documenting the removal of out dated or contaminated medications that are quarantined to be destroyed by the Vendor Pharmacy in accordance with state and federal laws. The sheet listing the controlled substances to be destroyed will be signed and dated and the record will be maintained with the annual inventory.

5.6. Items obtained from the Vendor pharmacy that are found in an inmate's possession/room/area are considered contraband if the period for use of that independent refill has expired. These items are to be disposed in accordance with Federal, State, and local regulations.

5.7. All Controlled Substances received from inmates and county jails at an Intake Facility will be sent to the Vendor pharmacy for destruction or as per policy and mandated by State and Federal law.

Chapter 2, Sec. 3.0. Medical Sharp and Tool Control

REFERENCES: DEPARTMENT ORDER 712
NCCHC STANDARD P-A-01
NCCHC STANDARD P-B-02

PURPOSE: To provide a procedure for the safe and effective handling, control and disposal of potentially dangerous items and materials in the correctional medical/dental environment and to comply with the OSHA Hazard Communication Standard, 29 CFR 1919.1200. To provide guidance to the Contract Vendor Health staff and ADCRR Security Operations staff in controlling and documenting tools that are used in the provision of health services within the facility's health units. To serve as an adjunct to the guidance delineated in Department Order 712.

RESPONSIBILITY: The Contract Vendor Facility Health Administrator or designee shall ensure that all tools that are used in the provision of health services are perpetually accounted for and controlled. The Vendor Supervisory personnel are responsible for the regular accounting activities for areas under the control of professionals and technicians assigned under their supervision. The Vendor Facility Health Administrator or designee is responsible to ensure that all tools, instrumentation, devices, and hand-held tools are identified and controlled in accordance with the guidelines of Department Order 712.

PROCEDURES:

1.0. Health Services Tools. The Vendor Facility Health Administrator or designee will identify and designate Health instruments and Sharps in accordance with Department Order 712 and in consultation with the Complex Warden.

1.1. Health Services tools, sharps, and instruments are defined to consist of Class "A" (restricted) medical sharps which could be used by inmates in effecting an escape or causing death or serious injury. These include (but are not limited to) the items listed in Department Order 712.

1.2. A Master Tool Inventory report for all non-disposable surgical, dental instruments, devices and hand held tools; (form 712.03) must be maintained by the Vendor Facility Health Administrator or designee.

1.3. Narcotics count is performed as a distinctive and unique activity from sharps accounting. The activity is performed under the direction of nursing services. Direction is provided in Medical Services Technical Manual policy (MSTM Chapter 5 Section 6.5.) and is not addressed in this policy section.

2.0. Storage: Health Services sharps and tools shall be considered tools as defined by Department Order and maintained in a secure area consistent with professional health services practice and in accordance with the appropriate Medical Services Contract Monitoring Bureau Policy or Facility Post Order.

2.1. Professional health services practice requires placement of equipment in a location that offers a clean or sterile environment, does not hinder the provision of health care, reasonably immediate access, and ability

to store like items or kits in close association to tools used concurrently. Security control areas are defined by an observable and/or limited access location.

2.2. Items that are stored or held in a limited access areas includes item stored in lock boxes that are sealed with a numbered tamperproof tag, items that are in locked drawers, items that are held behind locked doors, and items that are held in cabinetry designed to be locked by installed locks or padlocks. All locking mechanisms used by ADCRR Health Services Vendor to control access to Vendor's Health Services tools and sharps, must be approved and/or installed by ADCRR locksmiths.

2.3. 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.

2.4. Bulk supplies of needles and disposable syringes should be stored in the area designated by the Vendor Facility Health Administrator and may be checked out by the Vendor Health Services Personnel for use as needed. The bulk supplies will be held in the in the area designated by the FHA. This area will be maintained under the supervision of the complex FHA.

2.5. Needles and syringes will be procured, received, and stored to assure a sufficient supply for normal clinic operations. Supplies on hand in a clinic will normally be limited to a one week supply. The facility will develop post orders that describe specific maximum balances to be held at each clinic.

2.6. All receipt/ issues of syringes/needles to and from the bulk supply inventory will be maintained in a perpetual inventory log with a current balance.

2.7. Medical Units may requisition needles/syringes from the medical liaison or designee on an as needed basis, per local post orders, using an inventory control form (Inventory Control Log, form #40000157, 12/17/91, or Material Requisition Form #40300012). The original will be kept in the medical liaison area records for three years.

2.8. All needles and syringes issued to the Medical Units will be signed for by Vendor nursing staff per MSTM guidance. Syringes and needles issued to Medical Units will be logged out to those specific areas (Health Unit level, e.g. ASPC E Cook, ASPC-E Meadows, etc.).

2.9. Other hazardous instruments and supplies are obtained and stored in the same manner as all other supplies in the clinic with the exception that only the minimum amount needed to provide services are to be kept in any area that is accessible by inmates under treatment.

2.10. Remote site distribution of sharps: The Vendor correctional Nurse, Administrative Assistant or designee will provide distribution of sharps/needles/supplies for each facility health care unit.

2.11. Wholesale use of "shadow boards" is not consistent with clinical access needs of the provision of healthcare and is not authorized for medically designated tools and sharps that are routinely used by Vendor Health staff. The Vendor Facility Health Administrator will determine, in consultation with the Warden, what classes or groups of infrequently used medical sharps may be maintained on shadow board mechanisms.

2.12. Tools that cannot be engraved due to risk of alteration of clinical capability or decreased ability to sterilize will be identified by the Facility Health Administrator in accordance with Department Order 712.

3.0. Disposal and destruction of instruments shall be accomplished and documented in accordance with Department Order 712. Sharps are to be discarded in appropriate sharps containers that prevent puncture and inhibit retrieval from the container. The container should be labeled to show the nature of its contents.

3.1. Infectious waste and hazardous materials are to be discarded in appropriately labeled containers, i.e.: red bags, barrels, biohazard containers etc. for the safe and efficient removal and destruction of such material.

4.0. Inventory Controls

4.1. A Master Tool Inventory described in Department Order 712 shall be maintained by the Vendor Facility Health Administrator. The Master Tool Inventory may be maintained by the FHA in a single binder or may be maintained by each Vendor supervisory personnel for their areas of responsibility. If the decision is made for each Supervisor to retain their section, the FHA or designee must have unrestricted access to

the section. Each Supervisor from each medical discipline with sharps and tools will maintain a section (original or copy) of the Master Tool Inventory for their area of responsibility.

5.0. Accounting

5.1. General Accounting Requirements include:

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

5.1.2 A set of multiple instruments shall note the contents of the set on the outside of the container. The set shall be counted as one set and not the number of individual instruments.

5.1.3 During repair, medical/dental tools shall be removed from the inventory as directed in Department Order 712.02.

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

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

5.2. Daily Counts: A daily inventory of all the instruments in the health area will be conducted to maintain control and accurate records. An inventory will be performed at the beginning of each shift that is staffed by Health Services personnel and at the end of each shift that is staffed by Health Services Personnel. Well before the end of the Health Services shift, the responsible staff member will request (through locally negotiated procedures) a Correctional Officer to witness the count. If a CO is not available within a reasonable amount of time (i.e.: less than 15 minutes), two Health Services Staff members will perform the inventory. If only one Vendor Health staff member is available and a CO was not able to attend, the Health staff member will perform the inventory and provide an Information Report (IR) to the Facility Health Administrator documenting the attempt to acquire a CO and the outcome of the inventory. The Vendor FHA will share the IR with the appropriate Deputy Warden and develop systems to prevent future single count events.

5.2.1 A Daily Tools Inventory Count sheet, or sheets, (see Attachment A) are to be maintained within the clinic, lab, health unit, etc., where instruments are kept. Disposable Sharps such as needles, scalpels, carpules, etc. must also be accounted for on the Daily Tools Inventory Count. The count sheet must accurately reflect the number and type of instruments kept in the respective drawer, cupboard, etc.

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

5.2.3 The staff performing the inventory and one witness will sign the Health Unit End of Shift Summary Count (304-15) (Attachment B). Each shift should be annotated on each line. Therefore, on a 24 hour fully staffed unit where there is face-to-face turnover between shift staff, there should be a minimum of three entries on three lines; beginning of day shift, beginning of swing shift, beginning of night shift. Note that this sample is for three 8 hour shifts in a 24 hour period. Units staffed with 12 hour shifts may have only two turnover entries per 24 hour period. If there is no face to face turnover, each shift will perform an opening and closing count.

5.3. Monthly Roll-up counts:

5.3.1 At the end of each month, the senior Vendor unit staff member responsible for the area will forward a copy of the individual Daily Tools Inventory Count to the pertinent Vendor Supervisor for review and development of the Master Tool Inventory (712-5PF).

5.3.2 The supervisor of the respective discipline or designee shall ensure that a Master Tool Inventory report for the prior month is completed and submitted to the Vendor Facility Health Administrator no later than the third business day of the month for the immediately preceding month or more often as directed by the FHA.

5.3.3 The Inventory Control Clerk will perform an inventory of all 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.

5.3.4 The Vendor Facility Health Administrator or designee will on a monthly basis, review and collate the Master Tool Inventory and forward a copy to the Complex Chief of Security within the time frame of dates negotiated between the FHA and the complex Warden. The Complex Chief of Security will review and distribute the inventory to the Unit Chiefs of Security. Since the FHA maintains the Master Tool Inventory on a month by month basis, the units are not required to retain prior month inventories unless directed by the respective FHA.

Inventory Control Log: Health Services

Health Unit	Date of First Entry
Item	Location

Date	Begin Inventory	Inventory Added	Inventory Deleted	Inventory Balance	Counted By (Signature)	Witness (initials)

304-14P
12/5/01

Health Services End of Shift Summary Count

Enter the date and time the inventory was reviewed. Two staff members are to review the inventory and acknowledge this review by their signature and position title.

Date	Time	Signature and Title	Signature and Title

304-15 (proposed)
9/15/2006

Master Tool Inventory

Institution/Facility for Month of: _____

Storage Location:	Prepared By:	Date:
Tool Description		

	Beginning	Added	Less	Ending
Classification	Inventory	Inventory	Lost/ Damaged*	Inventory

*Attach documentation with disposition of these tools. (716-6)

712-5

2115106

Arizona Department of Corrections Rehabilitation & Reentry	Budget and Inventory Control	OPR: MSCMB OPS Business Manager MS Contract Vendor Auth: al
Medical Services Technical Manual	MSTM Chapter 2 Section 4.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 2, Sec. 4.0 Budget and Inventory Control

REFERENCES: DEPARTMENT ORDER 304
NCCHC STANDARD P-A-04

PURPOSE: To ensure that ADCRR Health Services Division facilities are resourced and managed in accordance with sound business practices, regulation, and community standards.

RESPONSIBILITY: It is the responsibility of all ADCRR Contract Vendor staff to manage the resources entrusted by the citizens of the State of Arizona to achieve quality care for the inmate population.

Chapter 2, Sec. 5.0 Infection Control

REFERENCES: DEPARTMENT ORDER 116, Employee Communicable Disease Exposure Control Plan
DEPARTMENT ORDER 1102, Communicable Disease and Infection Control
2018 NCCHC STANDARD P-B-02, Infectious Disease and Prevention and Control
2020 ACA STANDARD 5-ACI-6A-12(M), Communicable Disease and Infection Control Program

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

RESPONSIBILITY: The Department's Medical Director or designee is responsible for directing the Department's Medical program to provide surveillance, prevention, diagnosis and treatment of suspected or confirmed communicable diseases. He/She is also responsible for notifying the Assistant Director for Medical Services, the Department's Occupational Health Administrator and other authorized recipients of each suspected or confirmed communicable disease in inmates and epidemiological information related to communicable disease in inmates. Wardens, Deputy Wardens and Administrators are responsible for ensuring that inmate workers, when appropriate, use approved universal precautions, engineering controls and personal protective equipment to prevent exposure to communicable disease. The Contract Healthcare Provider (CHP) is responsible for promulgating an inmate screening program for communicable disease.

PROCEDURE:

1.0. Department Order 1102 provides a standard guideline to ensure appropriate notification and documentation of reportable diseases, and for the appropriate management of inmates who require medical isolation to ensure that all inmates and staff are protected from communicable disease. It also provides an inmate tuberculosis screening program that is designed to control tuberculosis among inmates in the correctional work place.

2.0. Department Order 116 establishes a safety and loss control program for Department employees that includes safe work practices, accident investigation and prevention measures, construction and maintenance of safe facilities, timely accident and exposure reporting, related training and record keeping. The Department recognizes that Department employees may be exposed to communicable diseases such as Hepatitis B, Hepatitis C, Human Immunodeficiency Virus, COVID-19, and Tuberculosis, in the performance of their duties. The Department is dedicated to protecting employees from exposure to these diseases through the establishment of administrative procedures, engineering controls, and the use of personal protective equipment.

3.0. Exposure Control Plan: See ADCRR MANDATORY EXPOSURE CONTROL PLAN (Department Order 116)

Chapter 2, Sec. 5.1 COVID-19

REFERENCES: DEPARTMENT ORDER 1102, Communicable Disease and Infection Control
2018 NCCHC STANDARD P-B-02, Infectious Disease Prevention and Control
2020 ACA Standards:
- 5-ACI-2A-03, Physical Plant
- 5-ACI-6A-08 (M), Emergency Plan
- 5-ACI-6A-12 (M), Communicable Disease and Infection Control Program
- 5-ACI-6A-17 (M), Communicable Disease and Infection Control Program

Arizona Department of Health Services
https://www.azdhs.gov/index.php
BinaxNOW COVID-19 Ag Card- Instructions for Use
https://www.globalpointofcare.abbott/en/support/product-installation-training/navica-brand/navica-binaxnow-ag-training.html
Centers for Disease Control and Prevention
https://www.cdc.gov/coronavirus/2019-ncov/index.html
Centers for Disease Control and Prevention Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities
https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html
Centers for Disease Control and Prevention Janssen Vaccine Information
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/janssen.html

https://www.cdc.gov/vaccines/covid-19/info-by-product/janssen/index.html
Centers for Disease Control and Prevention Moderna Vaccine FAQs
https://www.cdc.gov/vaccines/covid-19/info-by-product/moderna/moderna-faqs.html

https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf
Department of Defense Guidance for Coronavirus Disease 2019 Force Health Protection Guidance (Supplement 11)
https://media.defense.gov/2020/Jun/12/2002315485/-1/-1/1/DOD-Guidance-for-COVID-19-Surveillance-and-Screening-with-Testing.pdf

Attachment A/B: Patient COVID-19 Information Sheet (English and Spanish)

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

RESPONSIBILITY: The Department's Medical Director or designee is responsible for directing the Department's Medical program to provide surveillance, prevention, diagnosis and treatment of suspected or confirmed communicable diseases. He/She is also responsible for notifying the Assistant Director for Medical Services, the Department's Occupational Health Unit Administrator and other authorized recipients of each suspected or confirmed communicable disease in inmates and epidemiological information related to communicable disease in inmates. Wardens, Deputy Wardens and Administrators are responsible for ensuring that inmate workers, when appropriate, use approved universal precautions, engineering controls and personal protective equipment to prevent exposure to communicable disease. Contract Healthcare Providers (CHP) who operate facilities for the Department are responsible for promulgating an inmate screening program for communicable disease.

1.0 GENERAL OVERVIEW:

1.1. Coronavirus disease 2019 or COVID-19 is a new respiratory virus first identified in Wuhan, China.

1.2. There are several known coronaviruses that infect people and usually only cause mild respiratory disease, such as the common cold.

1.3. COVID-19 is thought to spread mainly through respiratory droplets produced when an infected person coughs, sneezes, or talks.

1.4. Most people who contract COVID-19 will experience mild symptoms; however, like the flu, individuals who have the highest risk for severe illness are older adults and those with chronic conditions like heart or lung disease or diabetes.

1.5. Criteria for Persons Under Investigation (PUI) for COVID-19 include patients who have:

- 1.5.1. Fever (≥38°C, 100.4°F), or
- 1.5.2. Symptoms of lower respiratory illness (cough or shortness of breath), or
- 1.5.3. Close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset.

1.6. In addition, criteria for PUI include one or more of the following symptoms:

- 1.6.1. Fever
- 1.6.2. Chills
- 1.6.3. Repeated shaking with chills
- 1.6.4. Muscle pain
- 1.6.5. Headache
- 1.6.6. Sore Throat
- 1.6.7. New loss of taste or smell
- 1.6.8. Congestion or runny nose
- 1.6.9. Nausea or vomiting
- 1.6.10. Diarrhea

1.7. Given the wide range of symptom presentations, medical personnel should consider patients with even mild symptoms as possible PUI.

1.8. All inmates shall be screened for symptoms of COVID-19 upon arrival to the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) facility.

1.9. This will take place at during the Intake screening process.

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

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

- 1.11.1. Surgical (medical) mask
- 1.11.2. Gown

1.11.3. Gloves

1.11.4. Face shield and/or eye protection

1.12. Only essential healthcare personnel with designated roles should enter the patient's room to evaluate or care for the patient.

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

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

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

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

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

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

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

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

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

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

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

2.8. Risk stratification of patients based on age and chronic conditions, including lower risk, moderate risk, and higher risk patients

2.9. Classification of illness severity, including asymptomatic/presymptomatic, mild illness, moderate illness, severe illness, or critical illness

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

2.10.1. Monitoring frequency and protocols

2.10.2. Staff adherence to infection control procedures

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

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

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

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

2.13.1. Encouragement of inmates and staff to report symptoms of illness

2.13.2. Copay policy regarding COVID-19 related services

2.13.3. Meal delivery

2.13.4. Medication distribution

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

2.14.1. Coordination of transportation and housing

2.15. Reporting to local health authorities, including:

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

2.15.2. Reporting may include:

2.15.2.1. Provision of updates on the number of infected individuals

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

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

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

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

3.0 Testing:

3.1. COVID-19 testing is useful for a variety of purposes including clinical testing of symptomatic patients, contact tracing in response to identified COVID cases or an outbreak, routine testing of asymptomatic persons at risk of acquiring or spreading infection, testing as part of inter-facility and healthcare-related transfers, and public health surveillance testing.

3.2. Before testing, it is important to be clear about the following:

3.2.1. The type of test being used

3.2.2. The reason the test is being performed

3.2.3. Action plan based on test results, including isolation and quarantine options

3.3. COVID-19 Strategic Surveillance Testing

3.3.1. Following the Department of Defense (DoD) Force Health Protection Guidance (Supplement 11) involves targeted testing for infections in selected populations to detect disease early and direct public health action.

3.3.2. "Effective sentinel surveillance for Covid-19 requires testing asymptomatic persons; these persons should be in populations with a higher likelihood of infection and for whom actions can prevent widespread transmission."

3.3.3. Testing a designated portion of the inmate patient population per month shall be initiated or discontinued under the direction of the Department's Medical Director or designee and ADHS.

3.4. COVID-19 Testing After Vaccination

3.4.1. Inmates

3.4.1.1. Fully vaccinated inmates no longer need routine testing for COVID-19, as long as they do not have symptoms of COVID-19 and do not have a known exposure to COVID-19.

3.4.1.2. Any fully vaccinated inmate who becomes symptomatic for possible COVID-19 will be isolated and tested for COVID-19.

3.4.1.3. Any fully vaccinated inmate who is exposed to a known case of COVID-19 will be isolated and tested for COVID-19.

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

3.4.2. Employees working in ADCRR facilities and private prisons

3.4.2.1. Fully vaccinated employees no longer need routine testing for COVID-19, as long as they do not have symptoms of COVID-19 and do not have a known exposure to COVID-19.

3.4.2.2. Any fully vaccinated employee who becomes symptomatic for possible COVID-19 will be sent home. In order to return to work, clearance must be done by a primary care provider and the Occupational Health Nurse.

3.4.2.3. Any fully vaccinated employee who is exposed to a known case of COVID-19 and is asymptomatic may continue to work, while following COVID-19 precautions (mask, social distancing, handwashing, etc.).

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

4.0 Vaccinations:

4.1. Vaccination Protocols

4.1.1. ADCRR shall oversee COVID-19 vaccinations for employees, including ADCRR employees and contractors, with guidance from Arizona Department of Administration (ADOA) and ADHS.

4.1.1.1. The following consent form should be used for employees.

4.1.1.1.1. Arizona State Employee – COVID-19 Vaccine Consent Form

4.1.2. The Medical Services Contractor shall provide COVID-19 vaccinations for inmates, under the guidance of ADCRR and ADHS.

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

4.1.2.2. ADCRR has developed patient consent forms and patient information sheets pertaining to the COVID-19 vaccine.

4.1.2.2.1. Patient COVID-19 Vaccine Consent Form (Form 1101-110)

4.1.2.2.2. Patient COVID-19 Information Sheet (English and Spanish)

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

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

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

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

4.1.3. Adverse Events

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

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

Definitions/Glossary:

'**Fully Vaccinated**' refers to individuals for whom 2 weeks have passed since completion of their single/double dose vaccine series.

Isolation - the procedure of separating a person who is already sick from others who are not ill in order to prevent the spread of disease. The term isolation is distinct from the term quarantine.

Incubation period - the length of time between an exposure to an ill person and the development of symptoms in another person. The incubation period of COVID-19 is 2 to 14 days, with an average of 5 - 8 days.

Non-Pharmacologic Measures - Actions taken to prevent the spread of virus within a facility that include mask wearing, handwashing, environmental cleaning, and social distancing between well and unwell individuals.

Person Under Investigation (PUI) - person with symptoms and epidemiological risk factors for being infected with COVID-19 from whom a sample has been obtained, though the results are pending.

Personal Protective Equipment (PPE) - Used upon entry into patient space (< 6 feet) or exam room of patients confirmed or suspected to have communicable disease. Includes impermeable gown and gloves, N95 mask or Powered Air Purifying Respirator (PAPR), and eye protection.

Quarantine - the procedure of separating and restricting the movement of persons who are not sick yet, but who were exposed or are being investigated for possible exposure. This allows rapid identification of those who will become sick.

Social Distancing - Keeping space between oneself and other people. To practice social distancing, people should remain 6 feet apart, not gather in groups, stay out of crowded places, and avoid mass gatherings.

Attachment A

Patient Information for the COVID-19 Vaccine

What is COVID-19?

- COVID-19 disease is caused by a coronavirus called SARS-CoV-2.
- You can get COVID-19 through contact with another person who has the virus.
- It is mainly a respiratory illness that can affect other organs.
- People with COVID-19 have had symptoms ranging from mild symptoms to severe illness.
- Symptoms may appear 2 to 14 days after exposure to the virus.
- Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

Who should get the COVID-19 vaccine?

- The Food and Drug Administration has authorized the emergency use of COVID-19 vaccines in individuals as young as 16 years of age and older.

Who should not get the COVID-19 vaccine?

- You should not get the COVID-19 vaccine if you:
    - Had a severe allergic reaction after a previous dose of this vaccine.
    - Had a severe allergic reaction to any ingredient of this vaccine.

Will the COVID-19 vaccine give me COVID-19?

- No. The COVID-19 vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

Will there be enough vaccine for everyone?

- Not everyone will be able to be vaccinated right away.
- The goal is for everyone to be able to easily get a COVID-19 vaccine as soon as large quantities are available.

How many shots of COVID-19 vaccine will be needed?

- Some COVID-19 vaccines need two shots to be effective.
- Other COVID-19 vaccine use one shot.

If I have already had COVID-19 and recovered, do I still need to get vaccinated with a COVID-19 vaccine when it's available?

- There is not enough information currently available to say if or for how long after infection someone is protected from getting COVID-19 again; this is called natural immunity.
- Natural immunity from COVID-19 may not last very long.
- A vaccine may give longer lasting immunity to COVID-19.

Why would a vaccine be needed if we can do other things, like wearing masks, to prevent the virus that causes COVID-19 from spreading?

- Stopping a pandemic requires using all the tools available.
- Vaccines work with your immune system so your body will be ready to fight the virus if you are exposed.
- Covering your mouth and nose with a mask helps to reduce your chance of being exposed to the virus or spreading it to others.
- Getting a COVID-19 vaccination and following CDC's recommendations will offer the best protection from COVID-19.

Do I need to wear a mask and avoid close contact with others if I have received 2 doses of the vaccine?

- Yes. While experts learn more about the protection that COVID-19 vaccines provide under real-life conditions, it will be important for everyone to continue using all the tools available to us to help stop this pandemic, like covering your mouth and nose with a mask and washing your hands often.

When can I stop wearing a mask after I have been vaccinated?

- You should still continue to wear your mask even after completing your COVID-19 vaccination series.
- There is not enough information currently available to say if or when CDC will stop recommending that people wear masks.

What should I mention to my vaccine provider before I get a COVID-19 vaccine?

- Tell the vaccination provider about all of your medical conditions, including if you:
  - Have any allergies
  - Have a fever
  - Have a bleeding disorder or are on a blood thinner
  - Are immunocompromised or are on a medicine that affects your immune system
  - Are pregnant or plan to become pregnant
  - Have received another COVID-19 vaccine

How is the COVID-19 vaccine given?

- The COVID-19 vaccine will be given to you as an injection into the muscle.
- If it is part of a 2 dose series, after you receive one dose of the COVID-19 vaccine, you should receive a second dose of this same vaccine 3-4 weeks later (depending on the type of vaccine).

What are the benefits of the COVID-19 vaccine?

- The COVID-19 vaccine has been shown to prevent COVID-19 following completion of the vaccination series.
- The duration of protection against COVID-19 is currently unknown.

What are the risks of the COVID-19 vaccine?

- Side effects that have been reported with the COVID-19 Vaccine include:
  - Injection site pain
  - Tiredness
  - Headache
  - Muscle pain
  - Chills
  - Joint pain
  - Fever
  - Injection site swelling or redness
  - Nausea
  - Feeling unwell
  - Swollen lymph nodes (lymphadenopathy)
- There is a remote chance that the COVID-19 vaccine could cause a severe allergic reaction.
- A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine and can include the following signs:
  - Difficulty breathing
  - Swelling of your face and throat
  - A fast heartbeat
  - A bad rash all over your body
  - Dizziness and weakness

What should I do about side effects?

- If you experience a severe allergic reaction, notify a member of the healthcare staff or an officer right away.
- If you experience side effects to the vaccine that are not an emergency, please submit a Health Needs Request.

What if I decide not to get the COVID-19 vaccine?

- It is your choice to receive or not receive the COVID-19 vaccine. Should you decide not to receive it, your standard medical care will not change.

What if I am pregnant?

- If you are pregnant, discuss your options with your healthcare provider.

What is an Emergency Use Authorization (EUA)?

- The Food and Drug Administration has authorized the emergency use of COVID-19 vaccines to prevent COVID-19 under an EUA.
- The United States FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives.
- Scientific evidence shows that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known benefits of the product outweigh the known risks.

If you have any questions or concerns related to the COVID-19 vaccine, please submit a Health Needs Request.

Sources:

https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/index.php#novel-coronavirus-vaccine

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

Attachment B

Información para el paciente sobre la vacuna COVID-19 (Spanish)

¿Qué es COVID-19?

- La enfermedad COVID-19 es causada por un coronavirus llamado SARS-CoV-2.
- Puede contraer COVID-19 a través del contacto con otra persona que tenga el virus.
- Es principalmente una enfermedad respiratoria que puede afectar a otros órganos.
- Las personas con COVID-19 han tenido síntomas que van desde síntomas leves hasta una enfermedad grave.
- Los síntomas pueden aparecer de 2 a 14 días después de la exposición al virus.
- Los síntomas pueden incluir: fiebre o escalofríos; tos; falta de respiración; fatiga; dolores musculares o dolores en el cuerpo; dolor de cabeza; nueva pérdida del gusto u olfato; dolor de garganta; congestión o secreción nasal; náusea o vómitos; diarrea.

¿Quiénes deben recibir la vacuna COVID-19?

- La Administración de Alimentos y Medicamentos ha autorizado el uso de emergencia de las vacunas COVID-19 en individuos tan joven como 16 años de edad y más.

¿Quiénes no deben recibir la vacuna COVID-19?

- No debe recibir la vacuna COVID-19 si:
    - Ha tenido una reacción alérgica grave después de una dosis anterior de esta vacuna.
    - Ha tenido una reacción alérgica grave a cualquier ingrediente de esta vacuna.

¿Me dará COVID-19 la vacuna COVID-19?

- No. La vacuna COVID-19 no contiene SARS-CoV-2 y no puede darle COVID-19.

¿Habrá suficiente vacuna para todos?

- No todo el mundo podrá vacunarse de inmediato.
- El objetivo es que todos sean capaz de recibir fácilmente una vacuna COVID-19 tan pronto como estén disponibles grandes cantidades.

¿Cuántas inyecciones de la vacuna COVID-19 se necesitarán?

- Algunas vacunas COVID-19 necesitan dos inyecciones para ser efectivas.
- Otra vacuna COVID-19 usa una sola inyección.

Si ya tuve COVID-19 y me recuperé, ¿todavía necesito vacunarme con una vacuna COVID-19 cuando esté disponible?

- No hay suficiente información disponible actualmente para decir si, o durante cuánto tiempo después de la infección, alguien está protegido de obtener COVID-19 nuevamente; esto se llama inmunidad natural.
- La inmunidad natural contra COVID-19 puede no durar mucho.
- Una vacuna puede brindar inmunidad más duradera al COVID-19.

¿Por qué se necesitaría una vacuna si podemos hacer otras cosas, como usar máscaras, para evitar que se propague el virus que causa COVID-19?

- Para detener una pandemia, es necesario utilizar todas las herramientas disponibles.
- Las vacunas trabajan con su sistema inmunológico para que su cuerpo esté listo para combatir el virus si está expuesto.
- Cubrirse la boca y la nariz con una máscara ayuda a reducir la posibilidad de estar expuesto al virus o contagiarlo a otras personas.
- Recibir una vacuna COVID-19 y seguir las recomendaciones de los CDC ofrecerá la mejor protección contra COVID-19.

¿Necesito usar una mascarilla y evitar el contacto cercano con otras personas si he recibido 2 dosis de la vacuna?

- Si. Mientras los expertos aprenden más sobre la protección que brindan las vacunas COVID-19 abajo de condiciones de la vida real, será importante que todos sigan utilizando todas las herramientas disponibles para ayudar a detener esta pandemia, como cubrirse la boca y la nariz con una máscara y lavarse las manos con frecuencia.

¿Cuándo puedo dejar de usar una máscara después de haberme vacunado?

- Aún debe continuar usando su máscara incluso después de completar su serie de vacunación COVID-19.
- Actualmente no hay suficiente información disponible para decir si o cuándo el CDC dejará de recomendar que las personas usen máscaras.

¿Qué debo mencionar a mi proveedor de vacunas antes de recibir la vacuna COVID-19?

- Informe al proveedor de vacunación sobre todas sus condiciones médicas, incluso si:
  - Tiene alguna alergia
  - Tiene fiebre
  - Tiene un desorden sangrante o está tomando un anticoagulante
  - Está inmunodeprimido o está tomando un medicamento que afecta su sistema inmunológico
  - Está embarazada o planea quedar embarazada
  - Ha recibido otra vacuna COVID-19.

¿Cómo se administra la vacuna COVID-19?

- La vacuna COVID-19 se le administrará como una inyección en el músculo.
- Si es parte de una serie de 2 dosis, después de recibir una dosis de la vacuna COVID-19, debe recibir una segunda dosis de esta misma vacuna 3-4 semanas después (según el tipo de vacuna).

¿Cuáles son los beneficios de la vacuna COVID-19?

- Se ha demostrado que la vacuna COVID-19 previene el COVID-19 después de completar la serie de vacunación.
- La duración de la protección contra COVID-19 es actualmente desconocido.

¿Cuáles son los riesgos de la vacuna COVID-19?

- Los efectos secundarios que se han reportado con la vacuna COVID-19 incluyen:
  - Dolor en el lugar de la inyección
  - Cansancio
  - Dolor de cabeza
  - Dolor muscular
  - Escalofríos
  - Dolor articular
  - Fiebre
  - Hinchazón o enrojecimiento en el lugar de la inyección
  - Náusea
  - Sentirse mal
  - Inflamación de los ganglios linfáticos (linfadenopatía)
- Existe una posibilidad remota de que la vacuna COVID-19 pueda causar una reacción alérgica grave.
- Una reacción alérgica grave suele ocurrir entre unos minutos y una hora después de recibir una dosis de la vacuna y puede incluir los siguientes signos:
  - Dificultad para respirar
  - Hinchazón de su cara y garganta
  - Un latido cardíaco rápido
  - Un mal sarpullido por todo el cuerpo
  - Mareos y debilidad

¿Qué debo hacer con los efectos secundarios?

- Si experimenta una reacción alérgica grave, notifique de inmediato a un miembro del personal de atención médica oa un oficial.
- Si experimenta efectos secundarios de la vacuna que no son una emergencia, envíe una Solicitud de necesidades de salud.

¿Qué pasa si decido no recibir la vacuna COVID-19?

- Es su elección recibir o no la vacuna COVID-19. Si decide no recibirlo, no se le cobrará su atención médica estándar.

¿Y si estoy embarazada?

- Si está embarazada, hable de sus opciones con su proveedor de atención médica.

¿Qué es una autorización de uso de emergencia (EUA)?

- La Administración de Drogas y Alimentos ha autorizado el uso de emergencia de las vacunas COVID-19 para prevenir COVID-19 bajo una EUA.
- La FDA de los Estados Unidos puede emitir un EUA cuando se cumplen ciertos criterios, lo que incluye que no existen alternativas adecuadas, aprobadas y disponibles.
- La evidencia científica muestra que el producto puede ser eficaz para prevenir COVID-19 durante la pandemia de COVID-19 y que los beneficios conocidos del producto superan los riesgos conocidos.

Si tiene alguna pregunta o preocupaciones relacionada con la vacuna COVID-19, envíe una Solicitud de Necesidades de Salud.

Fuentes:

https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/index.php#novel-coronavirus-vaccine

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

Chapter 2, Sec. 6.0 Environmental Health

REFERENCES: DEPARTMENT ORDER 404 DEPARTMENT ORDER 503
DEPARTMENT ORDER 519 DEPARTMENT ORDER 1102
NCCHC STANDARD P-B-03

PURPOSE: To ensure that inmates are housed, work, study, and receive health care in a clean, safe, and healthy environment. To ensure that Health staff work in environmentally safe and sanitary conditions.

RESPONSIBILITY: Department Order 519 establishes a programmed approach in the management of employee health conditions which affects the ability to work. Department Order 404 describes the fire and safety programs in the Department. Through the programs described in the references and the following policy, the Contract Vendors administrative practice and procedures that assures public safety in the facility, specifically, the health of the inmate, staff and visitors as applicable are protected through the maintenance of a clean and orderly facility.

PROCEDURE:

1.0. Regularly scheduled environmental inspections of the facility will be conducted in accordance with the guidance of Department Order 519.

1.1. The inspection shall include (as a minimum): cleanliness and safety of all inmate housing; laundry and housekeeping practices; pest control measures; risk exposure containment measures; equipment inspection and maintenance; and occupational and environmental safety measures.

1.2. The Vendor Facility Health Administrators are responsible to ensure that all manufacturer and state regulatory agency required inspections are completed on Health Services Division equipment.

2.0 Written reports must be reviewed by the Facility Health Administrator or designee. However, the filed original may be retained by the appropriate supporting staff (e.g., Office of Safety and Environmental Services Liaison, Occupational Health Unit, etc.).

3.0 Corrective actions must be documented.

4.0 All Vendor health staff are responsible to comply with the safety and style requirements set as clothing standards under Department Order 503. Of particular interest is the health industry requirement to wear non-skid shoes which are securely fastened to the foot. Crocs, toeless sandals, and clogs are not acceptable footwear in a clinical setting.

Chapter 2, Sec. 7.0 Kitchen Sanitation

REFERENCES: DEPARTMENT ORDER 703
DEPARTMENT ORDER 912
NCCHC STANDARD P-F-02

PURPOSE: The purpose of this policy is to ensure that inmates are provided nutritional, cost-effective food service and that the food is prepared in a manner that is efficient and sanitary, and includes safe food preparation practices and operation.

RESPONSIBILITY: Health Services Contract Vendor Regional Medical Director is responsible for monitoring the Department's diet program to ensure food preparation is performed in an effective manner. The Vendor Regional Medical Director or designee is responsible to advise regarding clinical aspects of food preparation to preclude spreading of communicable disease.

PROCEDURE:

1.0. Department Order 703 provides a standard guideline for inspection of facility kitchens.

2.0. Department Order 912 establishes a kitchen and food preparation program for the Department.

Chapter 2, Sec. 8.0 Ectoparasite Control and Treatment Procedures

REFERENCES: DEPARTMENT ORDER 1102
NCCHC STANDARD P-B-01
NCCHC STANDARD P-E-02 (receiving screening)

PURPOSE: The purpose of this procedure is the prevention of the spread of ectoparasites within the prison population.

RESPONSIBILITY: It is the responsibility of the Contract Vendor complex DON or designee to ensure that all licensed Vendor Nurses are trained in identifying, screening, and providing appropriate treatment to inmates for LICE (Pediculosis), Scabies, RINGWORM OR TINA CAPITIS, or Body Lice.

1.0. Upon initial nursing screening intake done at Alhambra/Phoenix, ASPC/Perryville, Tucson Minors Unit or a case screened on Nurse's/Practitioner's line at the prison complex**,** the licensed Nurse will screen the individual for ectoparasites. If the individual is found with ectoparasites, they are isolated from the rest of the population until appropriate treatment is rendered. This person is immediately issued proper intervention for either shampoo for the hair or cream for the body. The Nurse is responsible for instructing the individual in the treatment of ectoparasites according to nursing procedures. The Nurse is responsible for documenting the ectoparasite nursing procedure and instructions to the inmate in the health record. The licensed Nurse will notify the Complex DON of the situation. The DON will notify the Vendor FHA. The FHA will notify the Warden of the situation. All roommates will be screened for ectoparasites by the nursing staff and treated accordingly.

2.0 Hygienic maintenance of clothing, bedding, and personal hair items. This needs to be performed SIMULTANEOUSLY.

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

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

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

3.0 Isolation of the inmate:

3.1. For Head Lice/ *Pediculosis:* Once the shampoo treatment occurs, the bedding, clothing, and the mattress are to be washed and the isolation cell cleaned and sanitized with disinfectant cleaner, then the inmate is released from isolation.

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

3.1.2 The inmate will remain isolated from 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.

3.1.3 If treatment is initiated with any oral medications such as ivermectin®, the inmate can be released from isolation after 24 hours after administration of the first dose or as directed by the drug maker's recommendations.

3.2. For Ringworm or Tina Capitis.

3.2.1 If the vector is identified as an animal, the Warden or Deputy Warden of Operations must be contacted and informed so they can remove the animal.

3.2.2 See nursing: Nursing ENCOUNTER TOOLS (NETS) and Nursing Assessment Protocols, Appendix E, for treatment of RINGWORM OR TINA CAPITIS.

3.2.3 The inmate does not have to be isolated from the other population. The Nurse will monitor the inmate weekly on nurses' line until the situation is resolved.

4.0. Inmate follow-up for Head Lice/Pediculosis, Scabies or body lice.

4.0.1. In seven days the Nurse will evaluate the inmate on nurse's line for re-occurrence of signs and symptoms of lice/scabies. Appointments need to be scheduled at the time of the initial incident, in case of a transfer, then review the below procedure.

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

4.0.3. A Woods light may be needed to screen for lice/scabies.

5.0. Inmates who are transferred to another facility after receiving treatment.

5.0.1. When an inmate is transferred the transferring Vendor Nurse will write in red pen or via stamp in the right hand corner of the Continuity of Care form (if paper record is utilized) or otherwise annotate electronically, "Follow up for ectoparasites on _____ **(**the date**)**."

5.0.2. The receiving Vendor Nurse who performs the chart review for intake will schedule this inmate on Nurse's line on the filled in date. This visit will be for the purpose of screening the inmate a second time for ectoparasites. If the date falls on a weekend, the Vendor nurse on duty on that date needs to screen the inmate for ectoparasites, and treat according to NETS and Nursing Assessment Protocols.

5.0.3. All process is documented in the SOAPE notes.

Chapter 3, Sec. 1.0 Responsible Authorities & Staff Administration

REFERENCES: DEPARTMENT ORDER 514
NCCHC STANDARD P-A-02
NCCHC STANDARD P-A-03

PURPOSE: To provide understanding of the supervisory structure (chain of command) of the Medical Services Contract Monitoring Bureau (MSCMB) staff. To provide guidance relative to the assignments and work schedules of the monitoring staff. To provide direction regarding communication between the MSCMB staff and the MS Contract Vendor staff and promote an atmosphere of shared information/communication. To provide a mechanism for meetings of Health Services monitoring staff for purposes of communication, instruction, and project development.

1.0. RESPONSIBILITIES:

1.1. Health care shall be delivered through a joint effort of Health Services Contract Vendor and Security Operations. Vendor Health care staff are subject to the same security regulations as other Department employees.

1.2. ADCRR MSCMB Assistant Director is responsible to provide strategic direction to the MSCMB staff. His/Her shared responsibility with ADCRR Contract Vendor is to ensure that all inmates are provided access to scheduled and emergency health care, and are not refused health care treatment. The MS Contract Vendor shall develop medical staff by-laws.

1.3. Wardens, Deputy Wardens and Administrators are responsible for ensuring security/transportation staff transport inmates for scheduled and emergency health care, and for ensuring appropriate security escort is provided when inmates are transported by ambulance.

2.0. The Contract Vendor Facility Health Administrator (FHA): The Responsible Health Authority is the on-site FHA at each complex. His or her responsibilities are delineated in the Vendor's, PDQ and this MSTM. The Responsible Health Authority is responsible complex- wide, for all levels of health care, providing quality accessible health services to all inmates.

2.1. The Vendor FHA or designee will discuss with the Warden or designee the implementation of any new or revised health services programs which have an impact on institution operations. The FHA shall ensure that all facility health staff are knowledgeable of their technical, professional, and operational responsibilities.

3.0. Physicians:

3.1. Matters of medical judgment and orders are the sole responsibility of the Contract Vendor Clinical staff with appropriate monitoring by MSCMB. Clinical decisions and actions regarding health care services provided to inmates are the sole responsibility of qualified health care professionals. Medical and dental judgments are the sole responsibility of qualified health care personnel and are not to be compromised for security reasons. Final clinical judgments will rest with the Vendor site Medical Director, who is

designated as the Responsible Clinician for each complex. Medical and Dental staff are assured that clinical decisions are allowed to be made for clinical proposes and will not be interfered with by other personnel.

3.2. Specialists who hold clinics are required to provide ADCRR Contract Vendor with a copy of their State medical license to practice within their specialty.

4.0. Mid-Level Practitioners/Providers:

4.1. The Contract Vendor's Nurse Practitioners and Physician Assistants are designated as Mid-Level Practitioners/Providers. Matters of medical judgment and orders that fall within the educational and clinical capability of these individuals will be the sole responsibility of these individuals.

4.2. Nurse Practitioners in the State of Arizona do not require Physician supervision. Physician Assistants will be assigned a Vendor Physician supervisor in accordance with Board of Medical Examiners rules and Arizona State law. Final clinical judgments will rest with the site Medical Director, who is designated as the Responsible Clinician for each complex.

4.3. These individuals will be included as "Practitioners"/"Providers" and will attend and consult during medical staff meetings.

4.4. Medical judgments are not to be compromised for security reasons. Vendor Medical and Dental staff are assured that clinical decisions are allowed to be made for clinical proposes and will not be interfered with by other personnel.

5.0. Dental Staff:

5.1. Matters of dental judgment and orders are the sole responsibility of the Contract Vendor. Clinical decisions and actions regarding dental health care services provided to inmates are the sole responsibility of the qualified Dental health care professionals. Dental judgments are the sole responsibility of qualified Dental health care personnel and are not to be compromised for security reasons. Final clinical judgments will rest with the Vendor Dental Director.

5.2. Dental staff are assured that clinical decisions are allowed to be made for clinical proposes and will not be interfered with by other personnel.

5.3. Specialists who hold clinics are required to provide ADCRR Contract Vendor with a copy of their State dental license to practice within their specialty.

6.0. Nursing Staff:

6.1. Matters of nursing care judgment and orders are the sole responsibility of the Vendor Director of Nursing (DON). Nursing clinical decisions and actions regarding health care services provided to inmates are the sole responsibility of qualified health care professionals. Nursing assessment and treatment judgments are the sole responsibility of qualified health care personnel and are not to be compromised for security reasons. Final clinical judgments will rest with the Complex DON and Responsible Clinician.

6.2. Vendor Nursing staff shall assure that nursing clinical decisions are allowed to be made for clinical proposes and will not be interfered with by non-clinical personnel.

7.0. Medical Records Librarians:

7.1. Separation of Duties Guidance. All matters related to issues concerning legal requirements of initiation, maintenance, storage/retention/destruction, confidentiality, and release of information or copies of medical records come under the professional oversight of the Vendor Medical Record Supervisor and Vendor Medical Record Librarians.

Chapter 3, Sec. 2.0 Staffing Patterns

REFERENCES: DEPARTMENT ORDER 512
DEPARTMENT ORDER 602
NCCHC STANDARD P-C-07

PURPOSE: To establish basic requirements assure that sufficient health staff of varying technical and professional specialties is available to provide adequate and timely evaluation and treatment to the inmates confined to Department facilities as the Contract.

RESPONSIBILITY: It is the Contract Vendor's responsibility to establish the standard schedule of personnel need and duty activity.

PROCEDURES:

1.0. Staffing Plans:

1.1. The MS Contract Vendor will establish a uniform approach to maintaining adequate staffing levels to ensure adequate services to the inmate populations. The Vendor will develop and monitor a staffing plan that will ensure that a sufficient number of qualified health personnel assigned to disciplines, is available to provide timely evaluation and treatment consistent with the standard of care within the community.

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

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

2.0. On Site Clinics:

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

Chapter 3, Sec. 3.0 Credentialing Responsibilities

REFERENCES: DEPARTMENT ORDER 1101
NCCHC STANDARD P-C-01
NCCHC STANDARD P-C-02

PURPOSE: To provide guidance in conducting peer review of the care provided to inmates. To validate the legal and performance qualifications of the Practitioners/Providers employed by ADCRR Contract Vendors. To ensure that all professional Contract Vendor staff providing care within the Department of Corrections are in good standing with their respective licensure/certification Board to practice their profession.

RESPONSIBILITY: The MS Contract Vendor is responsible to ensure that all care is provided in a manner that meets standards. The Contract Vendor is responsible to ensure that professional staffs continue working within their expertise/training and that the work remains at a high level of quality. It is the responsibility of the Contract Vendor FHA (or designee) to ensure that all appropriate professional health staff have copies of current licensure/certification kept locally.

PROCEDURE:

1.0. The Vendor shall ensure that professional health staffs requiring licensure/certification to practice their profession within the State of Arizona are in compliance with standards of conduct for their profession. This includes, but is not limited to: Physicians; Physician Assistants; Nurse Practitioners; Nursing Personnel; Radiology/Lab Technicians; Dentists; and Pharmacists.

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

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

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

3.0. If for any reason, a health professional fails to renew their license/certificate, comes under investigation, or has their licenses/certification revoked/suspended by their respective Board, the Contract Vendor shall administer appropriate corrective action.

4.0. The Vendor shall notify the Site Monitor and Program Evaluation Administrator of any information received regarding revoked/suspended and/or restricted license/certification, license under investigation or an expired license.

4.1. The Vendor shall notify the employee of the licensure revocation or suspension or restriction, or license under investigation, or expired license information and take appropriate action.

5.0. If for any reason during the calendar year, a Contract Vendor health care professional comes under investigation, or has their license/certification revoked/suspended by their respective Board, the health care professional shall notify the Vendor immediately and the Vendor shall immediately notify the Site Monitor and Program Evaluation Administrator and take the necessary appropriate actions.

6.0. The Contract Vendor shall be responsible for obtaining current licensure/certification on all their new employees whose position requires licensure/certification.

Chapter 3, Sec. 4.0 Orientation and Education for Health Services Staff

REFERENCES: DIRECTORS INSTRUCTION 509
NCCHC STANDARD P-C-03
NCCHC STANDARD P-C-09

PURPOSE: To provide consistency in the delivery of an immediate basic orientation for all Contract Vendor health care staff.

RESPONSIBILITY: It is the responsibility of the MS Contract Vendor to ensure that all Vendor health staff completes an orientation to the correctional setting and to the health services delivery system. All staff undergoing orientation is responsible to read this manual paying particular attention to their technical or professional areas. All Vendor health staff is also responsible to understand or seek explanation of the contents of the Medical Services Technical Manual.

PROCEDURES:

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

1.1. At a minimum, Orientation will include the review of the following directives: Health Services Department Orders

1.1.1 (DO) 1101 through 1105

1.1.2 DO 501 - Employee Professionalism

1.1.3 DO 503 - Employee Grooming and Dress

1.1.4 DO 509 - Employee Training and Education

1.1.5 DO 916 - Staff-Inmate Communication

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

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

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

2.2. Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau (MSCMB): Within 60 days of employment the new employee shall complete the Department's

mandatory 40 hours New Employee Orientation. Provide new employees with department handouts on sexual harassment. Employee shall sign acknowledging receipt of sexual harassment handout. Health Service personnel comply with security regulations of the Department. Health Services personnel receive training and/or are notified of security regulations for which they are to comply.

3.0. Annual Continuing Professional Education

3.1. Clinical Education is required for all staff in accordance with the ADCRR Annual Education Plan and NCCHC Accreditation standards.

4.0. Cardio-Pulmonary Resuscitation

4.1. All Health Services Contract Vendor staff who have direct patient contact and MS Contract Monitoring Bureau staff who have direct patient contact, must remain current in professional-level cardiopulmonary resuscitation techniques.

Chapter 3, Sec. 4.1 Medication Administration Training

REFERENCES: NCCHC STANDARD P-C-05

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

RESPONSIBILITY: It is the responsibility of the Vendor Facility Health Administrator and Nursing Supervisors to assure that Vendor staff comply with this Procedure.

PROCEDURES:

1.0 All new Contract Vendor Health staffs that will be required to deliver and/or administer medication to inmates must complete the Medication Administration Orientation Checklist within 30 days of hire.

1.1. The Nursing Supervisor, or preceptor, will:

1.1.1 Review medication procedures with each staff member.

1.1.2 Evaluate the staff member's understanding of medication administration by documenting the Medication Administration Orientation Checklist.

1.1.3 Meet with the staff member upon completion of the Checklist, review findings, and counsel staff member as appropriate.

1.1.4 Assure the staff member receives instructions on security issues related to medication administration.

1.1.5 Assure that the staff member is oriented to the Medication Incident Reporting policy.

1.2. The Contract Vendor Facility Health Administrator (FHA) or designee shall assure that a completed copy of the Medication Administration Orientation and documented training is maintained in each employee training file.

Chapter 3, Sec. 5.0 Clinic Space, Equipment, and Supplies

REFERENCES: Arizona Administrative Code R4-23-609 through 611
DEPARTMENT ORDER 401
DEPARTMENT ORDER 403
DEPARTMENT ORDER 703
DEPARTMENT ORDER 1101
NCCHC STANDARD P-D-03

PURPOSE: To ensure that all complexes and ADCRR facilities have designated adequate clinical space for providing health services to inmate-patients.

RESPONSIBILITY: The MS Contract Vendor is responsible to ensure that adequate spaces are available for provision of health care services to the inmate population. The Warden and Facility Health Administrator are responsible to ensure that facilities are monitored and maintained in working order and all maintenance needs are addressed in a timely manner.

PROCEDURE:

1.0. Clinic Spaces:

1.1. The policies currently in effect under Department Order 401 provide guidance in construction of health services spaces. Examination and treatment rooms must be large enough to accommodate the necessary equipment, supplies, and fixtures and to permit privacy during clinical encounters. Administrative files, health record storage space, and other clerical areas must be sufficient to provide unhindered health care. All ancillary areas must be sufficient to support provision of specialized diagnostic or medical activities. Waiting areas will be sufficiently designed and controlled to provide for adequate seating and access to drinking water and toilets.

1.2. The policies currently in effect under Department Order 402 provide guidance in maintenance of all facility spaces.

1.3. The policies currently in effect under Department Order 703 provide guidance in inspection of all facility spaces. Pharmaceuticals, medical supplies, medical equipment and mobile/portable medical equipment are to be available and inspected regularly. Chapter 2 Section 3.0 provides guidance regarding inventory and inspection of items that are subject to abuse or modification into weapons.

2.0 Equipment: The Contract Vendor Facility Health Administrator or designee is responsible to ensure that the facility has sufficient equipment, durable supplies, and consumable supplies to provide for examination and treatment of patients.

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

2.1.1 Hand washing facilities or other approved hand sanitation methods;
2.1.2 Examination tables and/or surfaces;
2.1.3 Adequate direct illumination lighting for clinical examinations;
2.1.4 Access to weight scales;
2.1.5 Thermometers;
2.1.6 Blood pressure measurement equipment;
2.1.7 Stethoscopes;
2.1.8 Ophthalmoscopes;
2.1.9 Otoscopes;
2.1.10 Oxygen;
2.1.11 Wheeled transportation equipment for patients (i.e., wheelchair, stretcher);
2.1.12 Biohazard identified (i.e., red) material trash containers;
2.1.13 Sharps (biohazard, puncture resistant) containers;
2.1.14 Equipment and supplies for pelvic examinations (female units only);
2.1.15 Automated External Defibrillator (AED)

2.2. Basic equipment for dental services includes but is not limited to:
2.2.1 Hand washing facilities or other approved hand sanitation methods;
2.2.2 Dental examination chairs;
2.2.3 Adequate direct illumination lighting for clinical examinations;
2.2.4 Sterilization equipment;
2.2.5 Blood pressure measurement equipment;
2.2.6 Dental electronic-, hydraulic-, or hand-powered equipment;
2.2.7 Biohazard identified (i.e., red) material trash containers;
2.2.8 Sharps (biohazard, puncture resistant) containers;
2.2.9 Dental care delivery equipment including:
2.2.10 Intraoral x-ray equipment w/developer and
2.2.11 Oxygen

3.0. The Contract Vendor Facility Health Administrator will coordinate with the Vendor complex Director of Nursing (DON) to maintain or update staff access to current electronic and written educational resources.

Chapter 3, Sec. 6.0 Student and Extern Clinical Rotation Programs

REFERENCES: NCCHC STANDARD P-C-03

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

RESPONSIBILITY: It is the responsibility of the MS Contract Vendor to ensure that all actions regarding students and externs are in accordance with Arizona Department of Corrections Rehabilitation & Reentry Department Orders, Technical Manuals, Personnel Rules and the Intergovernmental Education Agreement(s).

PROCEDURES:

1.0. Clearance

1.1. The university or college sponsoring the student/extern rotation with ADCRR will provide the name, date of birth, social security number, and any additional information required by ADCRR, to the appropriate receiving program manager or designee, to obtain a security clearance, at least 21 days prior to starting date.

1.2. The Contract Vendor Regional VP or designee, in conjunction with a representative from the university, will determine the rotation schedule for the students/externs.

1.3. The clinical rotation list shall be provided to the appropriate Vendor's site Medical Director, the appropriate Complex DON, and the appropriate Facility Health Administrator(s) at least one week prior to the beginning of the rotation.

1.4. The appropriate Vendor Director or designee will ensure that a security check has been completed and a temporary contractor I.D. badge issued. A copy of the completed clearance will be maintained by the appropriate program manager or designee.

2.0. The appropriate Vendor supervisor or designee shall ensure each student receive a proper orientation at the facility level to the correctional environment and role of health care provided to inmates. Each Vendor supervisor will, in coordination the receiving Vendor FHA, designate an individual from the appropriate discipline to conduct the orientation.

3.0. The Vendor Facility Health Administrator and appropriate Vendor supervisor shall ensure that each student or extern is oriented to the complex as well as the health unit(s).

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

3.1.1 How Health Services meets the medical needs of the inmate population;

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

3.1.3 The role of Security in the delivery of health care to inmates;

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

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

3.2.1 Describe how to manage communicable diseases in a correctional setting;

3.2.2 Identify personal safety issues in the role as a medical care provider in a correctional setting;

3.2.3 Identify appropriate therapeutic communication techniques when dealing with inmates;

3.2.4 Describe the philosophy of managed care in the correctional environment.

4.0. Students/externs will be offered the opportunity to evaluate their clinical experience in accordance with their sponsoring university policies and procedures and those of ADCRR. At or near the conclusion of the rotation, an appointment will be made for the student/extern to meet with the appropriate Medical, Nursing supervisor or designee to review the experience of the ADCRR rotation and the overall learning experience.

4.1. If required and provided by agreement, a completed university/college evaluation will be forwarded to the coordinator designated in the Clerkship agreement.

5.0. 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 diagnosed as limb or life threatening, they will not be referred to or treated by ADCRR Occupational Health.

STUDENT EVALUATION OF CLINICAL EXPERIENCE

University: _____ Dates of Clinical Rotation: _____

ADCRR Location: _____ Preceptor: _____

Directions: Read each statement and mark your response in the space provided. You do not need to enter your name. These evaluations are part of the assessment of program effectiveness.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Orientation to the Correctional environment/Security was sufficient to feel secure within the Complex.				
Orientation to the Health Unit was sufficient to function within the Unit, in order to meet the course objectives.				
Correctional Health Staff was readily accessible to facilitate my clinical experience.				
The range of health problems represented in the inmate population was sufficient to meet the course objectives.				
There were sufficient resources (staff and supplies) available to meet course objectives.				
The attitude of the Correctional Health Staff on the Units contributed to a supportive learning environment.				

What did you like most about your experience in Correctional Health Care?

What did you like least about your experience in Correctional Health Care?

Additional Comment

Chapter 3, Sec. 7.0 Inmate Workers

REFERENCES: DEPARTMENT ORDER 903
DEPARTMENT ORDER 918
NCCHC STANDARD P-C-06

PURPOSE: To provide guidance in the use and employment of inmates in health activities.

RESPONSIBILITY: It is the responsibility of the Warden and the Vendor Facility Health Administrator or designee to ensure that inmates are not placed in a position of authority over their peers. It is equally their responsibility to ensure that positions that allow inmates to serve or further their occupational capabilities are encouraged and supported.

PROCEDURE:

1.0. Inmate Workers: Department Order 903 provides guidance regarding authorized and prohibited duties of inmates.

1.1. Inmates shall not be employed in direct delivery of care services to other inmates.

1.2. Inmates may not have access to, nor handle, HNRs or other medically related documents that are not their own document.

1.3. Inmates may not have access to, nor handle, medications that are not their own.

1.4. Inmates may not have access to, nor handle, medical or surgical instruments.

1.5. Inmate Porters may be utilized as Porters under the guidance of Department policy. All assigned Porters must be appropriately trained in the chemicals used, tools available, and restrictions to be followed when performing their cleaning duties. Documentation of that training must be maintained in accordance with Department Order 903.

1.6. Inmate Fire Crew Selection Process. Fire Crew membership is voluntary. To be members of the fire crew, the following pre-screening criteria/Disqualifications apply:

- 1.6.1 Have a Medical Score of M-1, or Chronic Care Classification stable condition of M-2.
- 1.6.2 Have a Mental Health Score of MH-3 or lower; all MH 3 shall be assessed by complex MH lead.
- 1.6.3 No insulin dependent diabetic.
- 1.6.4 No HIV diagnosis.
- 1.6.4 No MEDICATION treatment phase of Hepatitis C.
- 1.6.5 No proven Asthma diagnosis or significant pollen allergies.
- 1.6.6 No anaphylactic reactions to bug bites, ant bites, bee stings or other insect bites.

1.6.7 No recent or active history of feet, ankle, knee, hip, and back/neck problems; no active or recurrent joint pain/treatments.

1.6.8 Must be able to ambulate (walk/run) without mechanical assistance.

1.6.9 No chronic headaches, dizziness or balance problems.

1.6.10 No history of seizures in the past 5 years; no epilepsy.

1.6.11 No mechanical hearing assist; average hearing.

1.6.12 Have average vision corrections if glasses are worn (must be able to walk/run on rough terrain should glasses be lost).

1.6.13 No weekly or re-occurring medication requirements, no directly observe therapy (DOT) meds. Monthly keep on person meds (KOP) may be authorized.

1.6.14 If NOT disqualified in the pre-screening chart review, the inmate(s) shall be scheduled for:

1.6.14.1 Dip stick Urinalysis

1.6.14.2 Completion of History and Physical (H&P) Form that meets Department of Transportation (DOT) requirements (DOT Form)

1.6.14.3 Medical Practitioner to review documentation and perform minimal exam, (e.g., prostate exam not necessary)

1.6.14.4 Physical exam form is filed on the left side of the paper health record or in the appropriate location in an EHR

1.6.14.5 Notation shall be made on the Problem List for "Wild Land Fire Clearance good for two years".

1.7. Inmate on-complex Tram/Bus Driver Selection Process:

1.7.1 Medical Score of M-1, No MH-4 or MH-5. MH-3 shall be assessed by the complex MH lead.

1.7.2 Chronic Care Classification of stable M-2 may be authorized.

1.7.3 No insulin dependent diabetics.

1.7.4 No medication treatment- phase of Hepatitis C.

1.7.5 Must be able to ambulate without mechanical assistance.

1.7.6 No chronic headache issues, dizziness, or balance problems. No seizures in the past 5 years; no epilepsy.

1.7.7 Average visual acuity if glasses worn. Not legally blind.

1.7.8 If an inmate is NOT disqualified based on the above criteria, they should be scheduled for:

1.7.8.1 Dip Stick Urinalysis.

1.7.8.2 Completion of History and Physical Form that meets Dept. of Transportation (DOT) requirements.

1.7.8.3 Medical Practitioner to review documentation and perform minimal physical examination (e.g., prostate exam not necessary).

1.7.9 Exam documents filed in appropriate section of health record.

1.7.10 Notation made on the Problem list for "Tram/Bus Driver Clearance-good for two years".

1.8 All questions regarding eligibility of Inmate workers shall be referred to the Health Care or Mental Health Care Practitioner who shall make the final clearance determination.

Arizona Department of Corrections Rehabilitation & Reentry	Training for Correctional Officers	OPR: Contract Vendor Regional Director of Nursing (RDON) MSCMB Program Evaluation Administrator MS Contract Vendor Regional VP/Administrator Auth: ta
Medical Services Technical Manual	MSTM Chapter 3 Section 8.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 3, Sec. 8.0 Training for Correctional Officers

REFERENCES: DEPARTMENT ORDER 509
NCCHC STANDARD P-C-04 (Health Training for Officers)
NCCHC STANDARD P-G-06 (pts ETD# and other drug problems)

PURPOSE: To provide appropriate health related training to correctional officers so that they may recognize when the need to refer an inmate to a qualified health care professional occurs and to provide emergency care until a qualified health care professional arrives on scene. Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations, and understand their part in the early detection of illness and injury.

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

PROCEDURES:

1.0. Correctional officers who work with inmates are to receive health-related training at least every 2 years.

1.1. The training will include the following minimum information; administration of first aid (BLS), recognizing the need for emergency care and intervention in life threatening situations, i.e., heart attack, recognizing acute manifestations of certain chronic illnesses, i.e., asthma, seizures, as well as intoxication and withdrawal, and adverse reactions to medications, recognizing signs and symptoms of mental illness, knowledge of procedures for appropriate referral on inmates with health complaints to health staff, knowledge of procedures and precautions with respect to infectious and communicable diseases, and cardiopulmonary resuscitation (CPR).

2.0. The appropriate nature of the health-related training is verified by an outline of the course length, course content and length of the course.

2.1. Each Complex has a training officer who maintains original training records and associated rosters. A certificate of completion or other evidence of attendance is kept on site by the Complex or Unit Training Coordinator for each employee.

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

Chapter 4, Sec. 1.0 Pharmacy Administration

REFERENCES: Arizona Administrative Code R4-23-612
NCCHC STANDARD P-D-01

PURPOSE: This policy is a guide to the daily operation of the Vendor pharmacy process. It provides a concise reference for orientation of personnel to the pharmacy process and a source of information to answer questions in the absence of the regular pharmacy staff. All procedures are developed to ensure compliance with Arizona State and Federal laws and policies established in Arizona Department of Corrections Rehabilitation & Reentry Department Orders.

RESPONSIBILITIES: This reference should be maintained by the Contract Vendor Pharmacy Director. All Vendor pharmacy staff are responsible to read and apply the contents of this manual to the pharmacy operations. Questions of interpretation and intent should be referred to the MS Pharmacy Monitor.

PROCEDURE:

1.0. Vendor Pharmacy Responsibilities.

1.1. Vendor Pharmacy Personnel Responsibilities. Vendor Pharmacy shall ensure that resources will be sufficient to assure compliance with state and federal regulations, timely procurement, proper storage, reliable record keeping, and accurate medication dispensing.

1.2. Staffing Certification and levels. Pharmacists/Pharmacy Vendor shall comply with all State Board and Federal Regulations.

1.3. The Contract Vendor Director of Pharmacy is Responsible for ensuring:

1.3.1 That daily pharmacy operations are conducted in accordance with State Law, Federal Law, ADCRR Department Orders, and the MSCMB Technical Manual and accepted standards for the practice of pharmacy.

1.3.2 Adheres to State and Federal Law when performing all controlled substance transactions.

1.3.3 Maintains proper storage and dispensing of all medications used in the institution; including inventory maintenance and pharmacy procurements. All record keeping associated with the procurement, storage, and dispensing of pharmaceuticals is monitored by the Vendor Pharmacy Director.

1.3.4 Routinely inspects clinic emergency medications in the urgent care room, emergency kits, and clinical stock.

1.3.5 Procures, maintains, organizes storage, inventories, and keeps records on bulk supply syringes and needles.

1.3.6 Provides ongoing education for all health service staff and inmates on medications and pharmacy policies. Plans and conducts training of clinic staff in pharmacology, pharmaceutical dosing, and pharmacy procedures.

1.3.7 Updates pharmacy publications including the Vendor Pharmacy directives and Vendor Formulary.

1.3.8 Assures that pharmacy/clinical directives issued by the MSCMB and MSCMB Pharmacy Monitor are carried out.

1.3.9 Maintains records of compliance for licensure, Pharmacists' continuing education, inspections, and reporting as required by Federal and State Law, ADCRR Department Orders, MSCMB Technical Manual, and Vendor's local procedures.

1.3.10 Maintains a "signature file" of all staff authorized to prescribe medications and/or record on any required pharmacy form or record.

1.3.11 Obtains and/or maintains all records of State of Arizona Pharmacy Licensure and renewals. Additionally, each pharmacy will maintain a DEA license through the Drug Enforcement Agency. The DEA license number will be used to identify clinic controlled substance activity by location and provider.

1.3.12 Performs inspections of medications stored in all clinic/healthcare unit work areas.

1.3.13 Participates in Facility Health Services' committees and meetings as they relate to drugs and drug therapy.

1.3.14 Maintains files of the combined MSCMB and Vendor Pharmacy and Therapeutics Committee Meeting Minutes and maintains the Master Formulary. Ensuring all complex Providers are in possession of an up-to-date formulary.

2.4. The Vendor Director of Pharmacy is Responsible for:

2.4.1 Maintenance and adherence to all State and Federal pharmacy regulations.

2.4.2 Safety/security of medications.

2.4.3 Education of Vendor policy/procedure concerning medications.

2.4.4 Other duties as assigned by the Vendor.

2.4.5 Serves as liaison between vendor and Pharmacy contract monitor.

2.4.6 Audits and follow up with negative findings.

3.0. Practitioners shall:

3.0.1 Prescribe only those medications which are therapeutically correct.

3.0.2 Follow procedures for obtaining non-formulary medications as prescribed in vendor policy procedure.

3.0.3 Review medications prescribed by outside consultants and issue a prescription for the medication or substitute a therapeutically equivalent medication available from the vendor Formulary.

3.1. The Vendor Pharmacy shall:

3.1.1 Maintain a sufficient stock of formulary medications to fill routine prescriptions and clinic stock orders.

3.1.2 Ensure that all prescriptions are dispensed in a timely manner so as not to contribute to morbidity or mortality.

3.1.3 Comply with all State and Federal laws governing the practice of pharmacy.

4.0. Facilities and hours of operation:

4.1. The vendor pharmacy area will be of sufficient size to meet State Board of Pharmacy (BOP) regulations and allow adequate work space and storage to accommodate pharmacy staff personnel and supplies for at least seven days of operation. Additional storage areas, accessible only by authorized Vendor's staff and ADCRR Monitors, shall be of sufficient size to accommodate storage of pharmaceuticals and supplies to

provide for uninterrupted vendor services including secured narcotic storage and records keeping area and shall comply with all state and federal regulations.

4.1.1 Equipment and resources will be maintained and provided to ensure that necessary medications are procured, stored, and dispensed in accordance with pharmaceutical standards and program procedures. Equipment will include those items listed in A.A.C. R4-23-612 (Arizona State Board of Pharmacy's Rules and Regulations).

4.1.2 Appropriate reference texts and journals will be maintained to provide up to date information for health care staff.

4.1.3 Antibiotics may be dispensed in up to 30 day increments.

4.2. Prescription Limits: General:

4.2.1 Prescriptions for chronic conditions may not exceed a 1 year time period. The period of ONE MONTH shall be interpreted as 30 days.

4.2.2 Keep-on-Person (KOP) maximum quantities dispensed may not exceed a 30 day supply or 120 dosage units whichever is less, except for unit of use medications (e.g., eye drops, creams, lotions, etc.) which expire when the prescription expires.

4.2.3 Controlled Substance prescription authorization will be limited by Department Program Technical Manuals, not to exceed State and Federal limitations upon each class.

4.3 Physicians, Psychiatrists, and Nurse Practitioners:

4.3.1 Controlled Substance (CII-CV) may not exceed 30 days to facilitate inventory tracking and control.

4.3.2 Phenobarbital used to treat seizure disorders may be prescribed for up to 6 months.

4.3.3 DEA Controlled Substances shall NOT be used for hypnotic purposes.

4.3.4 DEA Controlled Substances, used in cases of chronic or terminal illness resulting in unremitting pain not likely to abate in the short term, will be valid for one month.

4.4 Mid-Level Providers shall prescribe (Physician Assistants): (Arizona Revised Statute 32-2532) as determined by their license privilege or restrictions.

4.5. Patient product information (PPI) is required to be provided to patients each time a new prescription is provided for the following medications:

4.5.1 Birth Control Pills

4.5.2 Oral Estrogen Products

4.5.3 Vaginal Estrogen Products

4.5.4 Oral Progesterone Products

4.6. Exceptions to policy must be submitted and approved through the Non-Formulary process.

5.0. Medication Liaison for Remote locations:

5.1. A Medication Liaison may be designated by the Vendor Facility Health Administrator. This individual may be a correctional Nurse or administrative assistant or other health services staff member. The Medication Liaison and at least two back-up staff will be trained in the following areas:

5.1.1 Preparation of medication for delivery and distribution to nursing staff.

5.1.2 Ordering and distribution of Over the Counter medication to Providers and Nursing staff.

5.1.3 Medication liaison shall not be permitted in areas that stores controlled substances unless supervised by a licensed nurse.

Chapter 4, Sec. 1.1 Pharmaceutical Dispensing Procedures

REFERENCES: Code of Federal Regulations, 21 CFR 1306.04(a)
Arizona Revised Statutes 32-1901(66)
Arizona Administrative Code R4-23-672
NCCHC STANDARD P-D-01
NCCHC STANDARD P-D-02

RESPONSIBILITIES: It is the responsibility of the Vendor's pharmacy staff, provider staff, nursing staff, administrative staff and mental health staff to maintain the integrity of dispensing procedures to ensure that all prescriptions are dispensed in a timely manner so as not to contribute to morbidity or mortality and so that the inmate population receive excellent pharmaceutical care while under the supervision of ADCRR Contract Vendor.

PROCEDURES:

1.0. Authorized Prescribers:

1.1. Only Arizona Department of Corrections Rehabilitation & Reentry Contract Vendor employees legally licensed by the State of Arizona to prescribe medications shall be authorized to prescribe medications for inmates. Prescription orders written by consultants shall be considered "treatment plan recommendations" to the ADCRR Vendor Practitioner/Provider. The following ADCRR practitioners are required to have a DEA number:

1.1.1 Vendor Physicians (D.O.s and M.D.s) will have authority to prescribe any medication, with the exception of psychotropic medications (unless an emergency exists), and approved for use within the limits approved by the P&T Committee. Non-formulary drugs may be prescribed if prior approval for their use has been obtained.

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

1.1.3 Vendor Mid-Level Practitioners/Providers (Nurse Practitioners and Physician Assistants). Vendor Physician's Assistants and Nurse Practitioners are authorized to prescribe within the same parameters as ADCRR Vendor's Physicians and in accordance with and limits of State and Federal Laws. They may not institute, modify, or continue psychotropic medications (as outlined in the Drug Formulary).

1.2. Provider DEA Numbers: Every authorized Vendor Primary Care Provider in the Arizona Department of Corrections Rehabilitation & Reentry will have a personal identification number (DEA number) for the purpose of legally prescribing Controlled Substances. Upon employment and reporting to an ADCRR Complex, the Vendor FHA will assure that a DEA number is on file for the Vendor's Health Care Practitioners and in accordance with DEA regulations.

1.3. Vendor Pharmacists may write verbal orders from an authorized prescriber and immediately reduce it to writing. Providers must furnish an original prescription within seven days of a verbal CII prescription or

as per state and federal guidelines. All verbal order prescriptions must be annotated so as to clearly indicate that the prescription is a verbal order.

1.4. Vendor Nursing Staff may issue medications under Nursing Protocols, Nursing Encounter Tools (NETS) or Algorithm's authorized under MSTM policy. To ensure that health care treatment, performed by the Vendor's health staff member, in the absence of a health care Provider, (written treatment guidelines/protocol orders, or direct order of a vendor health care Practitioner/Provider as authorized by law), the Vendor Facility Health Administrator shall ensure:

1.4.1 That treatment guidelines/ protocol orders are limited to those promulgated by the MSCMB and the Vendor.

1.4.2 That all health care treatment is provided only at the direct order or treatment guidelines/ protocol order of an authorized Vendor health care Provider; and

1.4.3 That all treatment guidelines/ protocol orders are reviewed annually; and

1.4.4 That a copy of all treatment guidelines/protocol, orders/nursing, protocols/nursing assessment tools are readily available in the Vendor pharmacy.

2.0. Prescription Information: All prescriptions will be written on an ADCRR approved vendor prescription form or electronically transmitted by the Vendor Pharmacy Software in compliance with all State and Federal regulations.

2.1. Prescriptions presented to the Vendor Pharmacy will contain the following information in clear concise format and comply with all State and Federal regulations. (Prescriptions NOT submitted in accordance with these requirements will be returned to the Health Care Provider to correct or complete).

2.1.1 Inmate's name (last, first);

2.1.2 Inmate's ADCRR number;

2.1.3 Inmate's location and unit;

2.1.4 Date of issuance;

2.1.5 Full medication name;

2.1.6 Strength;

2.1.7 Dosage prescribed or device name;

2.1.8 The route the medication is to be given, e.g., oral, I.M., IV, if necessary;

2.1.9 Quantity to be dispensed (The exact number of days or doses to be given) and stop date;

2.1.10 For medications that are to be taken prn (e.g., NSAIDS, Aspirin, antacids, inhalers) or which are unit of use medications (e.g., eye drops, creams, lotions, etc.) it is important to specify the initial quantity and the number of refills authorized. (Chronic routine medications may be written for a specific length of time, without indicating the quantity and the number of authorized refills, e.g., HCTZ 25 mg. qd for 180 days);

2.1.11 The number of times per day the medication is to be given or used;

2.1.12 Diagnosis/Medical Condition and Allergies;

2.1.13 Complete, concise directions for the patient ("UD" or "as directed" is NOT acceptable);

2.1.14 Prescriber's legal signature and stamped name or electronic signature;

2.1.15 Any other specific information needed to fill the prescription (e.g., Unit, Release Medications, etc.);

2.1.16 All prescriptions shall comply with State and Federal regulations.

3.0. Inmate Patient Profiles/Record: The Vendor Pharmacy will maintain patient profiles/records on all inmates receiving prescription medication. The profile/record will contain the information listed above. Inmate Medication Administration Records (MARs) will reflect all prescription information required in the MSTM.

4.0. Prescription Quantities and Refill Information. Prescription quantities, duration, and dosages will be in compliance with ADCRR/Vendor Disease Treatment Algorithms/ Guidelines, the Vendor Drug Formulary, and the Medical Services Technical Manual unless approved otherwise via a Non Formulary Drug Request. Prescriptions that are not within the guidelines limits will be dispensed per guideline.

5.0. Release Medications

5.1. At the time of release to Community (Half-Way House, Home Arrest, or Release) the releasing Facility shall provide a 30 day supply of all active medication (P.R.N. or otherwise) pursuant to a new prescription. Prescriptions for release medications will comply with all State and Federal law.

5.2. Vendor FHA and Warden will designate a common point at their respective Complexes for release medications to be picked up by inmates being released. The chain of custody will be maintained and documented through a receipt process from Vendor pharmacy to Vendor nursing, Corrections staff/Operations to inmate. All inmates receiving release medications pursuant to a new prescription shall have printed drug information sheets for all medications received.

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

5.4. Birth Control Pills may be prescribed and dispensed to female inmates one month prior to release with an additional month's supply given at time of release at the Health Care Providers discretion.

5.5 Release medications placed in operations custody shall be brown bagged and chain of custody shall be maintained. An acknowledgement sheet from vendor health care shall be signed by the health care professional and the officer assuming the responsibility for release. The release form will contain at a minimum the inmate name, ADCRR number, and prescription number for each release medication for the individual inmate. The release form shall be signed by the inmate upon receipt of medication. The said form shall contain acknowledgement of non-child proof caps, access to consultation and medication information sheets. All medications while in vendor health care custody as well as correctional staff shall comply with all rules and regulations of the state board of pharmacy as well as maintenance of temperature logs. All controlled release medications shall be inventoried as per MSTM policy (shift counts). The controlled release medications shall also comply with the double lock requirement as per the MSTM and comply with existing vendor policy and procedure until issued to the releasing inmate.

6.0. Treatment Protocol Orders/Nursing Encounter Tools/ Program:

6.1. To ensure Pre-Packaged medications are available in each Facility for use on Nurses-Line in conjunction with authorized treatment algorithms or protocols or encounters, each vendor shall ensure that properly labeled prepackaged medications, in standard amounts, are routinely available.

6.2. Authorized medications will be stocked for distribution during the Nurse's Line.

6.3. Items available will be limited to those authorized by the MSTM.

7.0. Processing New Prescriptions and Medical Orders:

7.1. Prescriptions may be generated at the Health Care Unit and ordered from the Vendor Pharmacy for processing. Ordering should be completed in a timely manner and NOT left until the end of shift.

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

7.3 All information necessary for processing the prescription as required by the vendor pharmacy data base prescription program will be entered into the vendor pharmacy data base program and a label generated. The label generated will be in compliance with all State and Federal regulations. The label will also contain a contraband date printed on the label at the time of dispensing.

7.3.1 All prescriptions will be affixed with a control number which corresponds to the computer assigned prescription number. A process for tracking off site pharmacy use shall be developed by the Vendor and approved by the Department (Health Services Monitoring Bureau).

7.3.2 The prescription will be filled and initialed by the vendor Pharmacist (or via electronic means of recognition in compliance with state and federal regulations) responsible for filling the prescription. This includes orders filled by a technician, student or orienteer. (The requirements may be met by attaching a computer generated label to the prescription; a computer generated log sheet may be used to check accuracy of labels if compared against the original prescription).

7.3.3 The prescription label will be initialed, after checking, by the Pharmacist or an electronic signature will be maintained by the pharmacist checking the prescriptions.

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

7.3.5 The prescription will be delivered to the appropriate nursing unit for administration.

7.4. All medications shall be dispensed in plastic containers or ADOC approved packaging that meets all state and federal guidelines unless dispensed in the original manufacturers packaging, e.g., nitroglycerin, creams, ointments, etc. Whenever possible, avoid dispensing in glass or metal containers. Medications may be administered from but WILL NOT be dispensed in paper or manila envelopes. Medications not packaged in approved ADOC packaging shall be considered DOT.

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

9.0. Processing Prescription Refills:

9.1. Refills of chronic medications may not be written to exceed 1 year. Inmates must still be seen quarterly, or as directed per Medical Program policy.

9.2. Prescriptions for Prenatal vitamins and iron to be good for duration of pregnancy plus two months. Inmates will be seen for medical follow-up as determined by the HCP.

9.3. Refill requests for non-chronic medications (P.R.N.) will be initiated by the inmate by submitting a refill label or by filling out a Health Needs Request form (HNR) and submitting it (along with their empty medication container when mandated) to Health Services if the medication is NOT on automatic refill. The prescription will be reviewed for proper use (compliance, expiration date, and refill status). Refills for chronic medications (not prn) shall be captured in such a way that an HNR is not required for a refill, i.e. auto-refill.

9.4. If appropriate, the medication will be refilled through the following process:

9.4.1 The refill information entered into the Vendor pharmacy computer database, and the HNR completed with the full name and signature of the healthcare staff completing the HNR.

9.4.2 If the inmate's use of the medication is not in compliance with the written directions; the medication will not be refilled and the following process will be followed.

9.4.3 The ordering Practitioner/Provider will be contacted and the concern communicated.

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

10.0. Telephone and Faxed Prescriptions and Telephone Prescribing: [reference: A.R.S. 32-1901(66) and Code of Federal Regulations, 21 CFR 1306.04(a)].

10.1. Although prescriptions may be transmitted verbally to the vendor pharmacy, this should be discouraged and reserved for logistic situations that do not allow for routine processing of the prescriptions. Telephone orders to facilitate speed of medication delivery shall be immediately reduced to writing by the vendor Pharmacist.

10.2. Faxed prescriptions will be received by the pharmacy and prepared for administration and delivery to the inmate. The faxed prescription is considered a legal document and will be maintained by the pharmacy as required by state and federal statutes. Rules regarding Schedule II drugs require that an original prescription order be sent to the pharmacy within 7 days and attached to the fax copy or as mandated by state and federal law.

11.0 Vendor Dispensing:

11.1. Upon the receipt of a faxed, verbal, original, or electronic prescription from a Vendor Provider, the Vendor Pharmacy will:

11.1.1 Dispense the medication for administration and/or delivery.

11.1.2 Comply with the cut-off time for receiving prescriptions that has been set by the Vendor. Prescriptions received prior to that time will be filled for next day delivery.

11.1.3 Upon receipt of required documentation for dispensing medication for administration and/or delivery will produce and package the medications.

11.1.4 A copy of the faxed verbal, original, or electronic prescription and clinic stock orders will be maintained by the Vendor pharmacy for seven years as mandated by federal and state laws for document preservation.

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

11.2. If a discrepancy occurs between the ordered and received prescription, the Vendor pharmacy shall be notified that day and/or the prescription shall be sent re-/transmitted with explanation of. Offsite back-up pharmacy or clinic stock must be used if necessary to ensure continuity of care. With the introduction of an EHR (Electronic Health Record) the spirit of 11.1.5 and 11.2 shall remain in effect.

11.3. All Schedule II faxed prescriptions are considered to be a legal prescription by the DEA and the faxed prescription may be retained as the official record, but rules regarding Schedule II drugs also require that an original prescription order be sent to the Vendor pharmacy within 7 days and attached to the fax copy. All prescriptions must satisfy state and federal law. In addition if a missed dose of medication will create harm to an inmate a backup pharmacy must be used and documentation made in the medical record the Vendor health care Practitioner was notified and approval given.

12.0 Refill Requests:

12.1. Requests for “prn” refills will be processed through Health Needs Request Forms (HNR) and medication refill refills will be communicated to the Vendor pharmacy. Responses back to the patient’s HNR refill request concerning the refill will be communicated to nursing (i.e. no refills fills remaining, etc.). It is expected that these responses are communicated by the next business day and follow action taken as well as communication with the inmate/patient with an explanation as to why the fill/refill was not executed. Follow up may necessitate notification to the prescribing Practitioner.

12.1.1 Refill requests by pharmacy labels or otherwise will be processed by the vendor pharmacy via an ADOC approved process. If a discrepancy is noted by the vendor pharmacy, notification with an explanation of discrepancy will be returned to the originating unit/location for follow up/resolution. Notification may be by manifest, fax, email, or an otherwise ADOC approved communication. If medication is of an immediate urgent/emergent nature, continuity of care must be maintained by utilizing an offsite pharmacy. Upon receipt of the notification, nursing must rectify the discrepancy in a timely manner as to maintain continuity of care as well as notify the requesting inmate.

13.0 Non Formulary requests shall be answered via the vendor (approve, disapprove, ATP) within 2 business days of the prescription/request date. All medication ATP (Alternate Treatment Plan) as well as denials shall be resolved by the provider within one business day of the notification/issuance of the ATP or denial.

14.0 Pending Discharge Medication orders must be sent to the vendor pharmacy by nursing services at least one week prior (but no sooner than two weeks prior) to discharge for the medication to be filled by the

Vendor Pharmacy. An alternate procedure that meets the spirit of this requirement may be developed by the Vendor Pharmacy Director. Patient profiles must be reviewed for accuracy (additions, deletions, change in dose, directions, etc.) immediately prior to release to ensure appropriate therapy is received upon release.

14.1. Late notification for discharge medications will require a facility procedure using outside contracted pharmacy services to provide discharge medication.

15.0. Medications prepared for administration and/or delivery will be securely packaged in a medication tote and delivered to the remote location, by contracted delivery services.

15.1. The Vendor Facility Health Administrator (FHA) and the Vendor Pharmacy Director shall work closely with the Warden and Institutional Records staff, monitoring the daily transportation movement, rescheduled transports or cancellations, by the contracted delivery services. The Pharmacy Contract Monitor will be notified of any delays in transportation. It is expected that if prescribed medication is of an urgent/emergent need that alternate avenues to obtain the required medication be utilized and a process be developed to identify those inmate/patients in need.

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

15.1.2 A member of the contracted Health Services staff shall be responsible for the receipt of the medication tote at the receiving facility. The person responsible will be identified by the Facility Health Administrator and may be a medication liaison, correctional Nurse, Administrative Assistant or other designee.

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

15.1.4 Any discrepancies in contents shall be reported within 1 hour of receipt of tote by the medication liaison or designee to the Vendor sending pharmacy.

15.1.5 The vendor pharmacy shall take the necessary actions to address any content discrepancies and resolve the issue.

15.1.6 In addition, the prescription shall be reviewed against the Rx copy that was maintained by the sending facility. This shall only be performed by licensed medical personnel (nursing). This may also be accomplished via review of an Electronic Health Record (EHR).

15.1.7 Upon receipt of medication delivered by the contracted Vendor Pharmacy or alternate source, nursing shall sign and date the accompanying manifest as assumption of responsibility for follow up on medication issues/concerns documented by the manifest or other utilized form of notification. Signatures must include credentials (i.e. LPN, RN). All signatures must be legible and a stamp must be used in conjunction with the signatures. This will also ensure the maintenance of custody for said medications. Controlled substance manifests or other documenting source of delivery/return must contain the signature of 2 vendor licensed nurses and also satisfy the above mentioned criteria for manifest documentation. It is the responsibility of the 2 vendor licensed nurses that originally signed the controlled substance manifest or other utilized form of notification for delivery/return to also document the receipt/return of the controlled substance in the accepted Controlled perpetual inventory or other ADOC approved tracking system. Manifests and other sources of documentation for receipt/ return are considered extensions of the existing inventories and therefore require the same documentation that the existing perpetual inventories or other ADOC approved tracking systems require.

15.1.8 Any prescriptions not filled will be reported immediately to the sending pharmacy to resolve the issue.

15.1.9 Vendor Pharmacy shall communicate with the department (Pharmacy monitor) any delays in shipment.

Chapter 4, Sec. 1.2 Pharmacy Medications Issued to Clinic Stock

REFERENCES: Arizona Administrative Code R4-23-672
DEPARTMENT ORDER 302
DEPARTMENT ORDER 712
NCCHC STANDARD P-D-01
NCCHC STANDARD P-D-02

PURPOSE: To provide mechanisms and requirements for issuing supply and resupply and maintaining proper stockage levels of Clinic Medications (Clinic Stock).

RESPONSIBILITIES: The Vendor Pharmacy will provide pharmaceutical supply and resupply support to unit clinics. The Clinic Stock area is an extension of the Vendor Pharmacy. All State and Federal laws and Rules and Regulations pertaining to the practice of pharmacy shall apply to the Clinic Stock area.

PROCESS:

1.0 All controlled items, Controlled Substances, needles, and syringes, will be signed for by the receiving Vendor nursing staff. Two (2) signatures will be required with date of receipt, credentials and stamp.

1.1. All Controlled Substances (clinic stock, patient specific) sent to or returned from facilities/units will require two (2) signatures of receipt/return from vendor licensed healthcare staff (nursing). Please refer to 15.1.7 for further clarification. This will also include any manifest accompanying the medication as well as the perpetual inventories used to monitor medication use, waste, receipt and return. All records shall be maintained as per state and federal law (7) years.

1.2. Needles and syringes will be signed for by receiving Vendor nursing staff. The person responsible for distribution of needles and syringes will maintain the documentation. Nursing shall be responsible for the distribution of needles and syringes and will maintain all documentation. The Vendor FHA, DON, Warden and MS Contract Monitor will be notified of all discrepancies. Vendor Nursing Staff will accurately maintain all documentation pertaining to receipt/distribution/return.

1.3. All controlled items, Controlled Substances and needles and syringes, will be signed for by the receiving Vendor licensed staff and kept on file for seven years. All records shall be maintained as per state and federal regulations.

2.0 Clinic stock medications shall be determined by the Vendor Pharmacist with input from facility Practitioner/Providers. Stocked medications should be governed by anticipated usage. Medications stocked will include psychotropic bridge medications.

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

lead Dentist. The perpetual inventory will include: date administered, time administered, inmate name and DOC number, name of medication, quantity administered (dose), the name of licensed vendor staff administering the dose and the provider ordering the medication. The perpetual inventory shall be governed by a beginning total count and subtraction of each dose given stating final quantity of each dose given. It is the responsibility of the vendor licensed nurse or vendor lead dentist to maintain accurate perpetual inventories. The vendor licensed nurse or vendor lead dentist will sign acknowledging clinical stock (manifest). Receipt of controlled clinic stock shall be documented on the control manifest and perpetual inventory by the signature of two (2) licensed nurses. The addition of clinic stock shall be accurately noted on the perpetual inventory as well as wasted or returned medications. Notation of clinic stock use shall be accurately noted in the patients' medication administration record or electronic medical record with each dose. The record of administration source of medication (clinic stock), time administered, and accurate representation of dose given as compared to clinic stock removed and original prescription issued. If the dose/quantity of medication administered from clinic stock differs from the original prescription (dose/quantity), the prescription must be rewritten to capture this administration. Perpetual inventories must maintain an accurate date sequence, all count discrepancies (including corrected count, or otherwise) must be accompanied by an IR number located directly on the perpetual inventory where noted. Notations of wasted medication for controlled substances must be accompanied by 2 licensed vendor nursing signatures. Notations of waste for all other medications shall be noted by a licensed vendor nurse's signature. Information required on the inventory must be filled out accurately/completely and legibly in its entirety.

2.1.1 Allergies and diagnosis of inmate requiring clinic stock should be reviewed for interaction by nursing prior to administering a dose.

2.1.2 Use of clinic stock for a prescription should be logged in the vendor pharmacy computer as "information only" to ensure a complete medication record.

2.1.3 The Vendor Licensed Nurse or Vendor Lead Dentist will sign acknowledging receipt of the clinic stock.

3.0. Vendor Pharmacy shall issue clinic stock to the health care units.

3.1. Upon receipt of a valid order from a Vendor Provider, the Licensed Nurse, Lead Dentist or designee may administer a clinic stock to the inmate. Prior to administration, the Licensed Nurse, Lead Dentist (or designee) shall check the inmate's medical record to assure that the inmate is not allergic to the medication. The appropriate information is to be recorded on the perpetual Inventory.

5.0. Medication Pickup from vendor Pharmacy shall occur as follows:

5.0.1 Nursing staff and/or dental staff will sign the Vendor pharmacy manifest sheet acknowledging the receipt and count of medications.

6.0. DEA 222 order forms will be required for the transfer of all C-II drugs transferred for emergency stocking and dispensing from the Remote Drug Storage Area.

6.1. Active prescriptions (with patient name) dispensed by the Vendor pharmacy do not require this tracking mechanism.

6.2. All C-2 prescriptions as well as all prescriptions will comply with state and federal law.

7.0. Obtaining Licensure: Perryville will maintain their Pharmacy Hospital/Clinic DEA license for intake prescriptions. Alhambra will maintain their Pharmacy Hospital/Clinic DEA license for intakes and Mental Health Hospital prescriptions. Tucson will maintain their Pharmacy Hospital/Clinic DEA license for their facility and the In Patient Component Facility.

7.1. Obtaining & Processing DEA 222 Forms. Requesting Official Order Forms: Official Order Forms can be initially requested by checking "block 3" on the application for new registration (DEA Form-224). There is no charge. Send the form to:

Drug Enforcement Administration

Registration Unit Central Station P.O. Box 28083

Washington, D.C. 20038-8083

7.2. Records that must be maintained.

7.2.1 Official order forms (DEA Form 222)

7.2.2 Power of Attorney authorization to sign order forms

7.2.3 Receipts and invoices for schedule C-II thru V

7.2.4 All inventory record of controlled substances, including the initial and biennial inventories

7.2.5 Records of controlled substances distributed or dispensed

7.2.6 Report of theft or loss (DEA Form 106)

7.2.7 Inventory of drugs surrendered for disposal (DEA form 41)

7.2.8 Records of transfers of controlled substances between pharmacies

7.2.9 DEA registration certificate

7.3. Initial Inventories (see biennial inventory sample form): When issued a DEA registration, a registrant must take an initial inventory, which is an actual physical count of all controlled substances in their possession. The Code of Federal Regulations also requires that all inventories be maintained at the registered location in a readily retrievable manner for at least two years for copying and inspection. In addition, the inventory the Schedule II controlled substances must be kept separate from those for all other controlled substances.

7.4. Code of Federal Regulations (CFR) requires that the inventory include: The inventory date; the time the inventory is taken (i.e., opening or close of business); the drug name; the drug strength; the drug form (e.g., tablet, capsule, etc.); the number of units/volume; and the total quantity.

7.5. Inventory Record. DEA recommends that the inventory record include: the name, address, and DEA registration number of the registrant and the signature of the person or persons responsible for taking the inventory.

7.6. Biennial Inventory. Following the initial inventory, the registrant is required to take a biennial inventory (every two years, the onsite DEA Investigator suggested doing the inventory every 6 months to be safe) which requires the same information as the initial inventory (see list above) of all CLINIC STOCK STORAGE AREA controlled substances on hand. The biennial inventory may be taken on any date which is within two years of the previous inventory date. There is no requirement to submit a copy of the inventory to the DEA. When taking the inventory of Schedule II controlled substances, an actual physical count must be made. For the inventory of Schedules III, IV and V controlled substances, an estimated count may be made. A count of bottles must be made if the container holds more than 1,000 dosage units and has been opened.

7.7. Clinic Stock Dispensing Record: The dispensing record for C-II-V's will be sent to the remote facility with accompanying Dispensing Records. The dispensing record will contain the following: Date dispensed; the DEA number of the remote site receiving the controlled substance – a new requirement by DEA; the facility/yard; drug name; quantity/package size; pharmacy information; lot number information; blanks for required information to be filled in at the time of administration – date, I/M name, ADCRR #, ordered by; administered by, (change terminology from dispensed by to administered by) diagnosis, and allergies.

7.8. Nursing Supervisors: Receive training from Vendor FHA or designee on documentation of perpetual inventory. Train all nursing staff on documentation of perpetual inventory. Assume responsibility for proper documentation of the clinic stock dispensing record. Train all nursing staff in proper documentation of the dispensing record. Comply with all State and Federal regulations as required.

7.9. Dental Supervisors: Receive training from Vendor FHA or designee on documentation of perpetual inventory for controlled substances if included in their clinic stock. Train all dental staff on documentation of perpetual inventory for controlled substances if included in their clinic stock. Assume responsibility for proper documentation of the dispensing record. Train all dental staff in proper documentation of the dispensing record. Comply with all State and Federal regulations as required.

Chapter 4, Sec. 1.3 After Hours Pharmacy Support and Clinic Stock Medication Storage Area

REFERENCES: NCCHC STANDARD P-E-08

PURPOSE: Frequently, medical conditions of an urgent nature arise in an inmate population requiring the timely intervention of health staff.

RESPONSIBILITIES: The Contract Vendor and the Contract Vendor Pharmacy will establish a process to meet the needs of the institution after hours and in the absence of a pharmacy.

PROCESS:

1.0 The process designed by the vendor will ensure existence of a system to provide urgent, necessary medications ordered by healthcare practitioners and ensure continuation of chronic medications, if delaying until normal refill time would adversely compromise the inmate's health and ensure distribution of medications in compliance with provider orders or approved nursing protocols. Note that the need for urgent, necessary medications may occur during regular duty hours also. In addition to Clinic Stock, Off-site pharmacy may be utilized as an alternative.

2.0. Clinic stock storage areas shall be established in units deemed appropriate by Vendor Pharmacist, approved by the Unit Deputy Warden or Warden, the facility's Vendor supervising Physician/Dentist, the Facility Health Administrator, and ADCRR Pharmacy Monitor.

2.1 Clinic stock storage areas will be located at designated medical units as authorized by joint agreement between the Vendor FHA, and ADCRR Pharmacy Monitor.

2.2. The Clinic Stock Medication Storage Area is an extension of the Pharmacy. All State and Federal laws and Rules and Regulations pertaining to the practice of pharmacy shall apply to the Clinic Stock Drug Storage Areas.

2.3. The Medication Storage Area shall be maintained in a neat, organized and sanitary condition commensurate with all regulations pertaining to the operations of a pharmacy.

2.4. Controlled substances will be maintained separately from other medications and will be inventoried by licensed nurses at shift change as directed in nursing policy and procedures.

2.5. All legend medications shall be dispensed and labeled in accordance with state and federal law.

3.0. Access to the clinical stock and all prescription medication shall be key controlled.

3.2. The Licensed Nurse and Lead Dentist or licensed designee shall be the staff member responsible for the keys to their clinic stock storage area. The keys to the clinic stock storage area are to be under the responsibility of the Licensed Nurse and Lead Dentist at all times. The Licensed Nurse and Lead Dentist (or designee) is the only members of the staff permitted to access the clinic stock storage area for the purpose of obtaining medications.

4.0. Medications in Clinic Stock Storage Area.

4.1. Medications to be made available in clinic stock shall be those authorized by the Vendor Medical Director Vendor Regional Pharmacist and those approved by the P&T Committee for unit dose administration by nursing staff. Medications for use in the clinic, (e.g., injectables, vaccines), medications for unit dosed, and medications to be picked up or delivered are also authorized to be kept in the medication room. No other medications are authorized.

4.2. Medications in the clinic stock storage area remain under the supervision and responsibility of the Vendor Pharmacy and Vendor nursing and shall be handled in accordance with all applicable laws and the Rules and Regulations of the Arizona State Board of Pharmacy. This responsibility extends to the labeling regulations, freshness and integrity of drugs, inventory control (exclusive of weekly accountability records in the Dental clinic stock storage area and Medical clinic stock storage area which are the Lead Dentist's responsibility or nursing staff's responsibility and monthly audits conducted by the nursing supervisors or designees and reported in writing), accuracy of prescriptions, and all other aspects of requirements of the Food and Drug Administration and the Arizona State Board of Pharmacy. Exception: The weekly clinic stock inventory may be excluded if a safety seal secures the clinic stock storage area. The clinic stock storage area may be inventoried each time the seal is broken instead of weekly. The monthly audit may not be excluded and the seal must be broken to complete the audit. When the security seal is broken, the date and time will be documented on the flow sheet as well as the number occurring on the safety seal. That was removed and the safety seal number that replaces the removed seal.

4.3. The clinic stock storage area shall be the only source of medication when the medication is not filled as a prescription by the Vendor pharmacy, or obtained by an offsite pharmacy. All clinic stock and off site pharmacy fills will be considered DOT/WS.

4.4. All medications pre-packaged by the Vendor pharmacy shall be assigned a beyond use date which is twelve (see USP) months from the date of repackaging, or the actual expiration date of the medication, whichever is less. When the medication is packaged by the manufacturer, then the designated expiration date on the stock package will be in effect up to twelve months from the date of repackaging whichever is less.

4.5. Accountability for medications placed in clinic stock by the Vendor pharmacy and the accuracy of entries on the prescription inventory shall be the responsibility of the Unit Licensed Nurses or Lead Dentist. The Licensed Nurse, Lead Dentist or licensed designee shall sign the accompanying document acknowledging receipt of each separate medication placed in the clinic stock Receipt of controlled substances requires 2 licensed nursing signatures as well as transfer and return of controlled substances to the Vendor Pharmacy for destruction (or via an alternate reverse distribution entity). All instances of clinic stock use will be recorded accurately in the inmate's chart with the appropriate source of medication (clinic stock) identified.

4.6. Training in the use of the clinic stock is required for the personnel permitted to access the clinic stock storage area to obtain medications (Licensed nurses or their licensed designees, Lead Dentists or their licensed designees). Training is provided by pharmacy Vendor.

4.6.1 All clinic stock shall maintain a prescription inventory. Any discrepancy must have supporting documentation to justify the discrepancy. This information shall be placed in the proper inventory binder on the respective unit as proof that that the discrepancy has been resolved. The supporting document must be signed and dated by a Nursing Supervisor or Director of Nursing (DON). The ADCRR Pharmacy Contract Monitor shall have access to the documentation.

4.6.2 A compilation and reporting of all clinic stock storage area audits (weekly, monthly, and quarterly) shall be the responsibility of the Vendor for compliance monitoring.

5.0. Following a nursing assessment, determination of the medication and the health status of the inmate, and discussion with the Provider; it may be clinically acceptable to wait until the pharmacy services are available.

5.1. Expiration reports provide information for continuity of care follow ups with the providers and prevent the expiration of a prescription. Once the prescription has expired it will be necessary to provide emergency coverage through clinic stock or offsite pharmacy.

5.1.1 NOTE THAT expiration reports should be printed and reviewed monthly by unit nursing staff to provide follow-up for provider lines. Expiration reports identify needs for immediate follow-up and new prescription orders. This procedure will prevent "emergency status" of medication retrieval from our clinic stock storage area and offsite pharmacy use.

5.2. When a prescription order is received and is not available in the clinic stock, the Vendor Nurse may contact the on-call Provider for an alternate medication that is available in the clinic stock.

5.3. The final option is that the Vendor Nurse can acquire a new Rx from the Provider and have it filled at a local pharmacy.

6.0. Audit and Inspection of the clinic stock storage area.

6.1. To insure that all prescriptions are properly packaged and stored, that all medications are in date, fresh and safe for use and that proper documentation and accountability is being maintained:

6.1.1 The Vendor Lead Dentist or designee, or nursing staff shall conduct a weekly inventory of Clinic stock Storage Area. If the storage area is sealed with a safety seal, it can be inventoried each time the seal is broken instead of weekly.6.1.2 The unit Charge Nurse (or designee) and Lead Dentist or designee shall inspect monthly the contents of the clinic stock storage area; and Arizona license.

6.1.3 An Arizona licensed Vendor Pharmacist shall inspect quarterly all areas that medications are stored including clinic stock; the contents of the areas as well as all activity concerning these areas.

6.2. Audit Findings Medications which are found to be missing or unaccounted for by the vendor Pharmacist, Lead Dentist or designee, or nursing staff shall be documented on a Medication Incident Report using Form 70400033. A copy of each medication Incident report documenting a missing medication shall be sent to the Vendor Pharmacy and ADCRR Pharmacy Monitor, Vendor's DON, Lead Dentist, and the Facility Health Administrator.

6.2.1 Upon receipt of a copy of a Medication Incident Report documenting missing medication, the Lead Dentist or designee, (for dental clinic stock) Complex DON or designee (for medical clinic stock) and the Facility Health Administrator will attempt to account for the medication through review of the perpetual inventory activity, physical inventory, medical record review, etc.

6.2.2 If the missing medication is accounted for to the satisfaction of the Facility Health Administrator, pharmacy, dental and nursing staff, the resolution shall be noted on the Medication Incident Report and made available to the Pharmacy Contract Monitor.

6.3 Vendor's DON, Lead Dentist, Facility Health Administrator, Vendor Pharmacy Director and ADCRR Pharmacy Monitor shall be notified of action taken. For controlled substances, this may warrant State Board notification as well as a DEA notification via the appropriate form. Copies of all unresolved medication accountability reports shall be forwarded to the appropriate Vendor representatives as well as the Pharmacy Contract Monitor.

6.4. All incidents involving medications which remain unaccounted for will be reported to the Vendor Regional Pharmacist and ADCRR Pharmacy Monitor, by the respective Supervisors for further investigation and action, which may include reporting to Inspections and Investigations, the Drug Enforcement Agency or the Arizona State Board of Pharmacy.

6.5. Medication Storage areas shall be subject to audit at any time (upon obtaining the necessary security clearance) by the Arizona State Board of Pharmacy, the Drug Enforcement Agency, other law enforcement or regulatory agency, and specific personnel appointed or authorized by ADCRR Assistant Director including the Vendor Regional VP/Administrators, when such audit is within the legal purview of that authority.

6.5.1 The Regional Health Administrator may notify the Facility Health Administrator, who will notify the appropriate staff of the date of the onsite quality assurance audit.

6.5.2 The Vendor's Pharmacist, Nursing Supervisor or Lead Dentist (or their designees) will provide assistance to, and/or presence with, the auditors in conducting their audits.

6.5.3 The results of the audit will be reported to the Vendor Facility Health Administrator, who will report any irregularities or concerns to the Regional Vendor Pharmacist, Nursing Supervisor and/or Lead Dentist for follow-up. Results of the audit will be made available to the Pharmacy Contract Monitor.

7.0. Restockage Levels: The Vendor Pharmacy shall maintain adequate and appropriate stock to meet the need of the facility.

Chapter 4, Sec. 1.4 Pharmacy Security

REFERENCES: DEPARTMENT ORDER 702
NCCHC STANDARD P-D-01

PURPOSE: To provide general requirements and procedures for creating a secure environment and monitoring compliance with security regulations.

RESPONSIBILITIES: The Contract Vendor Facility Health Administrator and the Vendor Pharmacy Director are responsible to set procedures in place to ensure that pharmaceuticals are maintained in a clean safe and secure environment and monitored as per manufacturer suggestions i.e. Temperature logs, refrigeration, etc. This refers to environmental and access controls.

PROCEDURES:

1.0. Unauthorized persons will not have access to medications.

1.1. Distribution of medication in urgent situations or after hours shall be in compliance with State and Federal laws and Rules and Regulations of the Arizona State Board of Pharmacy and be uniform among facility health units in the procedure for storage, use, and accountability of medications for urgent/after hour use.

1.2 Medications will be acquired by an offsite pharmacy and received and documented by nursing.

1.3 Facility Security personnel may enter the medication area if a non-medical emergency situation threatens the pharmacy or adjacent buildings.

1.3.1 Examples of non-medical emergencies include but are not limited to:

a) Fire

b) Broken pipes or electrical wiring appliances

c) A break in or burglary of the medications area or an alarm sounding an unauthorized entry into the medications area.

1.3.2 A container prepared by the nurse or offsite pharmacy cannot be given to the inmate for self-administration (KOP).

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

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

3.0. All medication areas will participate in a system of key control which provides an exact accounting for all keys. A key control system will be instituted by the Warden to control access and accountability each time a key is issued or returned.

3.1. Inmates will not possess any key to an area where pharmaceuticals are stored. Keys are stored so that inmates do not have access to them when and if the keys are not in the possession of a staff member or other authorized person.

3.2. At the discretion of the Warden, emergency keys to areas where pharmaceuticals are stored may be authorized and held in a secure area. Emergency key rings shall:

3.2.1 Enable staff to access every part of the complex/ facility rapidly to respond to a riot, fire, or any other crisis.

3.2.2 Be clearly delineated from all other keys.

3.2.3 Be stored separately from all other keys.

3.2.4 Be designated as requiring that an IR be written on every use.

3.2.5 Vendor Employees shall be responsible for the safe-keeping and control of keys issued to them until the keys are formally relinquished and returned to the control area.

3.2.6 Employees terminating employment or transferring to another work site shall return all keys on their last workday.

3.2.7 Key control violations constitute a major breach of security. Employee negligence in key control shall result in disciplinary action.

3.2.8 If an employee does not return an assigned key, the cost of replacing the key or re-keying the lock may be withheld from the employee's paycheck.

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

3.2.10 No unauthorized Keys will be manufactured or duplicated to fit locks.

Chapter 4, Sec. 1.5 Post-Exposure Prophylaxis for Employees

REFERENCES: DEPARTMENT ORDER 116
NCCHC STANDARD P-B-01
ADCRR EXPOSURE CONTROL PLAN
OSHA STANDARDS 29 CFR 1910-1030

PURPOSE: To provide mechanisms and requirements for providing post-exposure prophylaxis support for ADCRR employees.

RESPONSIBILITIES: The Occupational Health Administrator or designee is responsible to support Occupational Health staff as they coordinate provision of post-exposure prophylaxis to ADCRR staff that have been potentially exposed to specific diseases. See Arizona Department of Corrections Rehabilitation & Reentry Exposure Control Plan.

Chapter 4, Sec. 1.6 Non-Formulary Drug Requests

REFERENCES: NCCHC STANDARD P-D-01

PURPOSE: To provide mechanisms and requirements for ensuring that medications that are necessary to provide quality care to inmates yet are not on the Contract Vendor formulary, are received by inmates.

RESPONSIBILITIES: The Contract Vendor Regional Medical Director and Vendor Pharmacy Director are responsible to set procedures in place to ensure that requests for necessary non-formulary medications are received by appropriate inmate-patients. All non-formulary requests shall be made available to ADCRR Pharmacy Monitor upon request and in a format that indicate the Inmate's name, name of the drug, Inmate's location, Practitioner's request with supporting documents, approval, ATP, denial, date submitted, dated reviewed, date responded.

PROCEDURES:

1.0. A Non-formulary Drug Request (NFDR) will be submitted and approved before the procurement of any drug, medication, or other medical item that is managed under the ADCRR Contract Vendor Formulary Process. This includes compounded medications prepared for dispensing.

1.1. Vendor Practitioner/Providers will provide formulary medication for continuity of care, if needed, while the NFDR is being processed. If a non-formulary medication is an urgent request the process must be expedited and obtained by offsite backup pharmacy until the non-formulary is approved or denied. Continuity of care must be maintained at all times. Non Formulary requests must be approved, denied, or ATP (Alternate Treatment/therapy Plan) within 2 business days of submission. If an ATP is issued the ATP must be reconciled by the issuing provider within one business day of notification\issuance.

2.0. A NFDR need only be submitted one time if approved for continual use throughout incarceration. However, it may be approved for shorter periods of time, in which case continuation of therapy will be dependent upon re-approval.

2.1. The NFDR will be initiated by the Vendor attending primary care Physician, Dentist, Physician's Assistant, or Nurse Practitioner. Attachments may be enclosed and are encouraged. Documentation shall be submitted to fully support the request for the non-formulary medication. Incomplete entries will be returned for completion before consideration.

2.2. The following example outlines the information necessary when requesting a NFDR:

- 2.2.1 Non-formulary Drug Requested
- 2.2.2 Drug Strength
- 2.2.3 Dose to be employed
- 2.2.4 Therapeutic Class

2.2.5 Date of Request

2.2.6 Indicate whether the use of the drug is intended for Urgent or Routine Acquisition, and Length of Anticipated Therapy

2.2.7 Document any and all significant labs that influence therapy and all diseases/conditions that impact therapy

2.2.8 List other therapies and formulary items used and why this requested item is superior to a formulary agent

2.3. ORC Recommendations are NOT required, but available if the issue was discussed at an ORC meeting.

2.4. Sign and Date the NFDR.

3.0. The Vendor shall have in place procedures to review, approve, change or deny the requests within 2 business days of the dated request/prescription order.

3.1. The vendor's approving authority will indicate approved, disapproved, ATP, or other documentation and additional comments may be supplied for clarity.

4.0 Upon receiving approval, disapproval, ATP, or other, the vendors approving authority will notify the originating vendor provider of the NFDR final decision, within 2 business days.

5.0. The Vendor will maintain a file of NFDRs to be accessible to the Pharmacy Monitor and the Department of Corrections. The vendor will maintain a file of NFDR's electronically or supply a report with all information previously discussed upon request or consistently to the Client (ADOC).

Chapter 4, Sec. 1.7 Compounding and Prepackaging

REFERENCES: ARIZONA ADMINISTRATIVE CODE R4-23-672
NCCHC STANDARD P-D-02

PURPOSE: To ensure that all pharmaceuticals and the pharmacy inventory is accounted for and actively managed at each Facility Health Unit and Pharmacy at all times, by the Contract Vendor.

RESPONSIBILITIES: Bulk compounding and prepackaging of prescription medications will be performed with authorization by the Vendor pharmacy.

PROCEDURES:

1.0. Drug Compounding: Unit-of-use compounding may be done at the time of dispensing; however every attempt will be made to substitute a commercially available formulary product. A compounded drug is NOT a formulary item and must be initiated via a Non-Formulary Drug Request Form. All compounded medications will be accomplished in accordance with professional pharmaceutical arts and training.

1.1. All compounding information including drug (or chemicals), manufacturer, lot numbers, expiration dates, and amounts will be annotated on the back of the prescription as well as the compounding pharmacist's initials. A short description of the technique used will also be included.

1.2. Compounding prescriptions will only be done on an as ordered basis and will not be bulk compounded or stored.

2.0. Prepackaged legend medications will be prepared for use in the clinic stock storage area as outlined in this manual in a plastic re-sealable bag (if properly labeled with drug, strength, date, inmates name/number, directions, and expiration date).

2.1. Other prescription medications may be authorized for pre-packaging by the Vendor pharmacy in accordance with State Board of Pharmacy regulations and recommendations.

3.0. The health services staff who prepares the medication for delivery is the person who is responsible for the delivery process of the unit dose delivery.

Chapter 4, Sec. 1.8 Drug Utilization Review/Evaluation

REFERENCES: ARIZONA Administrative Code R4-23-672
NCCHC STANDARD P-D-02

RESPONSIBILITIES: An ongoing Drug Utilization Review/Evaluation (DUR/DUE) program will be conducted as authorized by the combined MSCMB and ADCRR Contract Vendor P&T Committee.

PROCEDURES:

1.0. Drug use parameters will be developed and approved by the combined P&T Committee. DUR/DUEs will be reviewed and the results reported to the P&T Committee for evaluation and action if necessary. A file of DUR/DUEs will be maintained by Vendor Pharmacy. Facilities may conduct additional DUR/DUEs to meet their needs.

2.0. Mental Health staff monitors inmates placed on lithium therapy.

2.1. General provisions specify that Psychiatric Practitioners with prescribing authority will ensure that all patients receiving Lithium shall have serum Lithium levels within 30 days of starting lithium therapy, every 3 months during the first 6 months of therapy, and once stable every 6 months (or more often as clinically indicated), to ensure that an adequate therapeutic dosage is maintained and that the possibility of toxic side effects is obviated. Mania and bipolar manic depressive illness are comparatively rare conditions that usually respond admirably to prophylactic lithium therapy. However, side effects of this treatment may occasionally arise and it is essential that all possible steps be taken to minimize their occurrence. Copies of documentation of these goals and time frames, with the inmate's ADCRR number, shall be provided to the Pharmacy Monitor upon request.

2.2. The appropriate dosage of Lithium preparations is determined by the individual's clinical response, but in all cases the effective dose will result in a serum Lithium level falling between 0.8 and 1.5 mEq/L measured 12 hours after the last dose. Regular estimates are necessary to prevent toxic doses, and to ensure that the patient is, in fact, taking the prescribed medication.

2.3. Daily observation of the patient is necessary to note the possible onset of toxic side effects. Common side effects include tremors, abdominal cramps, nausea, vomiting and diarrhea. Less commonly, thirst, polyuria, fatigue, sleepiness, and weight gain may occur. In very rare cases, severe Lithium poisoning may cause seizure phenomena and even coma.

2.4. Because of Lithium's metabolic similarity to other ions, particularly sodium, certain precautions are necessary to maintain proper electrolyte balance. A normal diet, including salt and adequate fluids must be taken. Diuretics should not, as far as is possible, be given concurrently with long-term Lithium therapy. Of particular importance in Arizona are proper hydration and the avoidance of excessive sweating from prolonged exposure to the sun or strenuous exercise.

2.5. All Vendor Health Unit Staff will follow all rules and regulations prescribed for Lithium treatment.

2.5.1 Stabilization: Lithium therapy will only be initiated by a licensed Mental Health Practitioner with adequate training and experience in this treatment. Once stabilized at an optimum dosage, and only after serum Lithium estimates have been conducted to determine the normative dosage for each patient, a Lithium treatment regime will be developed and documented for each patient. This regime shall include a schedule of periodic serum Lithium estimates which, with rare exception, shall be made at no more than 180 days intervals.

2.5.2 Monitoring: Patients receiving Lithium therapy will be informed of potential side effects and instructed to report their onset to a member of the Vendor Health Staff immediately. All must be instructed to maintain a proper diet and fluid intake and to avoid situations in which excessive or prolonged heat and/or exercise may cause an electrolyte imbalance and consequent Lithium toxicity.

2.5.3 Incompatibilities: All Physicians, Dentists and Mid-level Practitioners/Providers will be aware of Lithium incompatibilities when prescribing treatment for other ailments. It is important that outside Practitioners/Providers to whom a patient is referred for treatment be appraised of the patient's Lithium therapy.

2.5.4 Toxicity: Should toxicity be diagnosed, whether by onset of clinical symptomatology, or by a serum Lithium level in excess of 1.5 mEq/L, the drug must be stopped immediately. As soon as possible the Vendor Mental Health Practitioner and/or the Vendor Medical Director must be contacted and their advice solicited. When a patient is referred to an outside Practitioner/Provider, the consultation will indicate that the patient is on Lithium therapy.

Chapter 4, Sec. 1.9 Drug Recalls

REFERENCES: Arizona Administrative Code R4-23-672
NCCHC STANDARD P-D-01

PURPOSE: To ensure that all pharmaceuticals and the pharmacy inventory is accounted for and actively managed at each Facility Health Unit and Pharmacy at all times.

PROCEDURES:

1.0. Drug recall notices may be received through several sources but usually via prime Vendor recall notices, ECHO on-line EMS, or from Manufacturer recall notices.

2.0. Upon receipt of a Drug Recall Notice the Vendor pharmacy staff will:

- 2.0.1 Note the class of the recall (I, II, or III)
- 2.0.2 Check all stock to ascertain if any of the recalled drugs are currently or have been stocked in the past.

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

3.1. Inmates will be instructed to stop taking the medication and return it immediately to the pharmacy.

3.2. All Practitioner/Providers will be notified and advised of the recall.

3.3. Comply with instructions in the Recall Notice.

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

3.5. File Recall Notice and retain for two years on file in the Vendor pharmacy.

Chapter 4, Sec. 1.10 Special Pharmacy Issues

PURPOSE: To provide mechanisms and requirements for responding to special issues in the provision of pharmacy care.

RESPONSIBILITIES: The Contract Vendor Facility Health Administrator and complex Medical Director are responsible to ensure that special pharmaceutical requirements are met. The MS Contract Vendor has the responsibility to consider and authorize special programs to meet these needs.

PROCEDURES: The following programs have been authorized by the Health Services Assistant Director or designee and the Contract Vendor Pharmacy Director or designee, to request pharmacy services to procure medications for programs that result in operational efficiencies through pharmacy contracts and procedures.

1.0. Investigational Drugs: Investigational and/or experimental drugs as designated by the FDA will not be used without the expressed written consent of the inmate and the Health Services Assistant Director or designee.

2.0. Clinical Trial Medications/Protocols: Clinical trials of medications approved by the Food and Drug Administration will proceed only according to drug use protocols developed and/or recommended by the combined ADCRR and Contract Vendor Pharmacy and Therapeutics (P&T) Committee and/or the MS Pharmacy Monitor and MS Medical Monitor. The trials will be dependent upon the written approval of the Health Services Assistant Director or designee. Trials will be conducted under the direction of the combined ADCRR and MS Contract Vendor P&T Committee and monitored as indicated by the Pharmacy Monitor, Medical Monitor, and the Health Services Assistant Director.

3.0. Use of Drug Samples in the Clinic: Drug samples will not be distributed within the institution. Manufacturer's representatives may not distribute drug samples through the pharmacy. Practitioners MAY NOT request medications for themselves or family from manufacturer’s representative during work hours and on ADCRR property.

4.0 Drug Manufacturer's Representatives: Drug manufacturer representatives are recognized as a valuable source or information and are encouraged to call upon ADCRR Institutions on a regular basis. The representative may only see Vendor staff by obtaining a prior appointment which can be made through the Vendor Regional Pharmacist or designee. All representatives will supply the Vendor Pharmacist or designee with current information needed to obtain clearance for their admittance to the facility at least three working days prior to their visit. Representatives are encouraged to provide new drug information, educational materials, and staff in-services which will be arranged through the Vendor Pharmacist in concurrence with the Vendor FHA.

Chapter 4, Sec. 1.11 Psychotropic Medications

REFERENCES: Arizona Administrative Code R4-23-672
DEPARTMENT ORDER 708 DEPARTMENT ORDER 909
DEPARTMENT ORDER 1103 NCCHC STANDARD P-D-01 NCCHC STANDARD P-D-02 NCCHC STANDARD P-I-02

PURPOSE: To provide a consistent and uniform system of delivery psychotropic prescription medications to the inmate/patient population. To ensure that medications are delivered in a uniform and consistent manner throughout the Department, and that accountability is maintained in all phases of the delivery process.

RESPONSIBILITIES: It is the joint responsibility of the Contract Vendor Mental Health Staff and Nursing Staff to deliver psychotropic medications to the inmate population.

PROCEDURES:

1.0. Psychotropic Medications: A Contract Vendor Psychiatrist or Vendor mental health Nurse Practitioner (or another attending Practitioner/Physician if a Psychiatrist or MHNP is unavailable) may order emergency psychotropic medication (see Glossary) for and administer it involuntarily to an inmate with a mental disorder if, after evaluating the severity of the inmate's symptoms and the likely effects of the particular drug to be used, the Psychiatrist or mental health Nurse Practitioner determines that:

1.0.1 An emergency exists in which the inmate's conduct presents an imminent likelihood of serious bodily harm;

1.0.2 Alternative methods of restraint are inadequate;

1.0.3 Forced medication is required, as a last resort, to deal with the emergency.

2.0. Possession of Psychotropic Medications

2.1. Vendor staff who discovers any psychotropic medication in an inmate's possession that was not ordered in a current prescription by a Vendor Mental Health Practitioner shall consider the medication to be contraband. Any staff member who discovers unauthorized medication in an inmate's possession shall seize the contraband and process the matter in accordance with Department Orders 708 and 909.

2.2. It is illegal for any inmate to possess a psychotropic medication that has not been ordered in a current prescription by a Psychiatric Practitioner. An inmate who possesses such medication may be charged with drug misuse and possession of contraband.

2.3. A person who provides psychotropic medication to an inmate that was not ordered in a current prescription by a Psychiatrist or MHNP may be charged with introduction of contraband.

3.0. When a non-corridor ADCRR Institution receives an inmate on psychotropic medications the intake/triage Nurse will immediately contact the ADCRR Vendor point- of- contact Mental Health Practitioner or MH Practitioner on call. The licensed Mental Health Practitioner will issue orders of care for the inmate that will include a medication care plan.

4.0. The Vendor Pharmacy will routinely stock psychotropic bridge medications for such situations:

4.1. If the Vendor Mental Health Practitioner cannot be reached, the Vendor Mental Health Urgent Notification listed individual to acquire guidance.

4.2. The medications contained in the unit's medication room shall be maintained in accordance with local post order and Vendor pharmacy policy. In no case shall psychiatric medications be separated into a distinct toolbox/cabinet of psychiatric medications.

5.0. The Vendor intake/triage Nurse shall subsequently advise the FHA of the inmate. The Vendor FHA will notify the Vendor Mental Health Director of the inmate's status and arrange for the inmate's transfer if psychotropic medications are continued as part of the inmate's treatment plan.

6.0. A Psychotropic Medication Review Board (PMRB) was developed for the purpose of evaluating patient needs for forced psychotropic medications. In general, the PMRBs are managed by the complex Vendor Lead Psychologist should medical clinical assistance be requested, the Vendor FHA will coordinate any non-psychiatric/psychological support services.

7.0. A Vendor registered Nurse or Licensed Practical Nurse may acquire and deliver psychotropic medications that have been duly ordered by a qualified Practitioner/Provider.

Arizona Department of Corrections Rehabilitation & Reentry	Methadone Use	OPR: MS Contract Vendor Pharmacy Director MSCMB Pharmacy Monitor MSCMB Medical Program Administrator Auth: mw
Medical Services Technical Manual	MSTM Chapter 4 Section 1.12	Supersedes: 06/01/2016 Effective: 09/12/2017

Chapter 4, Sec. 1.12 Methadone Use

REFERENCES: NCCHC STANDARD P-G-06

PURPOSE: Methadone is a Schedule II narcotic used medically to treat pain and in methadone treatment programs to address narcotic addiction. Methadone's use within the Arizona Department of Corrections Rehabilitation & Reentry is outlined below. This policy is created to provide a consistent delivery of Methadone for the inmate/patient population.

PROCEDURES:

1.0. Analgesic use: Used for chronic pain when it is determined to be the drug of choice. Also used when a long acting liquid formulation is necessary; e.g. disease states resulting in difficulty in swallowing and for terminally ill inmates with chronic pain.

2.0 Pregnancy stabilization: Used to stabilize pregnancy in Narcotic Addicted Inmates. ADCRR Contract Vendor does NOT treat narcotic addiction, or maintenance, with the exception of pregnant inmates upon a medical order from an official methadone maintenance program or a board certified Obstetrician.

2.1. Pregnant inmates, placed on methadone prior to ADCRR incarceration, will be maintained on methadone throughout their pregnancy to prevent withdrawal and catastrophic outcomes. Pregnant inmates will NOT be started on methadone maintenance without appropriate medical work-up, consultation and risk/benefit assessment.

2.2. ADCRR MS Contract Vendor shall have procedures in place to acquire methadone and appropriate clinical consultation, for the medical purpose of preventing pregnancy related complications.

3.0. Methadone Maintenance and Detoxification: Inmates will not be maintained on methadone maintenance unless they are pregnant and they are currently enrolled in a methadone maintenance program for the health and well-being of their undelivered fetus. Pregnant inmates suspected of narcotic addiction and impending withdrawal will be referred to Contract OB/GYN for immediate evaluation and treatment recommendations. Those inmates arriving at ASPC-Phoenix and non-pregnant females arriving at ASPC-Perryville on Methadone maintenance for opiate addiction will be tapered off methadone using standard protocols.

3.0.1 Methadone inventories must be maintained separately from other records.

Chapter 4, Sec. 2.0 Laboratory Procedures

REFERENCES: NCCHC STANDARD P-D-04

PURPOSE: To provide laboratory procedures to help the Vendor Medical Practitioner/Provider assess, diagnose and/or monitor an inmate's state of health.

RESPONSIBILITY: The Vendor Facility Health Administrator shall monitor compliance with all policies and procedures.

PROCEDURES:

1.0 General Laboratory Procedures: Laboratory specimens shall be obtained under the written or verbal order of a Vendor health care Practitioner/Provider, qualified Mental Health Practitioner, or Dentist. However, a court order issued by a Judge will also serve as an authorized order and must result in a laboratory specimen being collected. Necessary laboratory supplies and courier services shall be identified and provided by the contracted laboratory vendor.

2.0. Venipuncture and specimen collection, performed by authorized Vendor health staff, shall be done in accordance with generally accepted techniques and standards. Appropriately placed labels, provided by the contracted laboratory vendor, shall be utilized according to the contracted laboratory specimen requirement guidelines.

3.0. Certain laboratory testing requires special patient preparation. For individual test preparations, refer to contract laboratory requirements for collecting.

4.0. Specimens shall be processed and stored according to contracted laboratory requirements. Specimen preparation or storage and handling may require the use of the following equipment:

- 4.0.1 A refrigerator, used for laboratory specimens ONLY, located in the lab area of each lab draw site and one is to be at the main collection point.
- 4.0.2 A centrifuge for each lab draw site.
- 4.0.3 The centrifuge shall be available and calibration maintained by the Contract Vendor reference laboratory.
- 4.0.4 The centrifuge routine cleaning will be maintained by the Vendor laboratory technician on-site.

5.0. Safety in the Laboratory: Employee safety includes the following and must be observed as appropriate. Universal precautions shall be followed. Personal Protective Equipment (PPE) must be available in the work setting and used as appropriate. The following is the recommended, <u>but not inclusive</u>, list of personal protective gear:

5.0.1 Gloves

5.0.2 Protective eyewear

5.0.3 Face shield

5.1 In case of an exposure to bio-hazardous materials or body fluids, either by skin/mucous membrane contact or an inadvertent needle stick, the Vendor employee must follow the exposure control plan as provided by the Vendor Occupational Health staff.

5.2. Environmental Safety: Contaminated needles/materials shall be disposed of in appropriate bio-hazardous collection devices. Disinfection – the lab work area shall be disinfected regularly and when a contamination occurs using the recommended cleaning agent.

6.0. Laboratory Testing

6.1. On-site testing: The following testing is performed on-site by a Contract Vendor Nurse or designee, using the directions provided in the kit:

6.1.1 Blood glucose level by glucometer

6.1.2 Urinalysis by manual dipstick

6.1.3 Hemoccult testing of stool samples

6.1.4 Peak Flow Meter measurement of peak expiratory flow rate

6.1.5 Urine Pregnancy Test (hCG) for female inmates

6.1.6 International Normalized Ratio (INR) measurement for warfarin therapy monitoring

6.2. Off-site testing: All general laboratory services are provided by ADCRR Contract Vendor utilizing the full service of a reference laboratory. Paternity testing is ordered by a judge, processed by Central Office, and sent to the appropriate facility, where it is collected using guidelines provided with each kit.

7.0. Laboratory Test Results: All laboratory test results are to be reviewed by a medical Practitioner/Provider, qualified Mental Health Practitioner, or Dentist. "Panic" values as outlined by ADCRR Vendor's contracted laboratory are to be reported to the appropriate Practitioner/Provider immediately for review and action, as necessary. Routine results will process as follows:

7.0.1 Test results are received by designated computer(s) or per Electronic Health Record (EHR)

7.0.2 Results are attached to the inmate's paper health record or electronically, for Practitioner/Provider review, signature and disposition, PRIOR to scanning or filing in health record.

7.0.3 After Practitioner/Provider review, the lab results are filed or scanned in the health record.

Chapter 4, Sec. 3.0 Radiologic Imaging Procedures

REFERENCES: NCCHC STANDARD P-D-04

PURPOSE: To provide radiographic services to inmates utilizing either on-site equipment or off-site contracted vendors for assessing, diagnosing, or monitoring of an inmate's state of health.

RESPONSIBILITY: The Contract Vendor Facility Health Administrator shall ensure that only authorized Vendor personnel order and produce radiological studies within the confines of the facility. All pertinent policies and procedures must be followed to ensure the highest quality diagnostic care.

PROCEDURES:

1.0. Personnel and Equipment Certifications:

1.1. Radiographic procedures may only be ordered by a Vendor health care Practitioner/Provider or dental care Practitioner/Provider.

1.2. The Radiologist interpreting and issuing reports must have a current license issued by the State of Arizona, Board of Medical Examiners or the Arizona Board of Osteopathic Examiners in Medicine and Surgery.

1.3. Vendor Radiologic Technologists shall maintain a current certification issued by the Arizona Medical Radiologic Technology Board of Examiners and be posted in the work area.

1.4. An X-ray unit registration certification, issued by the Arizona Radiation Regulatory Agency (ARRA), must be posted for each machine on the complex.

2.0. Overview: Safety principals shall be adhered to at all times including environmental and personal safety. Environmental safety principles that shall be upheld include but are not limited to:

2.0.1 A material safety data sheet (MSDS) specific to the processing fluids shall be available in the radiology department.

2.0.2 The door to the x-ray room must be closed during radiographic procedures to avoid inadvertent entry and radiation exposure.

2.0.3 A sign stating "Caution Radiation Area" with the three blade radiation symbol shall be posted at all entrances to the radiology room.

3.0. Personal safety: Universal precautions shall be followed. For information, contact the Vendor's Occupational Health staff and refer to OSHA Standards on Occupational Exposure to Blood borne Pathogens.

3.1. The Vendor's technologist and dental staff shall wear radiation badges at all times to monitor x-ray exposure. The film badges are collected from all personnel by the Vendor Radiologic Technologist or designee. All film badges are then forwarded by the Contract Vendor for processing and analysis. A written report is returned from the Vendor contractor and results are made available for viewing by the Radiology Department.

3.2. Any abnormal results are reported immediately to the individual, the individual's supervisor and the Facility Health Administrator. The individual shall not be allowed to work in areas of possible radiation exposure until specifically authorized by the Facility Health Administrator.

3.3. During the x-ray procedure, the radiologic technologist shall be protected from radiation by standing in the protective designated area or wear appropriate lead protection.

3.4. Reasonable precautions shall be taken to protect the inmate in the radiology room. Pregnancy status must be determined prior to performing any radiographic procedure. A pregnant inmate may not receive routine x-rays unless the health care Practitioner/Provider determines the existence of medical necessity.

3.5. Lead shielding that is available and used when appropriate include the following: Lead Aprons; Gonad Shield (used on all inmates (male and female) of child bearing age); Lead Gloves; and Thyroid shield.

4.0. The following routine diagnostic radiographsmay be performed at each prison complex: Lower extremities; Hips; Upper extremities; Shoulders; Bony Thorax, Pelvis; and All head work (i.e. sinuses, orbits, facial, mandible, mastoid, skull, TMJs).

5.0. Examinations that may be authorized at designated facilities and performed by a Vendor Radiologist may include the following studies:

5.0.1 Esophagus: Barium swallow

5.0.2 Stomach: Upper Gastrointestinal Series

5.0.3 Small bowel follow-through

5.0.4 Colon: Barium Enema. Bowel preparation is required prior to this procedure. Barium enemas performed outside of the facility shall be prepared according to the attending radiologist or hospital protocols.

5.1. Require the inmate sign an informed consent prior to the procedure.

5.2. History regarding allergies to shellfish, iodine or a previous reaction to contrast medium "x-ray dye" must be brought to the attention of the health care Practitioner/Provider.

6.0 Other Radiographic Procedures. Specific radiographic studies beyond facility capabilities shall be arranged by ADCRR MS Contract Vendor. This includes angiography, special x-ray procedures, CT, MRI, ultrasound, mammography, nuclear medicine scans and radiation therapy.

6.1. All procedures require personal history and consultation generated by the Provider.

7.0. Equipment Maintenance:

7.1. X-ray units shall be calibrated and maintained regularly by ADCRR Contract vendor. X-ray unit calibration is verified by the Arizona Radiation Regulatory Agency (ARRA) and posted within the x-ray department.

7.2. Processors maintenance shall be performed regularly by ADCRR Vendor. This shall include:

7.2.1 Equipment cleaning and inspection

7.2.2 Changing of processing fluids

7.2.3 Disposal of processing fluids

7.2.4 Repairs as needed

8.0 Radiograph Interpretation and Reporting:

8.1. Routine radiograph interpretation. The Vendor Medical Practitioner/Provider shall review all radiographsprior to the submission for Radiologist interpretation and make an appropriate entry of the preliminary findings on the X-ray Request Form in the findings section. Radiographsare sent to the Contract Vendor Radiologist. The Radiologist reviews the films and issues a written report on each

radiographic study submitted. The radiographsand report are returned to the facility. The radiographsare filed in the Vendor radiology department based upon the inmate ADCRR identification number. The report is given to the Vendor medical Practitioner/Provider for review. The Vendor Medical Records Librarian or designee then files/input the report in the inmate's health record.

8.2. Emergent (STAT) Interpretation: The radiographs are taken to the Vendor referral Radiologist or the closest hospital staffed with a Radiologist for interpretation. Coordination of report is facilitated by the Vendor radiologic technologist.

8.3. Urgent: The Vendor radiologic technologist places a call to the ADCRR Vendor referral Radiologist, requesting the interpretation be expedited and followed by a written preliminary report sent via electronic transmission (facsimile or e-mail). These reports are given to the Vendor medical Practitioner/Provider for review.

9.0 Radiograph Transfers and Storage. Active inmate radiograph files are stored at the facility complex where the inmate resides.

9.1. Facility Transfers: The Vendor radiologic technologist is notified when an inmate is transferred to another facility. The radiographs are packaged and given to the Vendor Medical Records Librarian or designee to accompany the inmate along with the health record as appropriate (if paper records are utilized).

9.2. Consultations: If radiographs are necessary for a consultation (on-site or off-site) with a specialist, the Vendor clinical coordinator advises the Vendor radiologic technologist who then facilitates the delivery of the films for consultant review.

9.3. Release: The Vendor radiologic technologist is notified of release from custody of an inmate. Within 30 days following the release, all radiographs are retained at each prison complex for 3 months, processed in IHAS (Inmate Health Appointment System) or an equivalent electronic medical record inventory system, then forward to the State Library and Archives where they are retained for 6 years after which the films are destroyed.

10.0 Duplication of X-rays: Duplication of x-rays may be performed by the use of an x-ray copying machine which may be available at some complexes or utilizing a contracted hospital's radiology department.

Chapter 5, Sec. 1.0 Inmate Access To Health Care

REFERENCES: Arizona Revised Statute 31-201.01
DEPARTMENT ORDER 1101
NCCHC STANDARD P-A-01
NCCHC STANDARD P-E-01

PURPOSE: To ensure inmates have reasonable and appropriate access to care to meet their serious Medical, Dental and Mental Health needs. Reasonable fees will be charged. Scheduled health care appointments and emergency health treatment will be accomplished through cooperation and coordination between security, program, transportation and the Contract Vendor health staff.

RESPONSIBILITY: The MS Contract Vendor VP/Administrator shall ensure that all inmates are provided access to scheduled and emergency health care and are not refused health care treatment due to financial reasons. The Contract Vendor VP/Administrator shall ensure consistency and continuity of care in the delivery of Constitutional Health Care to the inmate population. The Contract Vendors Facility Health Administrator shall ensure that adequate services are available to the inmate population in each of the following areas: Dental, Medical, Mental Health Nursing, Pharmacy, Medical Records, Laboratory, and Radiology.

PROCEDURE:

1.0. Inmate Notification of How to Access Health Care

1.1. Reception Centers will provide every inmate with a handout (other necessary means, such as utilizing the Language Line service, and verbally as needed), which outlines how they are to access health care. The Center will ensure handouts are available in Spanish and English.

1.2. Complexes will:

1.2.1 Upon transfer of an inmate from another complex, the receiving complex must ensure that the inmate's orientation packets provided by Program staff contain information on how to access health care.

1.2.2 Ensure handouts and orientation packets are available in Spanish and English and when necessary, other means of communication to include interpreters when necessary.

1.2.3 Ensure that Access to Healthcare Signs are properly posted in areas accessible to inmates.

1.3. The handout/orientation packet is to be delivered to newly arrived inmates in a manner that encourages and supports Vendor health staff responsiveness to any questions the inmates may have regarding the process of accessing healthcare.

2.0. Access to Health Care Signs:

2.1. Ensure the signs are posted throughout the complex. At a minimum, signs will be posted at intake and on yard bulletin boards. Where possible, post signs in housing areas. Ensure all signs are available in Spanish and English.

3.0. Charges:

3.1. Inmates will be charged per Department Order 1101 and ARS 31-201.01.

3.2. Every inmate shall be charged a reasonable medical and health services fee for each medical visit an inmate makes pursuant to a health needs request form or for emergency treatment. Exceptions are noted in Department Order 1101.

3.3. No inmate will be denied care due to being indigent. He/she will be seen by Vendor health staff.

Chapter 5, Sec. 1.1 Transportation of Inmate-Patients

REFERENCES: DEPARTMENT ORDER 1101
NCCHC STANDARD P-E-10

PURPOSE: To assure that inmates have unimpeded access to health care services and visits irrespective of their housing location, temporary placement, and/or security classification.

RESPONSIBILITY: The Contract Vendor FHA and the Warden shall ensure that processes are in place to ensure continuity of care continues throughout the inmate inter-complex transportation process.

PROCEDURE:

1.0 Emergency

1.1. Security will provide support and will arrange for all send outs.

1.2. Any significant delay in transportation of an emergency send out will be reported by the senior on scene Vendor Health representative to the on-site Vendor Complex Administrator for immediate corrective action.

2.0. Offsite (Outside) Medical Appointments

2.1. Inmates are pre-scheduled for Offsite appointments and hospital visits.

2.2. Depending upon locations around the state and the appointment location, the inmate may be transferred to a centralized "transitory holding area" via statewide.

2.3. Single day appointments to local facilities will generally have escorts provided by the sending complex. For example, the Florence, Eyman and Lewis complexes are responsible for transporting their inmates to the hospital facilities for day appointments and returning with the inmates the same day. Additional escort supervision may be provided by ADCRR Security personnel as available at the hospital or other treatment locations. However, the sending complexes remain responsible for escorting the inmates both to and from the appointment.

2.4. Escort officers for these offsite appointments are responsible for also transporting the confidential medical information and securing any medications that may be involved during the day or upon discharge from the hospital and/or the inmate's appointment.

2.5. Upon return to the complex, escorting officers will bring the inmate into the designated complex health unit for review of the medical information, assessment of the inmate, and determination of any additional medications and/or interventions that area required for the inmate.

3.0 Diabetic Inmates:

3.1. Transportation has several well defined categories: in-complex movement, local movement, statewide medical movement, and statewide routine movement. All types of movement must be considered and must be designed to enable diabetic inmates to have their medication and dietary needs met. Diabetic patients may be transported by any of these methods at any time. Off-complex travel poses special risks to a patient with diabetes. Therefore, when a diabetic inmate enters travel status, their special dietary needs must be met through communication between the Vendor Health Services and the Operations Transportation Group.

3.2. In-complex and local movement: This type of movement may be medically driven or operationally driven. It may include short off complex travel distance for a local appointment or transportation from one unit to another (of the same complex). The transportation is typically arranged and performed by the inmate's home unit or complex.

3.2.1 The traveling diabetic inmate's dietary needs shall be noted in the comments section of the accompanying ADCRR Vendor Health Services appointment list.

3.2.2 The annotation should indicate the period of time he is scheduled for absence from his unit, and the specific times that his meals are required.

3.2.3 The Unit Shift Supervisor shall review the Vendor ADCRR Health Services appointment list and ensure that the necessary meals (the providing kitchen will already be aware of this patient's dietary orders) are provided at the required time in accordance with current transportation policy.

3.3. State-wide Non-medically directed transportation of inmates: When the medical unit is informed that an inmate is scheduled for travel from his 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 requirements during his/her offsite travels.

3.3.1 The Vendor unit Nurse shall complete the inmate's health record Continuity of Care form. The Nurse will complete a Travel order sheet form for those inmates with special diabetic dietary needs. This will be included with the paper Health Records that is sent to the Vendor Medical Records department for preparation for transfer. This document shall note the daily requirements of the diet.

3.3.2 Additionally, if the departing patient is determined, by recorded entry in the ACIS system and/or by health staff review of the health record, that the patient is diabetic, the word "DIABETIC" must be written in the lower left corner of the Travel order sheet that is provided by the Offender Information Unit to initiate the travel.

3.3.3 These documents shall be compiled by the unit Vendor medical records staff and provided with the health records or electronically to the Offender Information Unit or the transportation officer. The Inmate Transportation Dietary Needs document shall be attached to the outside of the paper Health Record envelope and in full view of the Transportation staff or transmitted electronically.

3.3.4 Complex Transportation staff shall ensure that the proper diet is ordered, received, and delivered to the patient during the transportation event as directed in the Inmate Transportation Dietary Needs document and in accordance with transportation policies.

3.4. Statewide Transportation for Medical Care and or Treatment:

3.4.1 The Vendor Offsite Consultation Request form, or an electronic equivalent, is the primary document that directs the need for offsite special medical care that is not available on complex or at a local unit. Therefore, this document, or an electronic format, shall note the special diet needs of the inmate.

3.4.2 When an Outside Consult Request is requested or written for a patient with diabetes, the word "DIABETIC" should be written by the requesting Practitioner/ Provider in the lower left corner of the Consult Request Document or otherwise annotated in an electronic format.

3.4.3 The specific menu that is appropriate to the patient's diagnosis and status should be entered next to the above annotation (e.g., "2400 calorie 6am and 3pm").

3.4.4 The annotation on an approved Consult Request will serve as the directive for the Vendor Clinical Coordinator to make arrangements for a shelf stable meal to be served to the patient during the transport.

3.4.5 The sending Complex Transportation Supervisor shall ensure the necessary meals are provided at the specific time in accordance with the Clinical Coordinator's orders and current transportation policy. The sending Supervisor shall ensure that these orders are transmitted to the transportation hub staff should the transportation require a transfer from one travel branch to another Coordinator.

Chapter 5, Sec. 1.2 Special Handling Intake/Medication Issues Intake/Gender Dysphoria Issues

REFERENCES: DEPARTMENT ORDER 1101

PURPOSE: Special Handling inmates are typically processed through intake facilities in less than a 24 hour period. This policy is to provide guidance for coordinating immediate needs of Special Handling inmates entering the system. This document delineates the procedure for the transfer of inmates between facilities specific to the continuity of care and of health care information.

RESPONSIBILITIES: It is the responsibility of Contract Vendor Facility Health Administrator to ensure that inmate treatment records and health care information is transferred to the receiving complex health services facility within the timelines provided.

PROCEDURES:

1.0 Definition: Special Handling Inmates may include inmates condemned to a life sentence, Strategic Threat Group, Protective Segregation and other "high visibility" inmates such as those with gender identity issues.

2.0 Intake Facility:

2.1 The Health Services Contract Vendor must work out a system through which staff will be notified of the arrival of Special Handling, Lifers, STG and Transgender inmates under the methods and processes described by Institutional Order. The Vendor FHA will also work with the Warden to develop a local system to ensure that health services are informed of a "no-notice" departure of an inmate.

2.2 The Vendor Facility Health Administrator will develop Post Orders that direct specific actions in support of the Institutional Order. The Post Order (and/or Institutional Order) shall address the following elements:

2.3 Methods of notification of the Vendor Health Services that a special handling inmate has arrived. This must ensure that Vendor health staff is notified at the arrival of the inmate to reduce or eliminate the late surprise transportation of the inmate out of the intake facility.

2.4 Verification and acquisition of the sending county jail's summary sheet, continuity of care, Prescriptions, SOAPEs, Medication Administration Record, etc.

2.5 Filing/inputting of any received medication information/printouts into the newly created paper health record or EHR.

2.6 Filing of all loose records received in paper health record with the intake inmate before the departure of the inmate.

2.7 Forwarding of all loose records by fax or electronically to the permanent facility. The faxed original will be annotated with the date, time, and sender's identity. This should be performed by a stamp with pen and ink entry.

2.8 Method of informing special needs patients for permanent complex review of these special handling inmates. Method of communication may utilize telephone, email, electronically or faxing. In any case, the intake facility must document the contact and forward the contact to the permanent facility for inputting/filing in the health record.

2.9 All medications including controlled substances received from inmates and county jails upon intake are to be forwarded to the Vendor pharmacy for destruction, as guided by the State Board of Pharmacy, or placed in a Pharmacy Red Hazard Container. Inmates entering ADCRR custody with medications from a private prison/county jail shall have medications confiscated and administered DOT for a period not to exceed 7 days in order to maintain continuity of care. The medication card shall be signed and dated by the reviewing practitioner and noted in the inmate chart. A stop date not to exceed 7 days will be calculated by date of intake. The medication administration record (MAR) must reflect and document the source of the medication (i.e., name of dispensing pharmacy). All efforts shall be made for the inmate to be evaluated at intake and a new prescription written, if indicated. The 7 day bridge is to be considered the exception in situations when the inmate cannot be evaluated at intake. Rescue inhalers, nitroglycerin, and glucose tablets may be considered KOP medications in this situation.

2.10 Methods must be developed by the Vendor to guide their health staff in responding to "no-notice" departures; including handling of incomplete records, transfer of medications, etc.

3.0 Receiving "permanent" facility responsibility:

3.1 The Vendor Facility Health Administrator will develop Post Orders that direct specific actions.

3.2 The Post Order shall address the following elements:

3.2.1 Requirement of reviewing the Continuity of Care/Transfer summary.

3.2.2 Requirement to review the medical record for significant medication, medical history, and treatment continuation needs.

3.3 Method of receiving information on pending arrival of a special needs patients an initiation of review of the records of these special handling inmates. The receiving permanent facility must document the contact in the record of the inmate.

3.4 Perform a chart audit of the received records. Specifically this audit is to be focused on identifying those items that are missing.

4.0 Pharmacy Responsibility: When an inmate arrives at and departs from an intake facility on the same day, the Vendor Nurse on the sending unit will acquire the needed prescription utilizing off-site pharmacy.

4.1 The Vendor health staff will prioritize these prescriptions as "STAT," fill them immediately via off-site pharmacy and assure that they are transported to the unit where the inmate is being held. The Vendor Nurse on the sending unit assures that the medications accompany the inmate.

4.2 If the inmate moves prior to the pharmacy filling the prescription, the sending Vendor Nurse shall notify the receiving institution's Inventory Coordinator of the medication(s), inmate name and any other information deemed appropriate.

5.0 Mental Health Issues: In all cases where the Vendor intake medical staff are informed of or discover that intake inmates have mental health issues, psychotropic prescriptions, or mental health concerns, the pertinent information will be passed immediately to the intake Vendor facility Mental Health Practitioner/Provider identified by local Post Order or Mental Health processes.

6.0 GENDER DYSPHORIA: Arizona Department of Corrections Rehabilitation & Reentry, through MS Contract Vendor, shall provide appropriate treatment for inmates meeting DSM criteria for a diagnosis of Gender Dysphoria (GD) and/or verified intersex conditions (i.e., a variation in sex characteristics including chromosomes or genitals that do not allow an individual to be distinctly identified as male or

female). An individual that is intermediate in sexual characteristics between a normal male and normal female.

6.1 Inmates diagnosed with GD shall have access to:

6.1.1 Psychological treatment that addresses ambivalence and/or dysphoria regarding gender identity and assists in better adjustment to incarceration.

6.1.2 Appropriate psychiatric treatment.

6.1.3 Hormonal treatment, although limited to those situations outlined elsewhere in this policy.

6.1.4 Other treatment and accommodations, although limited, to those determined to be clinically necessary by Vendor GD Working Group.

6.2 Due to limitations inherent in being incarcerated, gender-reassignment surgery is not possible for inmates who reside within a correctional facility.

6.3 An inmate who is receiving hormonal medication at the time of intake in Arizona Department of Corrections Rehabilitation & Reentry shall be continued on hormonal medications provided the following conditions are met:

6.3.1 The hormones represent an established treatment that has been prescribed under the supervision of a qualified Physician.

6.3.2 The inmate cooperates with the Contract Vendor staff in obtaining written records or other necessary documentation of his or her previous treatment.

6.3.3 Vendor health staff determines that the hormones are medically necessary and not contraindicated for any reason.

6.4 Hormonal therapy will be managed by the Vendor Practitioner and outside consultation will be obtained when necessary.

6.5 If an inmate chooses to discontinue hormonal medications while incarcerated and then wishes to restart those medications, the Vendor GD Working Group shall evaluate the request and make a determination on the course of treatment.

6.6 As per DO 810, an inmate who is NOT receiving hormonal medication at the time of ADCRR intake could receive treatment, if medically necessary for the purpose of starting or progressing gender reassignment therapy or surgery.

6.7 Vendor health staff who receives requests from inmates for any form of consideration or accommodations for GD, shall forward the requests to the Vendor Mental Health Director.

6.8 The Mental Health Director may assign a Psychiatrist or Psychologist to conduct an initial evaluation of the inmate to help determine whether a more special evaluation is needed.

6.9 The initial evaluation shall include:

6.9.1 A review of any prior medical or mental health treatment records related to GD diagnosis or treatment.

6.9.2 A detailed description of the inmate's reported gender identity issues.

6.9.3 Observations of housing unit staff, when relevant.

6.9.4 General mental health history in ADCRR and in the community and diagnoses.

6.9.5 Emotional and behavioral stability within ADCRR including adherence to prior treatment recommendations. Non-compliance with previous treatment plans may be considered in qualifying patient for further therapy.

6.9.6 Current mental health status.

6.10 The evaluating Vendor Psychiatrist or Psychologist shall submit a report to the Vendor GD Working Group within fifteen days of the request by the Vendor Mental Health Director.

6.11 The GD Working Group shall review the report and determine whether an outside consultant may be needed for further evaluation.

6.12 The outside consultant's recommendations (if one is requested) ARE NOT BINDING on ADCRR.

6.13 If new information becomes available that would significantly affect an earlier determination (e.g., prior treatment records becomes available), the GD Working Group may request a new evaluation or reconsider prior treatment decisions.

6.14 Facility and housing assignments shall be made on a case-by-case basis, by the Transgender working group considering the inmate's health and safety as well as potential management and security concerns. An inmate's own views regarding safety shall be given serious consideration.

6.15 Inmates who have completed surgical sexual re-assignment surgery prior to incarceration shall be placed in a correctional facility as determined by the GD Working Group.

6.16 For the purpose of facility placement, self-inflicted genital mutilation, does not constitute surgical sexual re-assignment therapy and should be evaluated by the GD Working Group on a case by case basis for appropriate placement.

6.17 Placement and programming assignments shall be re-assessed at least twice yearly at a re-classification hearing to review any threats to safety experienced by the inmate.

6.18 The Arizona Department of Corrections Rehabilitation & Reentry shall use the name of the inmate as it appears on the Conviction and Sentencing document, unless there is a subsequent court order for name change. If such a court order exists, a new set of documents must be issued and the court order must specifically state "change all records".

6.19 Property and apparel shall be consistent with the inmate's anatomical gender. Inmates may elect to have the institution provide state-issued undergarments of the desired gender. In addition, inmates may order undergarments from the commissary that corresponds to the desired gender, consistent with property limits described in ADCRR policies. Such undergarments (top or bottom) may be worn if they are NOT visible to others when leaving the cell and are not worn in a manner that is disruptive or provocative.

6.20 Facilities shall encourage staff to use gender-neutral forms of address (e.g., "Inmate Smith" or "Smith" for GD inmates who request it.

6.21 Inmates taking cross-gender hormones or with secondary sex characteristics of the desired gender (e.g., biological males with breast development) shall be offered the opportunity to shower separately from other inmates.

6.21.1 A Vendor health care Practitioner with prescriptive authority shall make this determination and issue a Special Needs Order (SNO).

6.21.2 Inmates with GD diagnosis but without these characteristics shall be given the opportunity to shower separately if they communicate a request to a Practitioner who may issue a SNO as appropriate.

6.21.3 Facilities shall provide opportunities for inmates in segregated housing to shave or apply approved hair removal products at least twice per week unless contraindicated by security concerns.

6.22 If an inmate has been identified or is diagnosed with an Intersex condition (developmental characteristics intermediate between those of a normal male or female):

6.22.1 Facility and housing assignments shall be made on a case-by-case basis considering the inmate's health and safety as well as potential management and security concerns. An inmate's own view regarding safety shall be given serious consideration.

6.22.2 Placement and programming assignments shall be re-assessed at least twice per year at a Re-classification Hearing to review any threats to safety experienced by the inmate.

6.22.3 Inmates with intersex conditions shall be showered separately from other inmates by choice. In addition, inmates with intersex conditions shall be given the opportunity to shower separately if they communicate a request to a Practitioner. A SNO shall be issued.

6.23 ADCRR Security staff shall not physically examine or search a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. Appropriate communications between Vendor

health staff and senior Security management staff may be necessary when addressing the housing accommodation needs of the transgender or intersex inmate.

6.24 A Transgender Working Group shall be formed as deemed necessary by MS Contract Vendor and:

6.24.1 Shall be composed of the Vendor's Regional Medical Director or designee, Regional VP for Mental Health or designee, Psychiatric Director or designee, Regional Director of Nursing (RDON) or Designee, and MSCMB Mental Health Monitor.

6.24.2 May consult with appropriate outside specialties in the evaluation and treatment of GD to make recommendations regarding medically necessary treatment.

6.24.3 Shall convene as necessary to address issues in the management of inmates diagnosed with GD. Inmates and institutional staff may address concerns regarding treatment or services, to the GD Working Group through their respective chain of command or other established process.

6.24.4 Shall make recommendations as needed regarding diagnosis treatment, management issues, and accommodations.

6.24.5 Shall consult with security staff when making recommendations regarding GD management and plans of care.

Chapter 5, Sec. 1.2.1 Paper Health Records – Transfer Process of Released Offenders

REFERENCES: DEPARTMENT ORDER 1104
NCCHC STANDARD P-H-05

PURPOSE: To provide a uniform system to prepare paper health records for transfer of the records of released inmates to Library and Archives at the time of the release of an inmate.

RESPONSIBILITY: The Vendor Medical Records Librarian is responsible for health records review and updates when an inmate departs the prison system. State complexes are to retain the released records for a minimum of 90 days, prior to sending to records retention. Private complexes are to retain the released records for a minimum of 30 days, prior to sending to records retention.

POLICY: RELEASED OFFENDERS

1.0 Extractions of the records of released inmates from general files may be accomplished up to once per month. The Vendor complex Medical Records Librarian and the Vendor FHA will make the determination. The following guidance is provided for Vendor Medical Records personnel if the decision is made for Daily Pulls.

1.1 No later than 0800 hours (Monday through Friday) obtain a copy of the Daily Movement Sheet supplied by the facility Institutional Record Office, listing the names of offenders who have been released from ADCRR during the previous 24 hours.

1.2 Obtain all required documentation for inclusion in the health record and place it in the health record jacket in the proper location as per MSTM policy. Ensure documents have been scanned into the Electronic Health Record.

1.2.1 Medication Sheets.

1.2.2 Laboratory, x-ray, Consultation and/or other Reports.

1.2.3 Secure any “loose sheet” filing from sorter.

1.3 Complete columns 4, 5, and 6 of the Inmate Chronological Movement Record (Form #1101-82P) on top of Section IV of the health record jacket.

1.4 For each released offender complete the last three columns on the Departure Log, mark the Transfer Date with the release date and MRL initials to designate as released.

1.5 Designate the health records as those of Released Offenders and keep them separate from other health records in the medical record office or area.

2.0 Processing released records:

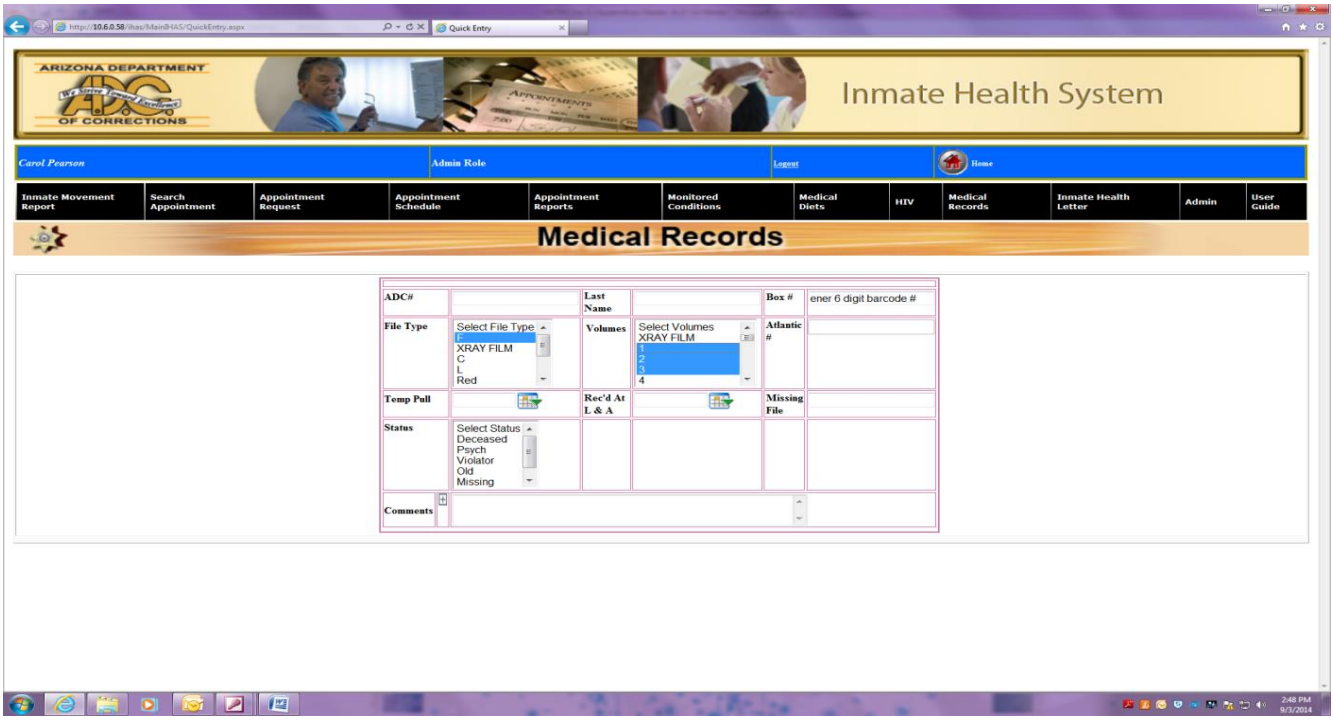
2.1 Pull records in date order of release – obtain all old volumes. If all volumes are not available, the Medical Record Supervisor and Medical Record Monitor are to be notified to issue an "APB" to the MRL's to search for the missing volumes.

2.2 Put volumes in box and log at same time into the IHAS Medical Record Inventory database. Leave two inches of space so records are able to be accessed and the box is not too heavy.

2.3 You will have 2 barcodes with the same number. Attach barcode label to the middle of the short side of the box with the label that says "Attach to Box".

This is the IHAS Medical Record Inventory screen to use when adding a released record to the database.

2.4 Enter: ADCRR #- then hit "enter" This will pull up the inmate's last name and other information. On the right side of the screen it will show if the inmate is Inactive or Active. If ACTIVE, it will show the complex name and unit. Send the record to Medical Records at the unit. Since the record is not being sent to storage- hit "Clear". If inmate is INACTIVE, continue with data entry:



2.4.1 Box #- this is the barcode number. Only enter the 6 digits – do not include the O's. Hit "Enter" and this will populate the "Atlantic #" field under the Box # field. Make sure the box number and Atlantic number are the same number if not cancel out the entire entry by using the "clear" and reenter the information.

2.4.2 File Type: Select "F" for folder- green chart.

2.4.3 Volumes: Enter volume number (be specific for each volume). Hold down the "Ctrl" button to enter additional volumes.

2.4.4 Release Date Past: The release date that is listed should be the current release date. Compare the date listed in IHAS with the release date in AIM's. They should match the release date on the record. If the date in IHAS is later than the release record and the inmate did not return to custody after release from your unit, then change the release date on the calendar which is located to the right of the Release date to the correct release date. If the Release Date is later than what is listed in the record that may mean that the inmate returned to custody at another unit and the chart was not sent there. The inmate was then released from another unit. Check AIM's for clarification. Do not change the Release date. In the COMMENTS field write the release date from your unit and the unit name.

2.4.5 COMMENTS: Type in the name of the unit the chart was released from and your first initial and full last name.

2.4.6 Continue to fill the box with other released inmate records.

2.5 Attach the other barcode (the one that says "Data Entry") to Boxed Record Data form.

2.6 Fill out the Boxed Record Data form with the record series data code "496" for adults. For Minor (Tucson/Perryville) records, the code is "497". Fill out the date range in the boxes from month/year to month/year. This determines the destruction date. Retention period is currently 6 years for adults. Retention period for Minors is until the individual is 24 years of age. In the COMMENTS section - print your name and title.

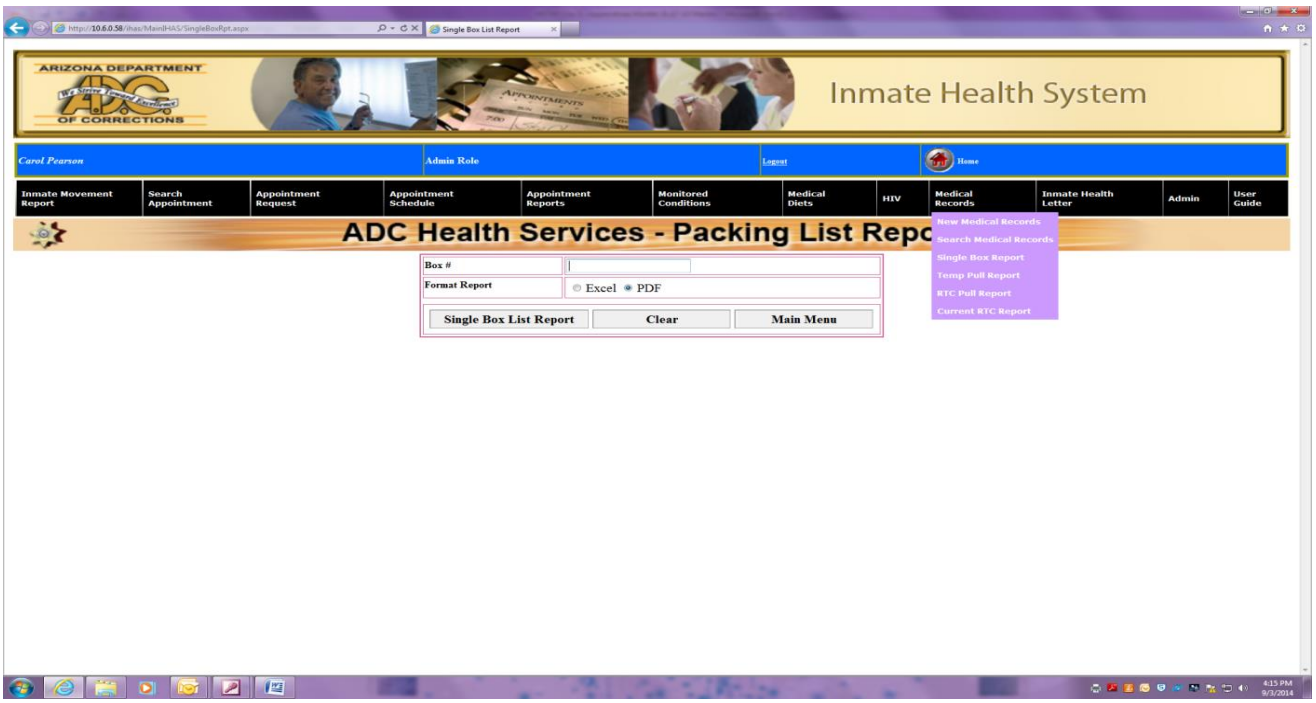
2.7 For Private Prisons: Mail the original boxed records data form with the original barcodes to Central Office CMB Medical Record Monitor. For State Prisons: Mail the original boxed records data form with the original barcodes to the Regional local Vendor MRL. The Vendor Contract Monitor and the Medical

Records Monitor coordinates with Library/Archives for an approved delivery date. Keep a copy of boxed record data form.

2.8 Library/Archives will notify the MRL with the delivery date and the number of boxes that will be accepted on that date.

2.9 Do not tape the boxes until they are ready to be delivered to Library/Archives, 1919 West Jefferson, Phoenix, AZ. 85007.

2.10 Place a copy of the Single Box Report inventory log in the box.



Keep a copy of the Single Box Report inventory log for your records.

If the Single Box Report has a Prison Complex and Unit listed on the line with the inmate name, ADCRR #, this means that the inmate is ACTIVE and the record needs to be forwarded to the new unit.

Notify the Medical Record Monitor if there are any deletions that need to be made from the system.

2.11. Put a cover sheet (Delivery notice) on the top of the box that specifies the enclosed are Arizona Department of Corrections Rehabilitation & Reentry Medical Records.

2.12. Write the date on the Single Box Report inventory log with the date of the delivery to the receiving location. Write the name of the person delivering the boxes to storage.

2.13. Retain logs for 3 years.

3.0. Any loss or absence of a record will be reported immediately to the Medical Records Monitor.

4.0. Refer to MSTM 8.5.0 Retention of Health Records for guidance on use of Arizona Department of Library, Archives and Public Records.

Chapter 5, Sec. 1.2.2 Transfer inmates to ICE

The following shall be done for inmates being transferred for ICE Releases from: State and Private Complexes to the new complex/unit for all ICE Transfers.

Note: The medical records do NOT go with the inmate to ICE. They only go to the complex/unit where the chart stays until processed for retention.

1. All volumes of Medical records are to be sent with the inmate to the new complex/unit. Charts do not go with the inmate to ICE; they stay at the complex/unit.
2. A 30 day supply of Medications is to be sent with the inmate to the new unit and then they go to ICE.
3. A Continuity of Care form is to be completed by Nursing and sent with the inmate and then it is sent with inmate to ICE.
4. X-ray films are to be sent to the new unit where they get sent to ADCRR/Corizon X-ray area and are then processed for retention.
5. Insulin supplies must be sent with the inmate to the new unit and then they go with the inmate to ICE.
6. Durable Medical Equipment must be sent with the inmate to the new unit and then this equipment goes with the inmate to ICE if Medically Necessary.

MRL's and or Nursing:

1. When you receive notification of the movement to ICE: Place the Inmate Transfer for ICE Release form (shown below) on top of the chart (rubber-band it so it stays with the chart).
2. Locate all volumes of medical records and mark the number of volumes on the form.
3. Give chart(s) and form to nursing to complete.
4. Once the form is completed: This form will then need to be scanned into eOMIS by the SENDING unit into the Legal/Administrative section and name it as: month/day/year ICE Releases checklist. Either Nursing or the MRL can scan this form into eOMIS.

When the inmate and chart make their way to the new unit, if the form wasn't scanned - please scan it into eOMIS.

The private prisons (as of this date) do not have eOMIS so the receiving unit MRL will then need to scan it into eOMIS.

MRL's at the RECEIVING UNIT: Since this chart will have the form on top of it- you will know that it is for an ICE release. Check ACIS for the actual release date so you can mark the Inmate Chronological Movement Record and then place in with the released charts for that month. Most of the inmates are released the next day, but some can stay at the unit for a few days before they are picked up by ICE personnel.

INMATE TRANSFER FOR ICE RELEASE
(NOTE: DO NOT SEND MEDICAL RECORDS TO ICE)

ADC #: _____

NAME: _____

DATE OF TRANSFER: _____

FROM: ASPC-_____

TO: ASPC-_____

MUST BE SENT WITH THE INMATE TO NEW COMPLEX/UNIT: (CHECK OFF)

MEDICAL RECORD(S) # OF VOLUMES: _____

30 DAY SUPPLY OF MEDICATION: _____

CONTINUITY OF CARE: _____

CIRCLE IF SENDING:

INSULIN SUPPLIES: INSULIN, SYRINGES, ACCUCHECK, ALCOHOL WIPES

DME: CANE, WALKER, CRUTCHES

X-RAY NOTIFIED - FILMS ARE BEING SENT: _____

NURSING SIGNATURE/TITLE: _____

Sending unit to scan document into eOMIS Legal/Administrative area

SCANNED STAMP: _____

Chapter 5, Sec. 1.3 Continuous Progress Notes (SOAPE)

REFERENCES: DEPARTMENT ORDER 1104
NCCHC STANDARD P-H-01

PURPOSE: To assure that documentation contained in the Progress Notes section of the Paper Health Record/Electronic Health Record (EHR) are made in a consistent and uniform manner throughout the ADCRR and that they meet requirements of the legal document which is the medical record.

RESPONSIBILITY: The accuracy of the information of the Paper Health Record/EHR entry is the responsibility of all professionals who are authorized to write in the medical record or make an electronic entry. Each individual making an entry must reference and conform to MSTM policy.

PROCEDURES: Documentation of all encounters with the inmate is vital. The inmate health record is no less important than a similar health care record in the private sector. Department Order 1104 provides primary guidance regarding the Health Record.

01.0. Delineation of who may make entries in the progress notes.

1.1. Only specified members of the Vendor health staff may make entries in the Progress Notes of an inmate's medical record. These include, but are not limited to: Health Providers, i.e. Physicians, Mid-Level Medical Care Providers, Health Educators, Dentists, Psychiatrists, Psychologists, Psychology Associates, Nursing staff, Dental Technicians, X-ray staff, Laboratory staff, Medical record staff, Pharmacists, and Facility Health Administrators.

2.0. Required format for the progress note.

2.1. All Progress Notes/EHR entries will be made in accordance with the following format or a functionally equivalent format:

S = Subjective- Inmate's complaint and answers to direct questioning about the current illness, other systemic complaints, past medical history, family medical history, and social history.

O = Objective- Pertinent findings in the physical exam, including vital signs, radiological imaging studies, and laboratory data. Vital signs and other important ongoing Objective and Assessment information may be recorded on the Monitored Condition Flow Sheet. This information does not have to be duplicated in the progress notes since it is readily available in a parallel dated note. Likewise, for inmates with chronic disease(s) that are being monitored important ongoing laboratory data may be tracked apart from the progress note on the Monitored Condition Lab Tracking Flow Sheet.

A = Assessment- Provider's diagnosis or differential diagnosis. A nursing assessment.

P = Plan- Treatment provided or diagnostic/treatment plan developed based upon the assessment. Specific directions provided to the inmate. An inmate's treatment or management plan for a monitored condition may be documented on a separate note of the health record.

E = Education- The education/advice given to the inmate.

3.0. Progress notes will meet the following general criteria:

3.1. General Guidance: There must be no irrelevant, inappropriate, or personal, statements included in the entries. Errors are corrected as described below.

3.2. Entries

3.2.1 The documentation will be made the same day as the contact and completed at or as close to the actual time of the occurrence or encounter as possible. All entries are to be completed within 24 hours of seeing the patient.

3.2.2 Vital signs, including weight, are documented at each clinical encounter.

3.2.3 Entries are chronological and continuous.

3.2.4 Should it become necessary to make an entry at a time subsequent to the occurrence or encounter (known as a Late Entry), the author will document the date and time of the 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. Late entries are to be made as soon as possible after the occurrence or encounter; the longer the time lapse is, the less reliable the entry becomes.

3.2.5 Entries include the date (month/day/year) and time (24-hour, military style).

3.2.6 If paper records are being utilized, entries should be made in black ink. Blue ink is acceptable if the writing is dark enough to be copied.

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

3.3. Format

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

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

3.3.3 Paper records entries will be legible. Handwritten entries must be legible and clear and can be either in cursive or print style.

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

3.3.5 The note includes complete identifying information on it.

3.4. Identification (if paper records are being utilized)

3.4.1 Entries are signed underneath the entries.

3.4.2 The complete signature (as found in legal documents) and initials of the author's professional title are required.

3.4.3 The author's name stamp is required.

3.4.4 If the author does not have a name stamp, then, the author will print his name and title under the signature.

4.0. Corrections when utilizing paper records.

4.1. Should it be necessary to make a correction to an entry, if the error is not lengthy in nature, the author must:

- 4.1.1 Draw a single line through the incorrect entry (original entry must be visible and legible).
- 4.1.2 Write "an error" above or beside the incorrect entry.
- 4.1.3 Make the correct entry; initial the correction and entry.

4.2. Should it be necessary to make a correction to an entry which is lengthy in nature:

- 4.2.1 The author must either draw a single line through the entire original entry, or draw a large "X" over the original entry (original entry must be visible and legible).
- 4.2.2 Write the word "Error" diagonally across the entry.
- 4.2.3 Make the correct entry.
- 4.2.4 Initial the corrected entry.

4.3. At no time is it acceptable to obliterate the original entry either by use of chemical White Out® liquid, or correction tape, or by overwriting, or by crossing out the entry that the original cannot be read.

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

Chapter 5, Sec. 1.4 Treatment Plans

REFERENCES: ARIZONA REVISED STATUTES 36-201.01 (G)
DEPARTMENT ORDER 1101
NCCHC STANDARD: P-G-01

PURPOSE: To insure that inmates with chronic conditions or conditions that require regular visits receive ongoing multidisciplinary care.

RESPONSIBILITY: It is the responsibility of the Vendor health care Practitioner/Provider to develop an individualized treatment plan at the time of diagnosis. It is the responsibility of the Vendor Medical Records Librarians to provide data regarding tracked conditions to provider staff for performance of required health care.

PROCEDURES:

1.0. Identification at Reception of inmates requiring ongoing care.

1.1. The Vendor reception personnel will complete the screening process immediately upon arrival to the facility to include a medical history. A physical examination will be done within the first three days after arrival of the inmate. Screening tests for tuberculosis (PPD) must be completed. Immediate health care needs must be identified and addressed. All chronic conditions and conditions that require ongoing care are to be identified on the problem list.

1.2. Mental Health will complete initial evaluations and assign needs scores in accordance with their policies.

2.0. All inmates with chronic conditions or other monitored conditions will have an annual physical.

2.1. Inmates with chronic or monitored conditions shall be examined at least every six months. Diabetic inmates will be seen at least once a quarter. Certain monitored medical conditions, if deemed stable by the health care Practitioner, (i.e. stable, controlled hypertension) may be followed up at longer intervals consistent with good medical practice but not to exceed 12 months. A treatment plan shall be developed and documented in the health record by a health care Practitioner within 30 calendar days of identification of the chronic (monitored) condition.

3.0. Inmates who have been identified with chronic or monitored conditions will have a treatment plan that includes:

- 3.0.1 Frequency of follow- up examinations.
- 3.0.2 Type and frequency of diagnostic testing.
- 3.0.3 Therapeutic medications and modalities.
- 3.0.4 Patient education given.

4.0. Every inmate will have a Problem List which is used by the Vendor Practitioner/Provider to:

4.0.1 Record all chronic conditions.

4.0.2 List special care needs required due to altered mental states.

4.0.3 Identify those patients having physical impairments such as: Loss of hearing or sight; Mobility issues; ADA accommodations needed; Positive PPDs and treatment completed date.

4.0.4 Record Practitioner/Provider- determined changes in medical condition.

4.1 The Vendor Practitioner/Provider are responsible for the accuracy and updating of the Problem List.

4.2. Problems shall be numbered as they are entered. When/if a problem listed is resolved; the Practitioner/Provider will make an entry indication resolution of the issue. That entry will be dated and initialed by the Practitioner/Provider. The problem list will not be renumbered.

4.3. When a Practitioner/Provider reviews the problem list, the date of review will be entered in pencil in the lower right corner of the document in the paper health, or otherwise documented in the appropriate format in an EHR.

5.0 Master List of chronic conditions

5.1. A data base of all chronic conditions will be maintained by Health Services Vendor in accordance with this Manual and A.R.S. 36-201.01 (G), and Department Order 1101.

5.2 Medical records staff at each facility will provide a list (that has been derived from the Monitored Care Database) of inmates needing follow-up care to the medical units.

5.3 Date of the next appointment for chronic clinics will be noted on the inter-facility transfer summary and on the appointment flow sheet in each health record.

Arizona Department of Corrections Rehabilitation & Reentry	Nursing Emergency Response Orders Nursing Encounter Tools (NETS) Nursing Assessment Protocols	OPR: MS Contract Vendor Regional Medical Director MS Contract Vendor Regional Director of Nursing MSCMB MS Coordinator MS Medical Program Administrator Auth: kc/vh
Medical Services Technical Manual	MSTM Chapter 5 Section 1.5.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 5, Sec. 1.5 Nursing Assessment and Protocols

REFERENCES: NCCHC STANDARD P-E-11

PURPOSE: The purposes of the Nursing Emergency Response Orders, Nursing Assessment Protocols and Nursing Encounter Tools (NETS), are to provide Vendor nursing staff with standardized nursing practices based on nursing statutes and regulations to deliver quality nursing care to the inmate population.

RESPONSIBILITY: It is the responsibility of the Vendor Director of Nursing (DON) to ensure that all licensed Vendor nurses are trained in providing emergency nursing care, health maintenance and prevention to the patient who is in need of these services. The Vendor FHAs are responsible to ensure compliance occurs within their facility.

PROCEDURES:

1.0. Nursing Emergency Response Orders (EROs)/Nursing Encounter Tools (NETS)/Nursing Assessment Protocols: The nursing triage protocol is broken down into three parts and is contained in Appendix E to this technical manual: The first part is a set of nursing Emergency Response Orders (EROs) are for life threatening emergencies only Appendices E, Section 1. The second and third parts are a set of nursing protocols/encounter tools that provide guidelines in the health maintenance of the individual Appendices E, Section 2- State, Section 3- Private.

1.1. Emergency Response Orders: The Emergency Response Orders (EROs) are step-by-step written instructions from the provider on providing emergency acute care to a patient during life-threatening event. The ERO assists the licensed nurse either by nursing assessment or triage to stabilize or maintain the patient until Emergency Medical Services (i.e., EMTs, Ambulance, or PMTs) have responded and/or the Practitioner/Provider is contacted to provide further instructions.

1.2. Nursing Encounter Tools (NETS/Assessment Protocols): The NETS/Assessment Tools are divided into triage and assessment because a Licensed Practical Nurse can only perform triage tasks and report the findings to a Registered Nurse or Practitioner/Provider per the nursing scope of practice. The NETS and Nursing Assessment Protocols provides step-by-step guidelines in the management of the patient, and provide the guidance to the Nurse in advising the patient what over the counter medication the inmate can utilize in the maintenance of basic illness/injury.

2.0. Nursing Triage Procedures (Nursing Assessment Protocols and Nursing Encounter Tools-NETS) including ERO annual compliance and maintenance:

2.1. The areas of the Nursing Encounter Tools/EROs Protocol/Nursing Assessment Protocols will be reviewed and signed annually by the Vendor Regional Medical Director, Vendor Regional Director of

Nursing, Director of Nursing (Private Prisons), ADCRR Medical Program Administrator or designee, ADCRR Nurse Monitor, Vendor complex Medical Director, Vendor FHAs, and Vendor Director of Nursing (DONS) at the assigned facilities.

2.2. Annual training in regards to the EROs, NETS, and Nursing Assessment Protocols, will occur with all Vendor licensed Nurses. The Vendor's complex DON's and FHAs are responsible for ensuring training occurs annually.

2.3. All health units will have the EROs, NETS and Nursing Assessment Protocols manual available to them. Original manual will be kept in the Vendor FHAs office.

2.4. Yearly renewal of signatures annotating review of the documents will be the responsibility of Contract Vendor and the Vendor FHAs. The updated signature sheet will be kept in original manual.

3.0. Training requirements of Nursing Encounter Tools/EROS/Nursing Assessment Protocols:

3.1. Demonstration of skills and knowledge in regards to the NETS, Emergency Response Orders and Nursing Assessment Protocols (Private Prison facilities), will be performed annually. The Vendor's FHAs and complex DONs are responsible for ensuring that the appropriate training occurs in each facility.

3.2. Annual documentation is required to demonstrate the licensed Nurse can perform the skills expected. A copy of the documentation must be kept in the employee's personnel file.

3.3. When new or revised NETS/EROS/Nursing Assessment Protocols are introduced it is the Vendor's complex DON responsibility to introduce them during the nurses meeting.

Chapter 5, Sec. 2.0 Intake & Return to Custody

REFERENCES: NCCHC STANDARD P-E-01
NCCHC STANDARD P-E-02
NCCHC STANDARD P-E-05
NCCHC STANDARD P-E-06
NCCHC STANDARD P-G-06

PURPOSE: To establish the requirements for receiving screening of all incoming inmates immediately upon their arrival to the Reception Center and upon return to custody at other facilities.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Facility Health Administrator or designee and Vendor supervisory staff, to ensure compliance with this Procedure. Designated Vendor nursing staff shall complete the receiving screening after normal business hours.

NEW INTAKE **PROCEDURE**:

1.0. Receiving screening by vendor nursing staff takes place as soon as possible upon arrival for all inmates, prior to Vendor Practitioner/Provider exam. Designated nursing staff shall complete the receiving screening after normal business hours.

1.1. Inmates who present with a possible life-threatening condition are immediately referred to a Vendor Practitioner/Provider for care. After normal business hours, the Vendor Nurse shall contact the Vendor Practitioner/Provider on the Urgent Notification List for orders to send the inmate to the emergency room per existing post order procedures.

1.2. Vendor Medical Records staff shall ensure that a health record is established for each reception inmate (including Parole Violators) and clear inmates for movement as all processes are completed.

1.3. The following exceptions are allowed to transfer inmates prior to the completion of all reception processes: DI67; Death Row or Life Imprisonment Sentences; and Security Threat Group (STG) inmates.

2.0. The Vendor's Facility Health Administrator and supervisory staff will ensure that the complex establishes a method for distributing information about the availability of, and access to, health care services to inmates upon their arrival at the facility.

2.1. One primary element includes signage on how to access health care is posted in the intake/processing area of each facility. Within 12 hours of their arrival, inmates are given written information (written information may be in the form of a facility handbook either by health services staff or operations staff, a handout, or postings in inmate housing areas) about how to access emergency and routine medical, mental health and dental services including instruction to the inmate regarding the purpose, use and preparation, and "Drop Box" system for the HNR form; the fee for service program; the grievance

process for health-related complaints; and that special procedures, such as interpreters, are available to ensure that inmates who have difficulty communicating understand how to access health services. Instructions are to be available in written form in English and Spanish, and provided verbally (or in a manner that the inmate can understand) for all inmates during intake. Video presentations may support an initial and follow-up to the Orientation Program.

3.0. The Vendor nursing staff shall review the intake record within 12 hours of the arrival of the inmate on the complex. This is required so that professional nursing staff can focus on making sure that medications and emergent/urgent needs are met in a timely manner. In addition, the vendor nursing staff, prior to Vendor Practitioner/Provider exam, will complete an initial health assessment, to include the following:

3.1. Reception Center Screening documentation including observations of the inmate's appearance (e.g., sweating, tremors, anxious, disheveled) and the inmate's behavior (e.g., disorderly, appropriately, insensible) this includes a mental status assessment of altered orientation potentially due to ingestion of drugs and/or alcohol. The form requires observation of 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). It also includes the requirement for an assessment for communicable conditions including scalp for head lice and skin for scabies.

3.2. Perform a nursing dental screening (visual inspection of the mouth) and referral to a Dentist as appropriate.

3.3. Complete a Medical History questionnaire.

3.4. Perform a nursing physical exam (including blood pressure, pulse, respiration and temperature), Snellen eye exam, and urinalysis (complete urine dipstick); female intakes will also receive a urine pregnancy test.

3.5. Completion of TB Symptomatology Checklist (Administration of PPD skin test to be read at 48 to 72 hours).

3.6. Inmate Acknowledgment of Rights, dated 12-19-12; wherein the inmate will acknowledge receipt of this orientation by signing at the bottom of the printed material (Form 1101-98). Inmates will be advised that they may, at any time, implement a Do Not Resuscitate declaration by submitting an inmate letter to their Correctional Officer III or the Vendor FHA. They will further be advised that if they wish to make such a declaration, they will meet with the Vendor Health Care Practitioner and, if deemed necessary, will meet with a Vendor Mental Health Practitioner.

3.7. Ensure that information on access to health care is provided to the inmate and documented on the screening form/ electronic entry.

3.8. Complete Transfer Summary/Continuity of Care.

3.9. When clinically indicated, there is an immediate referral to an appropriate health care service with the referral being noted on the receiving screening form/electronic entry. Immediate health needs are identified and addressed, and potentially infectious inmates are isolated. Inmates with "special needs" will be identified upon intake and individually oriented regarding access to non-emergency health care services.

3.10. The disposition of the inmate (e.g., immediate referral to a hospital, placed in general population) is indicated on the receiving screening form.

3.11. Receiving screening forms are dated and timed immediately upon completion and include the signature and title of the person completing the form.

4.0. The Vendor Medical Practitioner/Provider shall complete a physical examination of the inmate by day three of the inmate's arrival at the intake facility, write orders for routine labs, and others as appropriate and order chest, or other, x-rays as necessary.

4.1. All arriving inmates must receive the PPD-Mantoux 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. The applied PPD skin test must be read between 48 to 72 hours following administration. If the administered PPD test is inconclusive upon reading, order a repeat PPD in 7 to 12 days. If indicated, the inmate may be transferred prior to the completion of the repeat PPD and the Transfer Summary should note that a repeat PPD is required.

4.2. Continue documented transitional medications for 28 days (or up to 42 days for MH transitional medications).

4.3. Enter a medical score on the Physical Exam form (electronically), the Reception Center Checklist and the Problem List.

4.4. The disposition of the inmate (e.g., immediate referral to a hospital, placed in general population) is indicated on the receiving screening form. Receiving screening forms are dated and timed immediately upon completion and include the signature and title of the person completing the form.

5.0. Vendor Dental staff shall complete a Panorex x-ray of all inmates if not completed within the past year; provide instruction on oral hygiene and document this in the health record; and complete an initial dental exam for any inmate remaining at the Reception Center for over 30 days.

6.0. Vendor Lab staff shall immediately collect routine labs and document the collection on the Medical Work Up form for all reception inmates (including parole violators).

7.0. Vendor Mental Health staff shall complete the 14-Day Mental Health Assessment and refer inmates to providers in accordance with current Mental Health policy. The Vendor health Staff will provide any necessary medical or dental health assistance to support the patient's physical health needs.

7.0.1. A Pre-hospital medical care directive will be completed at this time and kept in the Vendor Nursing office. The inmate will be advised that he may revoke the declaration at any time by verbally advising any member of the ADCRR staff, or contract vendor staff.

7.0.1.1 The Vendor Practitioner/Provider must enter the date and identity of "DNR" on the inmate's "Problem List".

7.0.1.2 The Vendor Health Staff must mark "DNR" on the front of the record, under the name label.

7.0.1.3 The forms should be filed or scanned in Legal section of the Health Record.

7.0.2 A Life Care Planning Document at the assigned complex/unit, the CO III or IV shall provide ADCRR form # 1101.99 Inmate Acknowledgment of Rights. If the inmate wishes to fill out ADCRR forms # 1101.97 Durable Health Care Power of Attorney, and 1101.98 Living Will (End of Life Care) they will be provided to the inmate. The inmate will fill out the forms and return them to the CO III or IV. If the inmate decides to revoke his forms, he shall complete ADCRR form # 1101-90 Revocation of Medical Care Directives.

7.0.2.1 Life Care Planning forms will be forwarded to the MRL to make an entry in AIM's DT08 and DI35 screens.

7.0.2.2 The MRL must mark the front of the record with "LW signed <u>date</u>" or "POA signed <u>date</u>".

7.0.2.3 The forms should be filed and/or scanned in Legal section of the Health Record.

RETURN TO CUSTODY/NON-INTAKE LOCATION PROCEDURE:

8.0. All receiving screening directed in paragraphs 1.0 through 7.0 above shall be completed with the following modifications or additional guidance:

8.1. Parole Violators must also be screened by Vendor nursing staff, especially if they arrive after normal business hours.

8.2. Vendor Facility Health administrator and supervisory staff will ensure that the prison complex distributes complex specific information about the availability of, and access to, health care services to inmates upon their arrival at the facility; including all elements in 2.1 above.

8.3. All laboratory or diagnostic testing shall be provided in accordance with paragraph 4.0 above, with the following additional guidance:

8.3.1 PPD is not required for those inmates who are returning to custody and are documented to have had, within 30 days, a PPD administered and the results were read along with the measurements of the reaction site. Return To Custody repeat PPD and CXR if out more than 30 days.

8.3.2 PAP is not required for those inmates who are returning to custody and are documented to have had, within one year, a PAP administered and the results were negative.

8.3.3 Routine intake labs are not required for those inmates who are returning to custody and are documented to have been in ADCRR custody within 90 days of the return to custody.

Chapter 5, Sec. 2.1 Intake at Non-Reception Facility

REFERENCES: NCCHC STANDARD P-E-01
NCCHC STANDARD P-E-02

PURPOSE: To establish the requirements for assessing the status and immediate clinical needs of newly incarcerated inmates arriving at non-Reception Centers. This policy is provided as an adjunct to MSTM Chapter 5 Section 2.0. Its purpose is to guide the initial assessment of inmates who have not been previously processed or screened by the Arizona Department of Corrections Rehabilitation & Reentry.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections Rehabilitation & Reentry, through the MS Contract Vendor, to evaluate all inmates being placed under control of the Department through other than routine channels (i.e., not as a result of Return to Custody or through intake centers such as Phoenix or Perryville). It is the responsibility of the Contract Vendor's Facility Health Administrator and supervisory Staff, to ensure compliance with this procedure.

PROCEDURE:

1.0. Inmates may arrive at any facility at any time of the day or night, via a planned or unplanned transportation. Receiving screening must take place immediately upon arrival for all inmates.

1.1. The Vendor Facility Health Administrator and Warden of all non-Reception Center complexes shall develop local policy to ensure that the Vendor Health Services staff is informed when a newly incarcerated inmate arrives at the complex for temporary staging, intra-transportation delays, or other purposes.

1.2. This policy is not meant to replace the requirements for long term and in depth assessments and inmate education.

2.0. The local policy shall provide the following minimum elements:

2.1. Nursing staff perform a face-to-face interview and assessment of the inmate within the same shift that the inmate arrived; and

2.2. Inmates who present with a possible life-threatening condition are immediately referred for care following existing policies for after normal business hours referrals; and

2.3. Inmates who present with possible communicable diseases are immediately referred for clinical decision following existing policies for after normal business hours referrals; and

2.4. Inmates who present with possible severe psychiatric or mental health issues are immediately referred to designated psychiatric personnel.

2.5. Any clinical decisions to hold, treat, or transfer inmates will be made by a provider and fully documented on a Medical Progress Record form.

3.0. The assessment documentation shall include:

3.1. Observations of the inmate's appearance (e.g., sweating, tremors, anxious, disheveled) and the inmate's behavior (e.g., disorderly, appropriately, insensible). This includes a mental status assessment of altered orientation potentially due to ingestion of drugs and/or alcohol. Observation of 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). It also includes the requirement for an assessment for communicable conditions including scalp for head lice and skin for scabies.

3.2. TB Symptomology checklist

3.3. Transfer Summary/Continuity of Care

4.0. The following Reception Center or Return to Custody requirements not required at this screening. While not required, should the assessing staff member deem the item necessary to produce a complete picture of the patient, their conduct is not prohibited:

4.1. A nursing dental screening.

4.2. A Medical History.

4.3. Snellen eye exam.

4.4. Urinalysis (complete urine dipstick).

4.5. Administration of PPD skin test to be read at 48 to 72 hours.

Chapter 5, Sec. 3.0 Non-Emergency Health Issues

REFERENCES: Arizona Revised Statutes 31-201.01
NCCHC STANDARD P-A-01
NCCHC STANDARD P-E-01
NCCHC STANDARD P-E-04
NCCHC STANDARD P-E-07
NCCHC STANDARD P-G-01

PURPOSE: To provide general description of the responsibilities for providing periodic health care to those in the inmate-patient population who do not require emergent attention.

RESPONSIBILITY: It is the responsibility of the Vendor FHA to ensure that healthcare is provided in a timely fashion. It is the responsibility of the Operations staff to ensure that inmates are not impeded in their efforts to access healthcare services.

PROCEDURE:

1.0. Non-emergency Health Needs:

1.1. Non-emergency service requests are generated by a Health Needs Request. Also, services may be provided on a routine, scheduled basis for an identified Chronic Care condition.

1.2. Sick Call and appointment treatment and care must comply with the plan of care response entered into section IV of the HNR.

2.0. Vendor Medical and Mid-Level Practitioner/Provider Line:

2.1. When treating inmates during scheduled appointments with Health Care Professionals, more than one medical issue or complaint may be addressed as found to be clinically necessary in accordance with the determination of the Practitioner/Provider.

2.2. Chronic Condition (Monitored Condition)/Chronic disease is an illness or condition that affects an individual's well-being for an extended interval, and generally is not curable, but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. Inmates with a designated Chronic Condition as defined in DO 1101.

3.0. Nurses' Line:

3.1. Nurses' Line will be held for 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.

3.2. Nurses line will not be canceled except for security reasons. When canceled or disrupted for security reasons, the Vendor Nursing staff will immediately review scheduled inmates' primary complaint. If determined that a delay would jeopardize the health of specific inmates, the unit charge Nurse shall

coordinate with the Major of Security/Shift Commander to arrange for examination and treatment of the inmate(s) if at all possible within the bounds of safety.

3.3. Vital signs, including weight, will be taken and documented in the health record (Medical and Dental) on all urgent/emergent/routine inmate encounters. In addition, at each chronic condition Asthma and COPD encounter, three PEFR (Peak Flow) measurements shall be performed and documented in the health record as part of the management of these conditions.

3.4. Nurse line referrals to Practitioner/Provider will be evaluated on Provider Line within fourteen days of referral date.

4.0. Periodic Medical Appointments:

4.1. The Vendor nursing staff has the responsibility to schedule routine follow-up; Chronic Care visits for the inmate population; routine lab work; and physical exams in accordance with current policies.

5.0. Physical Examinations:

5.1. Chronic Condition: The unit Practitioner/Provider is responsible, when notified, to ensure that physical examinations are conducted on inmates who have been identified and documented as having a chronic condition at their scheduled chronic condition clinic appointment with the medical Provider. The Vendor Charge Nurse on each unit will ensure that these inmates are scheduled to receive an annual physical at their scheduled appointment with the medical Practitioner/Provider.

5.2. Inmates 55 years of age or older: The Vendor Charge Nurse on each unit will schedule inmates who are 55 years of age or older to have an annual physical examination by a medical Practitioner/Provider. Those inmates who are 55 years of age and older shall be identified for annual Physical Examination.

5.3. Inmates under 55 years of age without a chronic condition: Inmates will be scheduled for a physical examination following submission of an HNR. This visit will require charging of the authorized co-pay amount in accordance with Department Orders.

5.4. The Vendor Charge Nurse on each unit will schedule female inmates for age specific Well-Woman examinations and evaluations:

5.4.1 Pap smears shall be offered to all female inmates age 21 to 65 every 36 months after initial intake, unless more frequent screening is clinically recommended.

5.4.2 Baseline mammogram shall be offered to all female inmates starting at age 50 (sooner if clinically indicated), then every 24 months unless frequent screening becomes necessary.

5.5. All inmates age 50-75 years of age shall be offered colon cancer screening as per national guidelines.

5.6 The Pneumococcal vaccine shall be offered to the following inmates:

5.6.1 All adults 65 years of age and older.

5.6.2 Inmates who have a long-term health problem such as diabetes, alcoholism, cirrhosis, sickle cell disease, leak of cerebrospinal fluid, cochlear implant, Hodgkin's Disease, leukemia, chronic renal failure, multiple myeloma, nephritic syndrome, HIV or AIDS, organ transplant, absent spleen, generalized malignancy and inmates who are long-term corticosteroid therapy, chemotherapy, and/or radiation therapy

5.7 The annual influenza immunization shall be offered to all inmates.

6.0. SPECIAL PHYSICAL EXAMINATIONS:

6.1 Inmates who have been identified to be assigned as Food Service/Kitchen Workers must be medically cleared prior to assignment to the position in accordance with specifications of the Food Service Technical Manual. Known HIV positive inmates shall not be cleared for assignment to a kitchen. Food Service staff/inmate workers with any contagious illnesses are not to be allowed to work in any capacity that may present a health threat to the food service operation. All cleared inmates are considered cleared for kitchen duty as they move from complex to complex unless a medical entry has been made in the eOMIS entry into inmate management system.

6.2. These inmates will be identified to the unit's medical staff by the WIPP or CO III. Vendor Health staff shall review the medical record (or perform a physical examination if the record indicates a need for a

face to face evaluation) to ensure there is no danger posed by the inmate's performance of the assigned duty.

6.3. Upon receipt of a Health Needs Request (HNR) for Eye Clinic services, a Vendor health staff member shall perform an initial screening using the Snellen chart (for both near and far-sighted vision).

Visual acuity should be recorded as follows: (OD=Right; OS=Left)

FAR	Uncorrected	Corrected	NEAR	Uncorrected	Corrected
R eye	20/ OD	20/ OD	R eye	20/ OD	20/ OD
L eye	20/ OS	20/ OS	L eye	20/ OS	20/ OS
Both	20/ OU	20/ OU	Both	20/ OU	20/ OU

6.3.1 Corrected visual acuity >20/40 in either eye separately or in both eyes shall be referred to the Optometrist.

6.3.2 Visual Acuity <20/40 may be referred for routine follow-up according to the following schedule

6.3.2.1 <40 years of age - Every three (3) years

6.3.2.2 >40 years of age - Annually

6.3.3 Contact Lens are not provided unless medically necessary.

6.3.3.1 If contact lenses are prescribed by the Contract Vendor Optometrist/Ophthalmologist, the Vendor shall provide contact lens solution.

6.3.3.2 If contact lens are not a Vendor's prescription, the Vendor is not mandated to provide contact lens solution.

6.4. An HNR regarding a patient complaint of hearing loss shall be referred to nursing to perform a screening audiogram. This test shall record hearing in each ear according to air conduction of sound. Document the findings in the Health Record.

6.5. Screening audiograms with significant abnormal results (>25 dB loss) in either or both ears shall be referred to a Vendor Practitioner to evaluate the need for a referral to the Audiologist.

6.6. When hearing aid(s) are dispensed after the Audiologist's recommendations, re-evaluations on a biennial basis shall occur.

HEARING AIDS:

6.6.1 When an Inmate arrives in the Department of Corrections with their own hearing aid(s), the Vendor's Nurse shall document during reception assessment:

6.6.1.1 How long the Inmate has had the hearing aid(s).

6.6.1.2 How long has it been since the Inmate's last hearing evaluation.

6.6.1.3 Refer for scheduling an evaluation if needed.

6.6.2 Per HNR request by the patient, the Vendor's Medical Supply Coordinator or designee shall supply and dispense batteries to the nursing staff. Used batteries are to be exchanged when receiving new batteries.

Chapter 5, Sec. 3.1 Routine Appointments Health Needs Request (HNR)

REFERENCES: DEPARTMENT ORDER 1101, Inmate Access to Healthcare
NCCHC STANDARD P-E-07, Non-emergency Healthcare Requests and Services
ACA STANDARD 5-ACI-6A-03, Clinical Services

PURPOSE: To assure that all inmates have the opportunity to request healthcare services on a daily basis and to be seen in an appropriate timeframe by the most appropriate and qualified healthcare professional consistent with the inmate's identified medical needs.

RESPONSIBILITY: It is the responsibility of the Contract Healthcare Provider (CHP) through the CHP complex Director of Nursing (DON) to maintain the system and flow of Health Needs Requests by inmates. This includes the provision for collecting, triaging, distributing and making appointments for the inmate, and to document the disposition of each request.

PROCEDURE:

1.0. General Policy:

1.1. All inmates will access non-emergency healthcare by requesting an appointment.

1.2. A medical services appointment is made by completing a Non-emergency Health Needs Request (HNR) Form 1101-10ES or by submitting an electronic HNR 1101-10(e) via the inmate tablet program. The completed HNR is deposited in the appropriately labeled box. Health staff will collect paper HNRs daily from an appropriately labeled box or access them electronically daily through the inmate tablet program. CHP nursing will administratively triage the HNRs and schedule the inmate for an appointment.

2.0. Initiating Request for Non-Emergency Service:

2.1. The Health Needs Request is the primary written document for an inmate to request non-emergency medical services. The HNR form or an electronic equivalent (e.g., a program that allows patients to submit HNRs though the inmate tablets) is designed to enable the inmate to complete the form with little or no additional supervision or assistance.

2.2. Security is responsible for maintaining a supply of the paper HNR forms and assuring that every inmate on all yards and housing areas, including lockdowns, will have access to the forms, either in written or electronic format.

2.3. When paper HNRs are utilized, inmates will complete the HNR form, remove and retain the goldenrod copy, and place the original (white), pink, and canary copies in the "Drop Box". Any CHP health staff may collect the paper HNRs in accordance with local post orders. CHP staff will collect the paper HNRs by 2400 hours of each day.

2.4. The form should be handled as a confidential correspondence between CHP health staff and the patient. Security staff are not authorized to access or read completed HNRs.

2.5. Security, in consultation with CHP Health Services, will assure that appropriate weather proof collection boxes are available for inmate's daily use either on the yards or in the housing areas of the open yards. In the lockdown areas, the collection of HNRs will be done in such a manner as to assure medical confidentiality for the inmate. There shall be coordination with complex Warden, to ensure that an HNR "Drop Box" is available.

2.6. On a daily basis, seven days per week, CHP health staff will pick up the paper HNRs from the collection boxes on the open yards.

2.7. Inmates in a "Lock-down/lockup" status will be especially monitored to ensure that access to healthcare is not obstructed.

3.0. On the same day the HNR form is received, triage of the HNR by CHP nursing professionals is performed to sort and classify the inmates' health requests to determine priority of need and the proper place for inmate care to be rendered. This applies to paper requests, as well as requests submitted electronically. HNRs that are not healthcare requests do not require a face-to-face evaluation (e.g., extra blanket or co-payment question).

3.1. Qualified health professionals with the most experience should be assigned to triage inmate requests. The date and time of collection by nursing will be indicated on the top right corner of the form. Electronically submitted forms are automatically time-stamped and shall be triaged to ensure a face-to-face visit within the required 24 hours for healthcare requests including all medical, mental health, and dental requests.

3.2. Following collection of all of the HNRs CHP Nursing will sort them into disciplines, such as dental, mental health, nursing lines and provider lines.

3.3. A face-to-face encounter for a healthcare request (medical, mental health, or dental) shall be conducted by a Registered Nurse (RN) within 24 hours of receipt by health staff.

3.3.1 A healthcare request may include non-urgent requests for a face-to-face visit with a medical provider, mental health provider, or dentist.

3.3.1.1 Requests for dental cleaning qualify as healthcare requests if the patient has a clinical complaint.

3.4 Non-emergency mental health and dental requests shall then be provided to the relevant discipline within 24 hours of the face-to-face triage by the RN.

3.5 Face-to-face encounters for healthcare requests require that vital signs be obtained, including temperature, blood pressure, pulse, respirations, pulse oximetry, and weight each time a patient is seen during sick call. This includes telehealth visits.

3.6 HNRs that document or indicate that the patient may be suffering from an **emergent** medical, mental health or dental condition shall be seen for a face-to-face encounter by an RN **immediately**, and notification of the appropriate discipline will take place.

3.7 HNRs that document or indicate that the patient may be suffering from an **urgent** medical, mental health or dental condition shall be seen for a face-to-face encounter by an RN on the **same day** that the HNR is received. If the situation requires that the inmate be seen by another discipline, the triaging nurse will immediately initiate a referral to the appropriate area.

3.8 HNRs requesting only information may be returned to the inmate with the appropriate response without the need to make an appointment.

3.9 If the HNR is unclear or lacks sufficient information to formulate a response, the qualified health professional shall clearly state the reason for return in Section III and return the HNR form to the inmate via the mail system.

3.10 If the CHP triaging nurse is able to acquire/provide/schedule an immediate response to the patient's needs (e.g., medications update, blanket, diet comment, review of lab/x-ray report, or creating an inmate communiqué), he/she should do so. If the CHP triaging nurse cannot either determine what the patient needs or cannot provide what the patient requests, the patient shall be seen within 24 hours.

4.0. At the discretion of the CHP health staff and with consideration of time constraints and other inmates, at a given scheduled appointment more than one medical issue or complaint may be addressed or attended to. Irrespective of the number of issues addressed only one co-pay charge will be made for the single visit.

5.0 Documentation: All documentation of HNR responses or visits pertaining to HNR submissions shall be entered into the electronic health record by a qualified healthcare professional. Electronically submitted HNRs shall be exported from the HNR program and entered into the electronic health record.

6.0 Refusals: If, on the scheduled appointment day, the inmate refuses to go to the appointment or refuses to be seen, the inmate will sign the Refusal to Submit to Treatment (Form 1101-4) in accordance with Department Order 1101, Inmate Access to Healthcare.

Chapter 5, Sec. 3.2 Inmate Access to Appointment Locations

REFERENCES: DEPARTMENT ORDER 1101
NCCHC STANDARD P-A-09
NCCHC STANDARD P-E-10

PURPOSE: To assure that inmates have unimpeded access to health care services and visits irrespective of their housing location, temporary placement, and/or security classification.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Facility Health Administrator (FHA) to monitor and respond to any potential impediments of the inmate's access to care which includes Security's inability to bring inmates to health services. It is the responsibility of the FHA to ensure that all clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of health services. The procedure of turning inmates out to medical appointments may vary depending upon the classification of the inmate, the level of custody on any given yard and/or whether or not the yard has open circulation vs. controlled movement of inmates. In lockdown areas the traditional definition of escorting an inmate may apply. Alternatively, some medical services may be delivered in satellite locations closer to the inmate's housing unit. It is the responsibility of all Vendor health staff to comply with this policy and report all potential or observed barriers to inmate access to health care to the FHA.

PROCEDURE:

1.0 On-Site Open Yard Escorting

1.1. Movement on an Open Yard can take the form of unescorted movement, group movement (such as to the Chow Hall, or insulin medication turnout) up to a more restricted controlled movement. Medical and dental movements are based upon a pre-printed turn out list (Appointment Lists). On yards that utilize the IPP system of computerized turnout scheduling, the Appointment Lists are incorporated into the IPP list daily by the Security IPP coordinator.

1.2. Open yards allowing inmate unescorted supervision will permit the inmate to walk to their medical appointment based upon the pre-printed turnout sheet and/or appointment lists for the housing unit. The supervision of the inmate would subsequently be assumed up by the Security Officer working in medical who is coordinating the appointment list turnout for the health unit.

1.3. Yards with closed or supervised movement only will have a Security Officer accompany the inmate from their housing location, (or other location if they happen to be working or in school, etc.) to the health unit for their appointment. The inmate will be turned over to the Security Officer working in the health unit.

1.4. Security will provide escorts for emergency "add-ons" to the Appointment Lists for such things as urgent dental care, special lab/blood draws, urgent medical follow up due to new medical diagnostic information requiring immediate attention, etc. These types of turnouts would be requested by Vendor health services personnel following the original submission of the appointment lists on the prior day.

1.5. If an inmate feels the medical need for an unscheduled appointment/visit to medical his request will be reviewed by the Shift Commander on the respective yard (in accordance with Department Order 1101), who will discuss with Vendor medical personnel the circumstances, issues and symptoms of the inmate making the request in order to determine the disposition of the inmate, i.e., "bring the inmate to medical on an emergency basis" or "have the inmate submit an HNR to be triaged with other requesting inmates in the routine manner.

2.0. On-Site Closed Yard/Lockdown Escorting:

2.1. On Level 5 yards and lockdown areas such as CDU's the inmate is most generally escorted by an officer to the health unit for medical attention. Inmates will usually be restrained (shackled) according to the risk assigned by Security as they are escorted to the health unit and while in the health unit. At the medical Practitioner/Provider's request, alternate methods of restraining an inmate may be arranged with Security to permit the physical examination of the inmate and/or testing. In all cases staff safety will be a major consideration. Medical patient confidentiality will be maintained by requesting that the escorting officer distance himself from overhearing discussions with the inmate and medical personnel as far as possible.

2.2. There are a number of parties requesting turnout of inmates to accomplish the mission of the Contract Vendor Health Services. These may include nurse's line, doctor/provider lines, treatment lines for special monitoring of inmate vital signs, supervised exercises, eye exams, SVN treatments, lab blood drawing and x-ray turnouts, dental appointments, mental health appointments for both psychologists and psychiatrists, medical record chart reviews, etc. Vendor Health Services will work with Security to minimize the number of escorts required on any given day by coordinating the variety of turnout requests to avoid conflicting scheduling as far as possible. However, the provision of an appropriate number of escorts to provide inmate access to medical is ultimately the responsibility of Security and the Wardens. This includes not only the day shift but the PM shift for Security if the patient volume for additional escorts is necessary.

2.3. Several medical services may be delivered in satellite locations from the main health unit in these lockdown areas. These may include administering PPD's, insulin injections and glucose monitoring, delivery and administration of DOT medications, pre-scheduled injections, and delivery of KOP medications and personal eye glasses. In these situations, Security will provide an escort of the inmates from their individual cells to the satellite treatment area that provides a measure of security, medical confidentiality and convenience for both medical and security personnel.

3.0. Telemedicine Services:

3.1. The Contract Vendor shall provide Telemedicine Services on all of its major complexes to reduce the need for outside send-outs for medical attention, thus minimizing security issues and escort requirements.

3.2. Telemedicine Services are prescheduled by medical specialty each month and need to occur on a timely basis as the Complexes are scheduled in a pre-determined rotation. This makes it imperative that the inmates are brought to the central location for telemedicine clinics on a relatively tight time frame.

3.3. Security will provide escorts and transportation from the various yards and housing locations to the health services unit and will maintain escort supervision over the inmate during the telemedicine appointments.

3.4. Telemedicine Services will be pre-scheduled similar to offsite medical appointments to allow Security optimum notice to plan for escorting the inmates to their appointments. It is up to Security to determine the staffing and assignment of Officers to do the escorting of inmates from the various housing locations and how to provide continuous escort supervision during the appointment.

3.5. Telemedicine appointments will not be cancelled due to a lack of escorts, but will be referred to the appropriate Deputy Warden and/or Warden, if necessary, to assist in providing adequate escort personnel.

3.6 EHR and/or paper chart must be available to provider conducting TeleMed service.

4.0. Visual supervision of inmates by escorting officers will be maintained as much as possible while respecting the privacy issues of inmates during "sensitive physical examinations". Inmates in the maximum secured areas will have single inmate escorting to the health unit and the Officer will remain with the inmate unless turned over to the Officer(s) working in the health unit.

4.1. Clinical encounters are interactions between inmates and health care Practitioners/Providers that involve a treatment and/or exchange of confidential information. To the maximum extent possible, within the structure of safety and security, clinical encounters are conducted in private, without being observed or overheard by security personnel.

4.2. Privacy is made more difficult when triaging health complaints at the inmate's cell, in segregated housing, or in a lockdown setting. When cell-side triage is required, health professionals should take extra precautions to promote private communication between health staff and the patient.

4.3. When safety is a concern and full visual privacy cannot be afforded, privacy screens may be used.

4.4. Security personnel are to be personally present (in the same room) only if the patient poses a risk to the safety of the health care Practitioner/Provider or others.

Chapter 5, Sec. 4.0 Routine Appointments -Recording

REFERENCES: NCCHC STANDARD P-E-07
NCCHC STANDARD P-A-01
NCCHC STANDARD P-E-12

PURPOSE: To ensure that pending appointment information is transferred from the sending facility to the receiving facility for the following disciplines: medical, nursing, medical records, health education and supportive services.

RESPONSIBILITY: It is the responsibility of the Vendor's complex Director of Nursing (DON) to monitor the Vendor's correctional nursing staff for compliance with this written directive. In addition, the DON shall provide, as indicated, the necessary in-service training to accomplish this process in an accurate and timely manner. Management and supervisory staff shall ensure their respective disciplines comply with this written directive.

PROCEDURE:

1.0. Inmate Health Appointment System EHR:

1.1. Inmates shall be scheduled for appointments as indicated by the specific discipline providing the required service or exam. When scheduling inmates for appointments that require transfer to another facility within the Arizona Department of Corrections Rehabilitation & Reentry or to a non-ADCRR facility, Unit, or Jail a Continuity of Care Form and medication printout must be completed and sent with the transferring inmate. If a medication printout is not available, a copy of the most current MARs form should be forwarded. Refer to MSTM 5. 5.0.

1.2. Appointments will be scheduled using the EHR appointment system.

1.3. Information required will include the following:

1.3.1 Time the appointment was entered;

1.3.2 Date and time of scheduled appointment;

1.3.3 The appointment location;

1.3.4 The appointing discipline: e.g. NL, PL, Lab, MH

1.3.5 The reason for the appointment.

2.0 On-site Radiology and Laboratory

2.1. Upon noting the orders, the Vendor nursing staff member shall complete the EHR entry with the following:

2.1.1 Documentation Date / Date of the appointment entry

2.1.2 Appointment location; where the event will take place

2.1.3 Discipline, i.e. Laboratory

2.1.4 The diagnostic reason for the lab or x-ray procedure shall be noted in the "Reason for Appointment" section.

2.2. All prison laboratory and radiology reports shall be reviewed within five days of receipt. The reviewing medical Practitioner/Provider shall note the date he/she has reviewed/seen the report itself or in an electronic format.

2.2.1 A medical Practitioner shall review the diagnostic reports, including pathology reports, and act upon reports with abnormal values within 5 calendar days of receiving the report.

2.2.2 On-site diagnostic services shall be provided the same day if ordered STAT or urgent, or within 14 calendar days if routine.

3.0. Specialty Consultation on or off prison complex. Upon noting the orders that include a specialty consultation, these requests for specialty consultations shall be forwarded to the Vendor Clinical Coordinator for processing.

3.1. Upon notification of approval for scheduling of the actual appointment, the Vendor Clinical Coordinator shall notify the inmate's prison unit Nurse.

3.2. All specialty consultation medical records are to be reviewed and noted upon receipt by the Vendor attending medical Provider.

3.2.1 Inmates returning from an inpatient hospital stay or an ER transport with discharge recommendations from the hospital, shall have the hospital's treatment recommendations reviewed and disposition made by a Medical Practitioner within 24 hours.

3.3 All specialty consultation reports are to be reviewed and noted within seven days of receipt by the Vendor attending medical Practitioner/Provider.

3.4 A medical Practitioner shall communicate the results of the diagnostic study to the inmate upon request within seven calendar days of the request.

3.5 Inmate for whom a Practitioner's request for specialty services is denied shall be told of the denial by a medical Practitioner at the inmate's next scheduled appointment, or no more than 30 days after the denial has been received with Practitioner follow-up to the denial.

Chapter 5, Sec. 5.0 Continuity of Care Upon Transfer

REFERENCES: NCCHC STANDARD P-E-02
NCCHC STANDARD P-E-03
NCCHC STANDARD P-E-12

PURPOSE: To provide guidance for ensuring the continuity of care upon transfer to another facility within the Arizona Department of Corrections Rehabilitation & Reentry or upon transfer to a non-ADCRR Facility, Unit or Jail. This also provides guidance in the Reception of the Inmate. The ensuring of continuity is directed through review of arriving inmate health records by a qualified health staff member prior to transfer to another state ADCRR facility, contract facility, or out to court. To ensure that the inmate health records are reviewed upon arrival at the receiving facility and the inmate is interviewed by a receiving Vendor health services staff member.

RESPONSIBILITY: It is the responsibility of the Vendor complex DON to monitor that a Vendor Correctional Nurse completes a Continuity of Care Form prior to an inmate transfer; that the health record is reviewed by a correctional Nurse upon the inmate's arrival at the receiving facility; and the inmate is interviewed concerning the state of his/her health care and all related needs.

GENERAL PROCEDURES: All inmates shall have their needs communicated from the sending facility to the receiving facility by the Continuity of Care format (and verbally if necessary) at the time of transfer.

1.0 Sending Facility (Departing Inmates). The MRL will review the Movement list to ensure that all necessary clinical preparations are made to support continuity of care when an inmate transfers.

1.1. The sending facility Vendor nursing staff are responsible to immediately, upon notification of an inmate's impending transfer, review the inmate's health record; and complete the necessary information elements on the Continuity of Care Form prior to transfer. The report must identify any existing chronic illness/disease; and/or any medication ordered which must be continued during transportation and after intake at the new facility. They are also responsible to provide a copy of the inmate's medication profile. The nursing staff shall also contact the Vendor Clinical Coordinator for referral appointment information to an off-facility medical or dental provider, or to a clinic/hospital for evaluation; a follow-up appointment needed by an onsite medical or dental provider; and any special requirements which are to be documented under "Comments".

1.2. If the inmate is being transferred to another unit and a diagnostic report has been received in the health record but has not been reviewed and signed by the ordering Practitioner/ Provider: The report is to be placed on top of the SOAPE divider so the transferring unit can route the chart and report to the Vendor Provider assigned to that unit so treatment can be rendered if necessary.

1.3. Sending facility Vendor medical records staff are responsible to: Place the Continuity of Care Form in Section 2 of the paper health record to remain as a permanent part of the record.

1.4. The Medical Record Scheduled Appointment Document discussed in the "Outside Specialty Care Clinics" section and "Routine Appointments (Recording) section must be verified and provided to the receiving complex. Review of the document will allow nursing staff to advise a need to cancel the movement or to inform the receiving complex of any pending care/treatment.

1.5. The Vendor Facility Health Administrator (with the advice and assistance of the Vendor Medical Records Librarian, and the complex DON) will develop complex-based post orders or policies to ensure that the appropriate Vendor staff verifies that all health records and x-rays on file will accompany the inmate at the time of transfer and verify that all medication sheets and directly observed therapy (DOT) medications will accompany the inmate at the time of transfer. This policy must ensure that any non-administered Keep on Person (KOP) medications should accompany the inmate at time of transfer. Note that a one week supply of prescription medications should accompany all inmates transferred to ADCRR state prisons, private prisons and county jails.

1.6. Vendor Medical Record staff or, in their absence, other designated Vendor staff shall, beginning at 1000 hours and continually throughout the day, check ACIS (DI-71) for listing of inmates scheduled to depart the facility for another ADCRR facility the following day and review the current paper health record and the ACIS DI35 for Medical Holds or Restrictions.

1.6.1 If medical Hold or Restriction is in place, advise local Classification Office that a medical Hold or Restriction exists and the inmate may not be transferred except as listed on DI35.

1.6.2 If no Hold or Restriction exists; complete the inmate identifying information on a Transfer Summary/Continuity of Care format and (if paper records are utilized) affix it to the front of the health record jacket.

1.6.3 Give the health record to the designated Vendor nursing staff for completion of the Transfer Summary/Continuity of Care document and return to medical record staff. If nursing staff has identified an impediment to the pending transfer, nursing staff shall notify of the impediment, medical record staff shall then notify facility Classification staff as soon as possible.

1.7. When the health record with completed Transfer Summary/Continuity of Care document is received from nursing staff, Vendor medical record staff shall:

1.7.1 Obtain all required documentation for inclusion in the health record and place in the health record jacket in the proper location as per Organization of ADCRR Medical Record as outlined in Chapter 5, Section 5.3 of this Technical Manual.

1.7.2 For movement to a state prison from a private prison: The MRL's shall print one years' time frame of the electronic health record that were originated at the private prison OR remove one years' time frame at the private prison from the paper medical record that were originated at the private prison from the chart. The documents shall be placed in an envelope with the inmate name and ADCRR # on it, inside the medical record jacket in front of section 2.

1.7.3 For movement to a private prison from a state prison: The MRL's shall print one years' time frame of the electronic health record. The records shall be filed in the health record jacket in the proper location as per Organization of ADCRR Medical Record as outlined in Chapter 5, Section 5.3 of this Technical Manual.

1.7.4 Place Transfer Summary/Continuity of Care document on top of Section II of the health record jacket affixed in prongs.

1.7.5 Designate the health records as those pending transfer and keep them separate from other health records in the medical record office or area.

1.8. After 1500 hours Vendor medical record staff shall be advised by Classification staff that the transfer list is complete, so far. (NOTE: Despite this notification, inmates subsequently may be added to the list by Classification.) At this time, medical record staff shall: Complete columns 4, 5, and 6 of the Inmate Chronological Movement Record on top of Section IV of the medical record jacket. (Date Transferred:, Transferred To:, Medical Records Cleared By:).

1.8.1 Enter pertinent information for each transferring inmate (as listed below) in a Departure Log (NOTE: This may be either a manual or an electronic log). Transfer Date, ADCRR No., Inmate Name, Receiving Facility, M.R. Sent Today (Y/N), Date M.R. Sent (if after Transfer Date).

1.8.2 Package all volumes of paper health records of inmates who are to be transferred to the same facility in a sealed container clearly addressed to the receiving facility. For those facilities with more than one unit, each health record shall be marked with a removable label indicating the unit inmate is to be transferred to.

1.8.3 Deliver packaged health records to designated location where Security and/or Transportation staff shall pick up the health records of transferred inmates.

1.9. No later than 0800 hours (Monday through Friday), obtain a copy of the Daily Movement Sheet supplied by the facility Inmate Record Office, which lists all inmates who were transferred from the facility within the past 24, hours. On Mondays or following legal holidays, this time period may be expanded from 24 to 72 hours.

1.9.1 Check the names of the inmates listed on the Daily Movement Sheet against those listed on the Departure Log to ascertain that all of the volumes of the medical records for all transferred inmates were sent to the receiving facilities. If lists/log comparison demonstrates that medical record(s) were not sent, notify receiving facility and proceed as described above.

2.0. Receiving Facility. (Arriving Inmates) As above, the review of the Movement list will be performed to ensure that incoming inmates (from other complexes or jails) receive all necessary clinical responses to support continuity of care.

2.1. Receiving facility Vendor nursing staff are responsible to perform a chart review within 12 hours upon arrival. They must physically assess an inmate within twenty-four hours of his/her arrival at a permanently assigned facility. The nursing staff will complete and sign the Initial Inter-facility Assessment Form and refer the inmate for appropriate emergency or routine health care service as determined by the chart review and assessment. The nursing staff shall also complete a Medical Work-Up document, including date and signature and verify that the inmate has all required medical equipment, medication and supplies.

2.2. The Medical Record Scheduled Appointment document discussed in the "Outside Specialty Care Clinics" section and "Routine Appointments (Recording) section, must be reviewed to allow nursing staff to plan for any patient needs regarding pending care/treatment.

2.3 The MRL at the state prison shall scan the medical records into the electronic health record under "Document Type: Medical Records". The records shall be named: "Title: name of private prison and date range of records". The records shall be filed in the health record jacket in the proper location as per Organization of ADCRR Medical Record as outlined in Chapter 5 5.3 of this Technical Manual.

3.0. Current Medical/Dental Orders:

3.1. Receiving Vendor nursing services may continue an inmate's medication order up to ten working days in order to ensure continuity of care.

3.2. A Vendor Provider must renew required prescriptions within a ten working day period. This interim provision in no way diminishes the obligation of the receiving institution to do intake assessments in a timely manner.

3.3. Inmates who are received at a facility with a current Practitioner/Provider order that has not been complete shall have that order completed at the soonest opportunity.

3.4. Vendor nursing staff at the receiving facility are authorized to accomplish testing properly ordered by an ASPC-Phoenix Vendor Physician, Nurse Practitioner, Mental Health Practitioner, or Physician's Assistant.

4.0. Transfer Errors:

4.1. All errors relating to an inter-facility transfer must be communicated to the Vendor FHA at the time the error (inappropriate placement, inability for receiving complex to provide adequate care of the inmate's needs, etc.) has been identified.

4.2. The FHA shall assume the responsibility for taking appropriate action as required by the specific event.

5.0. Transfers under Immigration and Naturalization Service (INS) agreements. Inmates are often being transferred from Douglas, Safford and Fort Grant to Tucson for release to INS. Inmates housed at Kingman and Winslow are often transferred to Lewis for release to INS.

5.1. The paper health record will not be transferred to the new unit. However, a Continuity of Care form must be done in order for Vendor Nursing at the new unit to have medical information in case of an emergency. The original Continuity of Care document must stay in the paper record. A copy is to be sent in an envelope marked "Medical Information: inmate #, date of move, Tucson or Lewis transitory for INS release." This Continuity of Care document will be accompanied by the Discharge Medication. These items will be turned over to the Immigration and Customs Enforcement Officers.

5.2. In most cases, the inmate is released to INS the next day or within 2 days. ACIS will need to be checked to ensure the release date is written on the Inmate Chronological Movement Record form.

5.3. The record will then be processed with the other releases from your unit.

6.0. Transfers to County custody: Inmates are often being transferred to the various Arizona counties for court appointments or other legal actions. Their absence may be as short as one day and as long as several years. There is always a potential that these inmates may or may not return to ADCRR custody. The continuity of care for these inmates places a special burden on the sending complex.

6.1. The Vendor FHAs will, under the guidance of the appropriate Vendor Regional VP/Administrator or designee, remain in communication with the local county medical contact. The goals include ensuring that Continuity of Care documents are received and utilized by receiving county staff; ensuring that ADCRR has accurate contact numbers, addresses, and fax numbers.

6.2. FHAs shall create local post orders that describe the following:

6.2.1 The method of communication with local OIU re: pending transfer to county.

6.2.2 The method of reducing or eliminating missed appointments by communicating needed and pending ADCRR scheduled specialty appointments.

6.2.3 The method of communication of a patient needs to a receiving county agency.

6.2.4 The local method of monitoring returned inmates to reduce/eliminate the potential of missing necessary continuity of care requirements upon return from county custody.

6.2.5 A minimum of 7 day supply of all active medications shall accompany the inmate who goes out to court in order to maintain continuity of care.

7.0. Courtesy Releases: (example) The inmate, while released from Tucson, was actually a Safford Complex inmate (due to no bus service from Safford/ Wilcox area). A Transfer Summary/Continuity of Care form is prepared by Nursing. This form accompanies the inmate to the Tucson complex. The medical record stays at Safford complex since he will be released the next day. If the inmate returns to custody and the medical record has not been sent to storage, Safford Medical Records will be contacted to send the medical record to the current complex.

Chapter 5, Sec. 5.1 Chronic Condition Care (Monitored Conditions)

REFERENCES: ARIZONA REVISED STATUTES 31-201
DEPARTMENT ORDER 1101
NCCHC STANDARD P-G-02

PURPOSE: To provide consistent criteria for providing care to special needs inmate-patients who are identified as having a chronic disease.

RESPONSIBILITY: It is the responsibility of the Arizona Department of Corrections Rehabilitation & Reentry Director to comply with the guidance of statute. Certain conditions have been established as Chronic (Monitored) Conditions. These have been identified for legal and financial requirements and are not designed nor intended to serve as an exhaustive clinical listing of what may be considered clinically chronic.

PROCEDURES:

1.0. Chronic conditions require regular examinations and/or treatment.

1.1. Arizona Department of Corrections Rehabilitation & Reentry Contract Vendor's health care Providers shall determine whether regular examinations and/or treatment are directly related to a qualifying disability. There is no health care fee for these conditions.

1.2. The Medical Services Contract Monitoring Bureau (MSCMB) have established ADCRR chronic condition clinical practice guidelines that are consistent with selected national clinical practice guidelines that have been published by subject matter experts. Several of these guidelines are enclosed in Appendix C, D and E to this manual.

2.0. Chronic conditions are identified in the Department Orders Index, Glossary - All Terms.

3.0. Chronic Condition Examinations:

3.1. The Vendor Charge Nurse staff member on each unit will ensure that inmates with chronic conditions are scheduled to be examined and/or treated at least every six months by a medical Practitioner/Provider, except for LTBI which will require annual assessment by an RN, an LPN, or an annual Practioner's visit.

3.2. Those inmates with identified chronic conditions shall receive an annual physical exam at their scheduled appointment with the medical Provider, except for LTBI which will require an annual assessment by an RN, an LPN, or an annual Practitioner's visit.

3.3. Currently scheduled encounters for inmates with Monitored or Chronic Conditions are documented in a progress note in the medical record.

4.0. The conditions identified in Department Order 1101 will be monitored in accordance with A.R.S. 31-201.01 (G), via a chronic diseases electronic system.

5.0 The Vendor Facility Health Administrator or designee will ensure the existence and use of a chronic condition tracking system (database) by which inmates who have been identified as having a chronic condition (identified above and Department Order 1101) can be scheduled regularly for various examinations, evaluations and follow-up care.

6.0. Private/Contracted facilities are encouraged to discuss their administration and recording of the treatment of chronic conditions with the MS Contract Program Evaluation Administrator. The ADCRR Director has defined the conditions listed in 2.0 above as Chronic Conditions as a response to the guidance contained in A.R.S. §31-201.01(I)(12) which states that "Inmates who are undergoing follow-up medical treatment for chronic diseases" are exempt from the charging of health services fees.

Chapter 5, Sec. 5.2 Security of Accountability of Paper Health Records

PURPOSE: To provide a system for tracking and locating paper health records which have been removed from the numerical file shelving system.

RESPONSIBILITY: The MS Contract Vendor Medical Records staff shall ensure the security and accountability of all health records. When staff is not present in the unit, the door shall be closed and locked. In case of emergency, security does have access to the room, and must sign out the record using a red plastic out guide/out card.

PROCEDURES:

1.0 REMOVAL OF PAPER HEALTH RECORDS FROM THE FILE:

1.1. Authorized Personnel:

1.1.1 Only the Vendor staff may remove health records from the file.

1.1.2 Medical records may not be removed from the health unit and/or health administration area without the express authorization/direction of the Vendor Facility Health Administrator, Medical Records Supervisor, Regional VP/Administrator, or Contract Monitor.

1.1.3 Staff may not make copies or utilize medical documents for personal use (i.e., response to lawsuit, development of anecdotal files, etc.)

1.2. Time Limit: Health Records must be returned to file within three business days of removal from the file. If the health record cannot be returned to file within this period, a revision must be made to the out guide/out card by the person who originally removed the health record.

1.3. Requirement for out guide/out card:

1.3.1 An out guide or out card shall be inserted in place of every health record which is removed from the file system, unless there is an appointment/provider list posted. (See 1.4.1)

1.3.2 Out guide/out card must contain the following information: ADCRR number, Inmate: last and first name, Date of removal, Reason for removal, Location of medical record, Legible signature of health staff who removed the medical record from file.

1.3.3 The out guide used shall be red vinyl, comparable to Oxford, Style No. F21356.

1.4. Removal of multiple health records:

1.4.1 When numerous health records are removed for the same purpose (e.g.: Dental appointment, Outside Review Committee meeting, etc.), a listing of the medical records removed shall be posted in the medical record file room.

1.4.2 List must contain the following: Date of removal, Purpose of removal, Location of the removed medical records, ADCRR numbers, Inmate: last and first name, Legible signature of staff person who removed the medical records.

1.5. Filing documents while health records are out of file:

1.5.1 Any loose documents received for filing while the medical record is in "OUT" status from the file shall be placed in the pocket of the out guide/out card until such time as the medical record is returned to the file.

2.0 RETURN OF HEALTH RECORDS TO FILE:

2.1. Health records must be returned to file within three business days of removal.

2.2. All health records shall be returned to file by the discipline that removed it from the shelf. Records pulled for Dr.'s Line, Dental Line, Mental Health, Nurses Line will be filed by respected disciplines working in conjunction with medical record staff.

2.3. At facilities with no Vendor medical record staff, the respected disciplines shall be responsible for re-filing of the health records working in conjunction with the staff designated to perform the medical record functions.

2.4. As health record is returned to file, out guide/out card is removed.

2.5. Any documents found in the pocket of the out guide/out card are to be filed into the health record jacket according to the format as in Organization of ADCRR Health Records.

3.0. FOLLOW UP MONITORING AND TRACKING:

3.1. At least once per week, medical record staff or other designated vendor staff shall review each pending out guide/out card remaining in the file to determine those which are older than three business days.

3.2. A listing shall be made of each record out of file longer than three business days.

3.3. Vendor staff who removed the health record shall be advised they have a health record that is overdue and must: Return the health record(s) by end of current shift OR Revise the information on the out guide/out card AND notify the health record or other designated staff of the change.

3.4. If action as outlined in 3.3 does not occur, the Vendor medical record supervisory staff and the Vendor FHA shall be notified.

4.0 Order of Filing Medical Records on shelving unit.

4.1 Medical Records shall be filed on the shelving units by chronological number using the ADCRR number. i.e.: 123456, 123483, 211525, 248224, 255685.

4.2 Active and previous volumes shall be filed separately in ADCRR number order.

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

Chapter 5, Sec. 5.3 Organization of the Health Record

REFERENCE: NCCHC STANDARD P-H-01

PURPOSE: To provide a uniform document in which a record of an inmate'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 of the Health Record (paper version or electronic version), is the responsibility of the Vendor Medical Record staff. The maintenance of that uniformity is the responsibility of all Vendor Health Staff accessing the Health Record.

PROCEDURES:

1.0. Establishment of The ADCRR Health Record:

1.1. Origination of Health Records: Upon arrival at any of the designated Reception Centers Contract Vendor medical record staff shall originate the document which becomes the inmates' medical record.

1.1.1 Alhambra Reception & Treatment Center (ASPC-Phoenix-ARTC): Adult male inmates.

1.1.2 Lumley Reception & Assessment (ASPC-Perryville): All female inmates and female minor inmates.

1.1.3 Browning (ASPC-Eyman): Death Row male inmates.

1.1.4 Rincon Minors Unit (ASPC-Tucson): Minor male inmates adjudicated by the court as adults.

1.2. Organization of All ADCRR Paper Health Records Shall be:

1.2.1 Filed in 4-part classification-type binders, in standard letter size (81/2" X 11").

1.2.2 Only forms which have been approved as stipulated in Directors Instruction 14, Forms Control, may be used in the health record.

1.2.3 Contents of the health record must be organized as per the specified approved format.

1.2.4 (NOTE: THE ELECTRONIC VERSION OF ADCRR HEALTH RECORDS MAY BE ORGANIZED IN A DIFFERENT FORMAT.)

1.2.5 The MSCMB Medical Record Monitor, with input from the Vendor Medical Record Supervisor, may change, or revise this organization as may be required by statute, regulation, Department Order or procedural changes.

1.3. Inmate Identification Information: The health record jacket shall contain the following information in the upper right hand corner of the file jacket:

1.3.1 Inmate's full name (last name, first name).

1.3.2 ADCRR Number (which becomes the health record file number).

1.3.3 Information regarding any allergies the inmate may have (annotated in red on the Front of the file jacket).

1.3.4 List "AKAs" to the left of the name label.

1.4. The ADCRR Number adhered to the bottom edge of the back cover of the jacket. Inmate numbers shall be in the specified color-code.

1.5. Color-coded tabs indicating any specified Chronic Conditions which the inmate has been diagnosed as having. Color Code(s) for HIV+/AIDS shall be affixed to the inside front cover of the jacket, upper left hand corner.

1.6. A stamp or handwritten "MEDICAL RECORDS" is designated on the front of the medical record jacket in the right hand lower portion of the chart.

2.0. All forms contained in the health record must contain the following identifying information, and be filed in chronological order, with most current on top: Inmate's full name, ADCRR Number, Inmate's current location (Prison, Unit).

3.0. ORGANIZATION OF ADCRR PAPER HEALTH RECORDS:

3.1 SECTION I

1 Problem List (PL) (card stock) 1101-76 (Problem list MUST be maintained and kept current with the Vendor medical Providers making any additions, corrections, or deletions. File the most current on top. Health Provider: MD, DO, NP, PA, Dentist, Psychiatrist, Psychologist, Nursing may document on Problem List)

2 Annual Follow-up of PPD Converters (TB Symptomology Checklist 1101-61)

3 Monitored Condition Lab tracking Flow Sheets 1101-88

4 Diabetic Individualized Management Plan 1101-87

5 Health Education HIV Tracking Form

6 Health Education Diabetes Tracking Form

7 Hepatitis B/C Contraindications Table

8 Hepatitis B/C Screening Table

9 HCV Therapy Monitoring Log

10 Currently does not qualify for Hepatitis C Treatment

11 Serious Mental Illness (SMI) Determination 1103-13

12 Initial Mental Health Assessment 1103-27

13 ADA Checklist (Functional Assessment)

14 Chronic Condition Flow Sheets (Various Conditions)

15 Index Tab Divider: Intake Data

16 Initial/Inter-Facility Assessment 1101-67

17 Ebola Intake Form

18 Physical Examination(s) 1101-77

19 Nursing Staff Assessment

20 Reception Center Screening 1101-21

21 Medical History 1101-29

3.1.1 Index Tab Divider: Health Education:-Continuous Progress Notes

1 Health Education Diabetes Tracking Form

2 Health Education Consent Agreement 1101-24

3.1.2 Index Tab Divider: Pr(ior) Rec(ords)/Rel(ease) of Info(rmation)*

1 *NOTE: Documents in this section are NOT part of the health record!!

2 Previous MH records are removed from the medical record during offender review of the health record and are never copied and released as part of the health record unless the inmate specifically authorizes the release of Previous Records on "Authorization to Disclose Copies or Provide Information from Medical Records (form 1104-2).

3 Inmates are allowed to review previous health records and may release Previous Records.

4 Any health documents obtained from medical facilities for health care received prior to ADCRR incarceration.

5 Authorizations to Obtain Copies of Medical Records from medical facilities requests for records etc.

6 Transfer Summary/Continuity of Care (from County Jails).

3.2 SECTION II

1 NOTE: Items listed shall appear only in cases involving death of an offender

2 Central Office Mortality Review Documents

3 Autopsy Report/Medical Examiner's Report

4 Facility Mortality Review Documents

5 Significant Incident/Information Reports Related to Final Episode

6 Appointment Log/Health Services Scheduled Appointments (card stock)

3.2.1 Index Tab Divider: Practitioner's Orders

1 Practitioner's Orders

3.2.2 Index Tab Divider: Progress Notes

1 Continuous Progress Notes 1101-62

2 Medication Profile

3 Chronic Condition Follow-up Care 1101-12 Communique 1101-26

4 Wound Documentation Flow Sheet

5 Continuous Progress Record – Pharmacy

6 Transfer Summary/Continuity of Care (for Inter-facility Transfers, Court Transfers) (Located within the Progress Notes in chronological order as they occur) 1101-8

3.2.3 Index Tab Divider: Consults/Flow Sheets

1 In-House Consultation Reports

2 Consultation Reports

3 MRC Approval/Denial Form

4 IPC records (Florence, Perryville, Lewis & Tucson):

4.1 Request for In-House Consultation (Mental Health)

4.2 Emergency Room Records and/or Inpatient Medical Records for Admission During incarceration

5 NPO Instruction Sheets for Procedures (Barium Enema, UGI, Colonoscopy Prep, Thyroid scans, EGD, Outpatient surgery, dental)

6 Optometry Patient Record 1101-30/ Eye Glass Order

7 Flow Sheets (Various Types) Ebola Virus Daily Screening Flowsheet

8 Observation Records (CDU) 1101-16

9 Vital Signs 1101-64

3.2.4 Index Tab Divider: Dental

1 Dental Chart 1101-11 (3 pages)

2 Dental Chart: Continuation Sheet

3 Dental Communiqué

4 Dental Instructions

3.3 POCKET BETWEEN SECTIONS II & III (May be clear plastic pocket)

1 Dental Panoramic and bite-wing X-rays

2 May also file CDs, photographs

3.4 SECTION III

1 Medical Work-up/Follow-up (Pink Sheet) 1101-68

2 Immunization Record (Yellow) 1101-17

3.4.1 Index Tab Divider: Lab/x-ray/EKGs

1 Laboratory Report (Various)

2 X-ray Request and Report

3 Mammography Report

4 Other Imaging Reports (Scans, Ultrasounds, MRIs, etc.)

5 Audiometric tests

6 Pulmonary Function Testing

7 EKG Reports

8 Urinalysis Forms 1101-34

9 PPD Forms 1102-7

3.4.2 Index Tab Divider: Consents/Refusals

1 Refusal of Treatment Forms (for In-house and/or Outside Appointments) (must be witnessed x 2) 1101-4

2 Consent/Refusal for Substance Abuse Treatment

3 Post HIV Counseling Checklist

4 Consent to Test for HIV

5 Refusal to Treatment of Hep C 1101-50

6 Education/Consent for Possible Treatment of Hepatitis C

7 Vaccine Consents (MMR, Influenza, etc.)

8 Minor Surgery Consent 1101-49

9 PPD Conversion Counseling

10 Informed Consent for Oral Surgery

11. Eyeglass Agreement of Responsibility

3.4.3 Index

x Tab Divider: Medication Sheets/Miscellaneous

1 Patient Release/Transfer Form

2 Medical Delivery/OTC Flow Sheets

3 Medication Distribution Log

4 Medication Administration Record Log 1102-2

5 INH Administration Record 1101-42

6 Non-formulary Request

7 Psychiatry Non-formulary Request (1103-25)

8 Duty/Special Needs Orders 1101-60

9 Patient Disposition 1103-30

10 Shaving Waivers

11 Restricted Diet Orders 912-3

3.5 SECTION IV

3.5.1 Inmate Chronological Movement Record 1101-82

3.5.2 Index Tab Divider: Health Needs Request

1 Health Needs Request Forms (English/Spanish) 1101-10

2 Health Needs Request (For Emergency Requests)

3.5.3 Index Tab Divider: Mental Health

1 NOTE: Documents in this section are removed from the medical record during offender review of the medical record.

2 Mental Health Treatment Plans 1103-16

3 MH Data Sheet (Yellow cardstock) (1103-26)

4 Psychotropic Related Testing (Yellow cardstock) (1103-29)

5 The above two forms will always be the first 2 forms filed under the MH tab.

6 Mental Health Continuous Progress Notes

6.1 Group Progress

6.2 SMA Assessment

7 Psychiatric Follow-up Note (1103-37)

8 Psychiatric Evaluation – MH (yellow paper/3 page document) (1103-32)

9 Suicide Risk Screening Form

10 Medical Nursing Watch (1103-A40)

11 Mental Health Disposition (suicide/mental health watch)

12 Mental Health Consults

13 Any correspondence/letters from the inmate to MH staff

14 Step-Down Program Referral for Admission

15 Inmate Step-Down Admission Agreement

16 Mental Health Treatment Plan

17 WTU (Women's Treatment Unit) Diagnostic Page

17.1 Problem list

17.2 Problem Plan(s)

17.3 Signature Page

17.4 Treatment Plan Reviews

18 Informed Consent

19 Mental Health and WTU (Divider)

20 ADCRR inpatient progress notes (Flamenco) (for records that are not 6 part charts)

21 Psychological Assessments

22 Notification of Intent to Request Approval to Involuntarily Administer Psychotropic Medications 1103-15P

23 Consent for Psychotropic Medications

24 Cell front Checklist

25 Occupational Therapy

26 Recreational Therapy

3.5.4 Index Tab Divider: Legal/Administrative*

1 *NOTE: Documents in this section are NOT part of the medical record. They are removed from the medical record during offender review of the medical record (Medical and Mental Health) and are never copied and released as part of the Medical Record.

2 Requests for Copies of Medical Records (MRR) (outside requesters not on ADCRR Forms)

3 Authorization(s) to Release Copies of ADCRR Medical Records

4 Documentation regarding specific medical documents released

5 HEP C Committee Follow Up Information Request.

6 Medical INCR Form (old form- some charts may have them)

7 Mental Health INCR Form (old form- some charts may have them)

8 Correspondence

9 Court Documents

10 DNA and/or Paternity Court Order and Test Confirmation

11 Guidelines: Inmate Medical Record Reviews

12 Inmate Acknowledgment of Rights 1101-99

13 Durable Health Care Power of Attorney 1101-97

14 Living Will (End of Life Care) 1101-98

15 Revocation of Medical Care Directives 1101-90

16 Consent to Release Medical Information/Medical Record 1104.2

17 Release of Medical Information for Interstate Corrections Compact Transfer 1101-40

18 Right to Request Limitation of Extraordinary Life Support Measures (0ld form)

19 Consent to Release Medical Information/Medical Record (This is the verbal consent signed at intake)

3.5.5 PLASTIC POCKET, INSIDE BACK OF HEALTH RECORD JACKET:

1 VA Benefits Information Chronic Health Problem Card (During transport, and until needed for use in Chronic Condition System). Chronic Condition Cards

2 DOCUMENT PLACEMENT: DOCUMENTS ARE PLACED IN THE VARIOUS SECTIONS IN REVERSE CHRONOLOGICAL ORDER (Newest or most current on top). Unless otherwise noted, in sections where more than one type of the same form/document is included in the section, group all like documents together, file in reverse chronological order. (Example: all PPD slips, all x-rays, all EKGs, all Scans, all MRIs, etc.)

4.0 BAKER/FLAMENCO SECTIONS 5 AND 6 CHART ORDER:

1 CHART ORGANIZATION FOR ALHAMBRA BEHAVIORAL HEALTH TREATMENT FACILITY (ABHTF) NOTE: NOTHING IS TO BE REMOVED FROM SECTIONS 5 AND 6 UNTIL ADMITTED TO BAKER/FLAMENCO UNIT.

2 *SECTION 1)*: Same as green health record

3 *SECTION 2*: Same as green health record

4 BROWN POCKET/TAB or Plastic Sleeve: Dental X-rays

5 *SECTION 3I*: Same as green health record

6 *SECTION 4V*: Same as green health record (QUIET unit admission records are under the Mental Health Tab in this section until admitted to the unit. QUIET unit is not part of the licensed units).

4.1 BROWN POCKET/TAB:

1 Face Sheets

2 Extra Labels

4.2 *SECTION 5*: INPATIENT "MEDICAL" for Baker and Flamenco units only. DO NOT ADD ANYTHING OR REMOVE ANYTHING TO/FROM THESE SECTIONS, UNLESS FROM BAKER AND FLAMENCO.

TAB 1: PRACTITIONER'S ORDERS FOR MEDICAL AND MENTAL HEALTH WHEN INMATE IN ABHTF UNIT.

TAB 2: MEDICAL PROGRESS NOTES

2.1 All progress notes (medical)

2.2 Medical Physical Exam when done at ABHTF

2.3 Reception Center Screening when done at ABHTF

2.4 Medical History when done at ABHTF

TAB 3: ALL DIAGNOSTIC REPORTS

3.1 Lab reports

3.2 PPD

3.3 X-ray reports

3.4 EKG's

TAB 4: MEDICATION SHEETS/MISCELLANEOUS

4.1 Patient Release/Transfer Form

4.2 MAR'S

4.3 Non-formulary Drug Tracking Form

4.3.1 Special needs status

4.3.2 Limited duty status

4.3.3 Diet Restrictions

4.3 *SECTION 6*: for ABHTF MEDICAL RECORD - INPATIENT MENTAL HEALTH:

4.3.1 Documents in this section are removed from the medical record during offender review of the medical record. DO NOT REMOVE ANYTHING FROM THIS SECTION.

4.3.2 Discharge Summary

TAB 1: MENTAL HEALTH PROGRESS NOTES

1.1 All Mental Health progress notes

1.2 Group Notes

1.3 Cell front checklists

1.4 Mental Health Disposition forms

TAB 2: CONSENTS/ORIENTATION

1.1 Inmate Patient Orientation

1.2 Conditions to Admission

1.3 Mental Health Treatment Consent

1.4 Grievance Policy

1.5 Informed consent for Psychiatric medications

TAB 3: ADMISSION/ASSESSMENT

1.1 Jail/Prison Evaluation Request Form

1.2 Admission Note and Interim Treatment Plan

1.3 Psychological Report

1.4 Clinical Assessment Packet
1.5 Test Data
1.6 Occupational Therapy Assessment
1.7 Individual Problem Plan
1.8 Health Planning Coordination Form (MH only)

TAB 4: TREATMENT PLANS

TAB 5: LEGAL/ADMINISTRATIVE

1.1 Court-ordered Treatment
1.2 Court-ordered Evaluation
1.3 PMRB (PSYCHOTROPIC MEDICATION REVIEW BOARD)
1.4 Release of Information
1.5 Mental Health INCR's (WHILE IN ABHTF)

5.0. THINNING A CHART

5.1 Steps to creating a new volume:

5.1.1 Label volume
5.1.2 Name/# label
5.1.3 ADCRR # stickers
5.1.4 CC color stickers
5.1.5 Allergy
5.1.6 Mark old volume (STOP-DO NOT USE: SEE VOLUME # _____)
5.1.7 Mark new volume #
5.1.8 Mark "Health Record" on front of chart
5.1.9 Move appropriate documents to new volume (see below)
5.1.10 Documents to be carried forward to new volume:

Notes:

1.1 SMI CHECK LISTS go in SECTION 1 UNDER "PROBLEM LIST"
1.2 All FLOW SHEETS go in SECTION 2 UNDER TAB "FLOW SHEETS"
1.3 All REFUSAL OF TREATMENT'S go in SECTION 3 UNDER TAB "REFUSAL OF TREATMENT FORMS"
1.4 All HNR's go in SECTION 4 UNDER TAB "HNR"

SECTION 1	Problem List current Functional Assessment current Mental Health Assessment current CC-tracking forms current
Intake (tab)	Inter-facility Assessment – current Physical –current History –current
Previous Records (tab)	0
SECTION 2	Practitioner's Orders –1-6 months PROGRESS notes -1 to 6 months (depends on thickness)
Consults/Flow sheets (tab)	Consultation –1 to 6 months (depends on thickness) Ophthalmology Report w/Eyeglass Rx – current Flow sheets – current
Dental (tab)	All if possible
SECTION 3	Medical Work-up current Immunization Record- current
Lab/X-ray/EKG	Lab/PPD - current X-ray – current EKG - current Mammogram – current PAP – current
Consents/Refusals (tab)	0
Miscellaneous (tab)	MAR sheets – 1 month Duty status – current Diet – current Shaving waiver – current
SECTION 4	Chrono movement – entire
HNR (tab)	HNR-max 1 month worth
Mental Health (tab)	MH PROGRESS NOTES 1-6 MONTHS
Legal/Administrative (tab)	Release of Information- Verbal Information - Durable Health Care Power of Attorney 1101-97 - Living Will (End of Life Care) 1101-98

Arizona Department of Corrections Rehabilitation & Reentry	Medication Delivery - (Keep On Person)	OPR: MS Contract Vendor Regional Director of Nursing MS Contract Vendor Pharmacy Director MSCMB Pharmacy Monitor MSCMB Coordinator Auth: mw
Medical Services Technical Manual	MSTM Chapter 5 Section 6.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019 Updated: 08/21/2020

Chapter 5, Sec. 6.0 Medication Delivery (Keep On Person)

REFERENCES: Arizona Administrative Code R4-23-658
Arizona Administrative Code R4-23-672
Arizona Revised Statutes 32-1901 to 36-2515.A.2
Arizona Revised Statutes 32-1901 to 32-1996
Arizona Revised Statutes 36-2511 to 36-2552
Arizona Revised Statutes 36-2512.A.1 to 36-2515.A.1
DEPARTMENT ORDER 702
NCCHC STANDARD P-C-05
NCCHC STANDARD P-D-01
NCCHC STANDARD P-D-02

PURPOSE: To provide a consistent and uniform system of delivery of Keep On Person prescription medications to the inmate/patient population. To ensure that medications are delivered on a daily basis in a uniform and consistent manner throughout the Department, and that accountability is maintained in all phases of the delivery process.

RESPONSIBILITIES: It is the responsibility of the MS Contract Vendor Nursing Staff to deliver prescription medications to the inmate population. Keep on Person medication may be delivered to the inmate by medical staff.

PROCEDURES:

1.0. The complete audit trail for all medications issued by the Vendor Pharmacy must be maintained for subsequent inspection by Health Services Contract Monitor, as well as Federal and State enforcement, investigative and licensing agencies.

1.1. Medication for inmates who are out to court or in the hospital shall be maintained at the unit pending the inmate's return to the facility unless the order has expired.– Return any medication undeliverable to nursing immediately upon the inmate's return from the hospital the unit nurse will provide the discharge summary and hospital notes to the provider for review for medication formulary compliance or consideration of changing the medications. If there is no provider scheduled for that unit upon return of the inmate, the unit nurse will contact another facility provider or the on call provider to obtain orders based on the hospital discharge summary for the inmate and current medications provided by the ADCRR facility. All discontinued medications will be returned to the vendor pharmacy.

2.0. Keep-on-Person (KOP) maximum quantities dispensed may not exceed a 30 day supply, except for "unit of use" medications (e.g., eye drops, creams, lotions, etc.) which expire when gone.

2.1. Inmates shall receive KOP Medications from nursing staff. Documentation is to be accomplished in accordance with Pharmacy direction and medical records guidance to ensure that a complete record of treatment is maintained.

2.2 Medication will be placed in opaque bags to protect the identity of the medications delivered to the inmate. A sign-out log will be generated by the Vendor Pharmacy.

3.0. Medication Delivery:

3.1. Quantity:

3.1.1 The Contract requires a 30 day supply or a maximum of 120 units (pills) per fill. Certain medications recommended and approved by the combined ADCRR/Vendor Pharmacy and Therapeutics Committee may be dispensed and delivered to an inmate in more than a one month supply. These medications include topical preparations, inhalers, or other unit of use medications.

3.1.2 Antibiotic medications may be dispensed in the total amount of up to 30 days to complete therapy if the amount is considered safe.

3.1.3 Keep-on-Person (KOP) Preparation:

3.1.4 KOP medications will be prepared for delivery to the inmate by the Vendor pharmacy, medication liaison, or designee, under the supervision of the Facility Health Administrator. Unit Dose medications will be prepared for distribution to nursing services by the medication liaison or designee, under the supervision of the Facility Health Administrator.

3.1.5 Bar Coded systems and scanners may be utilized by the medication liaison or designee, to assure that the bar-coded prescription is placed in the correct bar-coded opaque bag for delivery to the inmate.

3.2 KOP medications are delivered directly from the Vendor Nursing Unit to the appropriate staff on a daily basis. Documentation of receipt of the medication by the inmate is returned to the pharmacy.

3.3. Delivery of medications shall be documented at every stage of the delivery system.

3.3.1 The nursing staff receiving medications from the medication liaison shall complete the "sign-off" sheets acknowledging receipt and count.

4.0. All discontinued medication shall be returned to the Vendor pharmacy.

4.1. Undelivered Unit dosed medications will be retained in the custody and control of nursing staff until determination is made regarding continuation of the prescription by the prescribing Provider. Documentation of non-receipt will be maintained in the Health Record.

4.2. Confirmation of whether or not a medication is still active for an inmate will be determined by accessing the Vendor Pharmacy and inmate's chart. If the prescription is in fact still active, and the inmate has changed locations, the nurse or medication liaison will provide transfer of the medication within the facility.

4.3. If the inmate has moved to another facility there must be no interruption in medication administration. The Vendor pharmacy receives daily download reports of transfers identifying relocation of inmates and shall process prescription replacement as needed.

4.4. Transmittal /signature documents showing the non-delivery of medication shall be returned to nursing with medications for review and reconciliation.

4.5. Notation shall be made on the prescription file in the Vendor pharmacy computer to show the medication returned and the reason for return.

4.6. Returned medications which cannot be "returned to stock" must be destroyed. Vendor Pharmacy shall document medication destruction or disposal through an approved vendor. Destruction shall comply

with applicable Environmental Protection Agency and Occupational Safety and Health Agency (OSHA) directives. Records shall be maintained for three years.

4.7. Every effort must be made to deliver KOP meds upon receipt from the Vendor Pharmacy. KOP medications must be delivered to inmates within 24 hours of receipt by Vendor nursing staff. Documentation as to why medications were not delivered must be maintained in the inmate's health record. Undeliverable medications shall be documented in the inmate's health record and on the medication administration record (MAR). If the medication is undeliverable due to patient refusal, the appropriate refusal document must be completed and signed and proof of Provider notification documented.

5.0. Medications delivered to Inpatient Beds (IPC and Wards) will be delivered by coordinated schedules established by the Vendor's FHA, complex DON, and Pharmacy. These medications are to be administered by Vendor Correctional Nursing Staff and will not be KOP medications. Post Orders must be written to delineate procedures.

6.0. Psychotropic medications provided to patients in the Men's Treatment Unit may be Keep on Person (KOP) unless ordered direct observe therapy (DOT) by a Psychiatrist.

7.0. Preparation of medications that are to be delivered by nursing staff must be carefully managed to ensure security and patient safety. Vendor Complex DONs and unit Charge Nurses are responsible to ensure that preparation of medications are performed only in accordance with the MSTM 4.1.7 guidance and to ensure that all delivery activities are performed within the guidelines of the Nurse Practice Act. The nursing staff who prepares the medication for delivery is the person who is responsible for the delivery process of the DOT medications.

8.0. The following are recommended and authorized elements of complex post order that guides staff in delivery of keep on person medications.

8.1. General Responsibilities: All prescriptions will be legible and contain the diagnosis and all known allergies. The prescriptions must meet all regulations set by both State and Federal agencies. The blister packs will be placed into a plastic bin for transport. The bin must be sealed with combination locks. The prescription packs must be stamped in English and Spanish. The blister pack will include the inmate's name, ADCRR number and housing location on the outside of the pack. The packs will be delivered in housing unit bundles by specifically assigned personnel. The medications will be placed in a health unit area for pick up by assigned delivery staff.

8.2. Vendor Pharmacy professional's Responsibilities: All Keep On Person prescriptions will be sealed as necessary, by assigned Vendor personnel. Vendor nursing personnel shall audit sign off sheets to ensure all medications are received, i.e. missing inmate signature requires investigation. Unclaimed medication must be returned to Nursing.

8.3. Staff's Responsibilities: Sign off sheets must be returned to health unit. The assigned personnel will hand the medication pack to the inmates after the inmate has signed their name on the sign-off sheet provided. Sign off sheets and unclaimed medication must be returned to the health unit in accordance with local policy. Completed sign-off sheet and unclaimed medication shall be returned to nursing. In the event that an inmate reports that medications were missing, inform Health Staff to write an Information Report for documentation purposes.

Chapter 5, Sec. 6.1 Transfer Medications

REFERENCES: NCCHC STANDARD P-H-05

PURPOSE: To provide mechanisms and requirements for ensuring continuity of care through maintenance of possession or delivery of properly ordered medications.

RESPONSIBILITIES: The Contract Vendor Facility Health Administrator and Vendor complex Medical Director are responsible to set procedures in place to ensure that transferring inmate-patients do not go without medications that have been duly ordered by a provider and provided by Vendor pharmacy services.

PROCEDURES:

1.0. Inmate Transfer Medications: Inmates transferring between ADCRR Facilities and ADCRR complexes will continue their current medications as ordered. Inmates will self-carry their currently issued Keep On Person (KOP) prescriptions in accordance with this manual and pertinent Department Orders. Directly Observed Therapy (DOT) medications will accompany the inmate to the receiving complex or facility.

1.0.1 The Vendor Medical Record Librarians print the DI 71 departure movement no later than 1400, pull the medical records (all volumes), and prepare Continuity of Care/Transfer Summary form for nursing to complete, prepare envelopes, and give charts to nursing.

1.0.2 The Vendor Unit Charge Nurse or designee (Registry staff must be adequately trained in this area if used) is responsible to complete the continuity of care/transfer summary and place inmate's DOT medication in the chart for transport to the receiving facility or complex. Count movement gives nursing a list in the evening of add-ons or cancellations for preparation of charts and medication for late notification movements.

1.0.3 The Unit Charge Nurse or designee will be responsible to prepare and administer the inmates evening dose or morning dose of watch swallow medication as part of the transfer procedure. Chart may be prepared before the p.m. or next morning a.m. dose have been given – in that case, medication would be prepared for those doses.

1.1. Vendor at any receiving institution will continue inmate prescriptions pending evaluation by a Vendor Provider at the receiving institution.

1.2. Medications (prescriptions) shall remain in effect for NO longer than the prescription expiration date as determined from the original medical order.

2.0. Controlled Substances DEA II-V will be transferable as per state and federal regulation.

3.0. Inmates received from other than an ADCRR facility, and have no medication records, will have their health record reviewed for current medication orders. A health record copy of current medication orders (SOAPE note) or transfer summary will be evaluated at the time of intake and presented to a Vendor Provider for assessment and medication orders. Medication orders will be presented to the vendor pharmacy at intake facilities. Established procedures will be used to obtain medication at the time of intake.

4.0. This interim provision in no way diminishes the obligation of the receiving institution to do intake evaluations in a timely manner and assign inmates to appropriate clinics for continuity of care.

Chapter 5, Sec. 6.2 Outside, Intake and Transfer Medication orders

REFERENCES: DEPARTMENT ORDER 909
NCCHC STANDARD P-E-02
NCCHC STANDARD P-D-02
Arizona Administrative Code R4-23-672

PURPOSE: To provide mechanisms and requirements for continuing prescribed pharmaceuticals ordered by non-ADCRR healthcare entities, to ensure continuity of care for inmates received at intake and to ensure continuity of care for transferred inmates.

RESPONSIBILITIES: The responsible Vendor Pharmacy will provide pharmaceutical support to individual patients in accordance with properly executed medical and nursing Practitioner/Provider orders.

PROCEDURES:

1.0. Outside Prescription Orders:

1.1. Externally generated prescriptions from referral health care Practitioners/Providers (off complex trips and hospitalizations) will be referred to a Vendor Practitioner/ Provider for review. Prescriptions written by consultants must be evaluated and rewritten (if determined to be necessary) by authorized ADCRR health care vendor.

1.2. The Practitioner/Provider must evaluate the medication order. If a non-formulary medication is required to treat a condition, the Provider will submit a non-formulary drug request along with the prescription to the authorized medical representative for evaluation. A response to the issuing provider with shall occur within 2 business days of the dated request or prescription order, indicating approve, disapprove, ATP. The Vendor Pharmacy will process the Non-Formulary Drug Request upon receipt. "If a Non-formulary medication is an urgent request, the process must be expedited and obtained by offsite backup pharmacy until the Non-Formulary is approved or denied." MSTM Chapter 4, Section 1.6 (1.1).

2.0. Intake Prescription Orders:

2.1 Vendor Services at any receiving institution may continue an inmate's current medication by receiving a Vendor Practitioner/ Provider's order pending intake evaluation by a Vendor Practitioner/ Provider at the receiving institution. No continuation of medication per existing Vendor nursing protocol shall remain in effect after its expiration date unless specifically authorized by the provider (This interim provision in no way diminishes the obligation of the receiving institution to do nursing intake evaluations, chart reviews, or provider evaluations in the required and timely manner.)

2.2 Intake and Return to Custody inmates received after normal clinic hours with documented current use medications may be continued on their medications. The Vendor Medical Practitioner/Provider or

Mental Health Practitioner/Provider may order a new prescription for the medication for up to 42 days. If the medication is not in current stock, the nurse shall call the prescribing Provider/Practitioner or on-call provider for direction and therapeutic alternatives. All medication shall be filled by offsite backup pharmacy, if necessary, to maintain the continuity of care.

2.3 Parole violators in need of medical care/prescription medication shall be seen by the Vendor Practitioner/Provider or a verbal order may be obtained at the time of reception and assessment. The Practitioner/Provider should evaluate the medication order and prescribe appropriately. If it is determined that a Non-Formulary medication is needed for continuity of care or mental health stability, a Non-Formulary drug request must be submitted and approved to continue the Non –Formulary medication. A Vendor Practitioner's/Provider's name should not be used to automatically renew the inmates' medication at the receiving facility.

2.4 All Intake Medications shall be bridged "continued" by the Vendor for up to 42 days so as to maintain the continuity of care. The Provider/Practitioner shall also have the authority to discontinue/change existing therapy upon a face to face documented evaluation of the inmate. If an inmate is in immediate danger or an urgent/emergent situation arises as the result of therapy (ie allergic reaction, drug interaction, toxicity etc.) the Provider/Practioner shall have the authority to discontinue/change medication without a face to face evaluation.

3.0 Patients not seen by Vendor Practitioner/Provider at intake.

3.1 Orders from transfer summaries from the sending facility for inmates coming from county jail or other correctional systems shall be reviewed and either counter-signed, rewritten or obtained by verbal order from the Vendor Practitioner/Provider at the time of intake at the reception facility.

3.2 All prescriptions shall be evaluated by the Vendor Practitioner/Provider for appropriateness.

4.0 Patients seen by the Vendor Practitioner/Provider at intake.

4.1 Orders for patients who have gone through assessment and evaluation by the Vendor Practitioner/Provider at the intake facility may be written for up to 1 year as formulary guidelines and MSTM permits.5.0 Documentation of Intake Orders.

5.1 All intake orders will be documented by the Vendor Nurse or the Vendor Practitioner/Provider on the prescription and in the health record. Any changes to the orders obtained through the Vendor Pharmacy will be documented by a S.O.A.P.E. note and sent to Medical Records.

6.0 Prescriptions will not be voided upon transfer of an inmate.

6.1 When an inmate is transferred to another facility, medication orders can be continued to the new facility and extended up to the expiration date of the prescription (if appropriate and indicated) and then becomes void. An intake review must still be completed by nursing.

7.0. Prescriptions will NOT be void upon transfer of an inmate. When an inmate is transferred to another facility, medication orders can be continued to the new facility and extended up to expiration date of the prescription (if appropriate and indicated) and then becomes void. An intake review must still be completed by nursing.

8.0. In the event an inmate leaves ADCRR's custody and is transferred with medication to a private prison facility, the inmate shall retain and continue all KOP and DOT medications in an effort to maintain continuity of care until the inmate is seen by a health care practitioner or submit a Health Needs Request (HNR).

Note: Removed: "Practitioner shall order no more than the maximum dosage approved by the FDA for any medications regardless of the amount the inmate was formerly receiving.

Chapter 5, Sec. 6.3 Adverse Drug Reactions

REFERENCES: ARIZONA REVISED STATUTES R4-23-672
NCCHC STANDARD P-D-02

PROCEDURES:

1.0. When an adverse drug reaction is suspected, the Vendor's Nurse, or Vendor Pharmacist will notify the attending Vendor Health care Practitioner/Provider for their review.

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

2.1. The reaction will be recorded by the Vendor staff on Form-FD 1639a or FDA Form 3500 (6/93) and a sent to the MS Pharmacy Monitor and MS Coordinator. The Vendor Pharmacist will evaluate and forward appropriate reports to the FDA at:

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

3.0. The Vendor Pharmacist will report to the FDA by calling 1-800-FDA-1088.

Chapter 5, Sec. 6.4 Medication Administration

REFERENCES: DEPARTMENT ORDER 702
NCCHC STANDARD P-D-02
NCCHC STANDARD P-C-05
NCCHC STANDARD P-I-06

PURPOSE: To establish a procedure for the general administration of medications to inmates, including unit dose and insulin medications.

RESPONSIBILITIES: It is the responsibility of the Vendor Supervisors to assure compliance with this procedure. The Vendor Complex Director of Nursing (DON) and unit Charge Nurses are responsible to ensure that pre-pouring (preparation) of medications is performed only in accordance with this policy and that all administration activities are performed within the guidelines of the Nursing Practice Act. The Vendor complex DONs are responsible to ensure that all vendor nursing staff follow this policy.

PROCEDURES:

1.0. General Procedures: Prescription medications are administered to inmates only upon the order of a vendor Health Care Practitioner/Provider, Dentist, Psychiatrist/Mental Health Practitioner or other legally authorized individual. Medications are prescribed only when clinically indicated. A quick reference is provided in the table below this policy.

1.1. All Controlled Substances and Tricyclic antidepressants will be Direct Observe Therapy – DOT only (Formerly called Watched Swallow).

1.2. All controlled substances shall be administered by DOT.

1.2.1 Mental Health Practitioners can restrict use to DOT as necessary in individual patients.

1.2.2 In addition, patients housed in CDUs under Mental Health Watch or Suicide Watch will have all their medication administered by DOT with no exceptions.

1.2.3 Diflucan: When Diflucan is ordered for pulmonary or disseminated coccidioidomycosis, the prescription must be annotated as a required "DOT."

1.3. The Vendor Pharmacy shall be notified of the change of a medication to a DOT by receiving a new order from the Practitioner changing the KOP medication to a DOT medication.

2.0. Medication Administration Lines for DOT medications (Med Lines) and Insulin delivery:

2.1. Med lines will be conducted at regularly scheduled times as determined by the Vendor FHA in consultation with the Deputy Warden. Medication refills and new medication orders may be picked up during this time ONLY if authorized by the FHA.

2.1.2 Med-lines will be conducted at the health care units or other location mutually agreed upon by the FHA and Deputy Warden. Requests for medications may only be approved or disapproved by the Facility Health Administrator following review of the situation, patient needs, and staffing issues.

2.2. Med-line medications to inmates in the Lock-down Units will be administered to the inmates by the Vendor health care staff assigned those responsibilities.

2.3. Medications administered at the med-line are determined by Central Office Contract Monitoring Bureau Health Services policy. No medications may be added to the list without prior approval from the ADCRR/Contract Vendor combined P&T Committee.

2.4. Exceptions are made via physician to physician authorization received from Vendor Medical Director for individuals that are suspected of abusing or misusing their medications; including non-compliance.

3.0. Directly Observed Therapy. Administering medications occupies a disproportionate amount of nursing time compared to Keep-on-Person medications. Vendor Practitioners should review and approve unit dosage medications administration of these prescriptions.

3.1. Dosing schedules for approved DOT drugs shall be prescribed at their least frequent dosing interval as appropriate. i.e., BID instead of TID or QID.

3.2. All DOT medications are administered directly to the inmates by Vendor Nursing Staff.

3.3. Medications are administered daily at a consistent time and location. The administered of medication is authorized to take place within an hour before the designated time or an hour after. If administered outside of these parameters, the Vendor Nurse must document the actual time of administration on the MAR.

3.4. Directly Observed Therapy may be ordered by any Vendor Practitioner.

3.5. Documentation of receipt (or non-receipt) of the medication by the inmate is completed by Vendor Nursing Staff in a Medication Administration Record (MAR). The health staff member responsible for the nurse's line will ensure that all documentation is complete. Vendor nursing staff shall document the administration of unit dose medications on the MAR. The inmates' medication record will be initialed in the appropriate time slot which will signify that the complete dose was administered.

3.6. Prior to the medication being administered to the inmate, the nursing staff member must verify the medication against the MAR to ensure the appropriate person, dosage, time, route, medication.

3.6.1 The MAR must accompany the nursing staff member during administration of the medication.

3.6.2 As soon as the medication is administered the nursing staff will document on the MAR. Pre-charting of medication administration on the MAR is not authorized.

3.6.3 Variances from the complete dose being administered will also be annotated on the MAR (e.g. "refused", "1 tab").

3.7. When unit security necessitates, medications may be administered through food traps in the cell door.

4.0. <u>Refusal of Psychotropic Medications</u> by any inmate may exacerbate a mental health condition. Refusal by an inmate on Mental Health or Suicide Watch is of particular concern. The following will be required for Vendor nursing personnel.

4.1. The refusal by inmate of prescribed psychotropic medication for a greater than three day period must be reported to the Vendor unit Mental Health staff.

4.2. If no Mental Health personnel are present on site, the urgent notification list for Mental Health personnel will be utilized for purposes of this notification.

4.3. For purposes of this directive, the notification to Mental Health personnel of a refused psychotropic medication shall occur immediately after returning from medication administration rounds.

4.4. The Vendor Health Staff who attempted to administer the medications will document the refusal immediately upon return to the nursing unit and after rounds are completed.

4.5 The refusal by an inmate of prescribed medications for greater than three (3) day period must be reported to the Vendor's Health Care Practitioner for further action.

5.0. Any Vendor Health Care Staff member may temporarily restrict a Keep-On-Person medication to DOT for/with cause for a period not to exceed ten days. If the patient has not seen a Vendor primary care Practitioner by the tenth day, the restriction will be ended unless extended by authorization of the Vendor complex Medical Director in consultation with the Vendor complex DON. The complex Medical Director will document any decision to continue in the patient's health record.

5.0.1 All medications will be "DOT" to inmates on suicide watch.

5.0.2 Any medication may be "DOT" for security reasons, non-compliance, or suspected abuse/misuse until the Vendor primary care Practitioner can review and evaluate the inmate.

5.0.3 All information supporting the need to have a medication administered by "DOT" will be documented in the inmate's medical record and the treating Practitioner will be notified. Additionally, the Vendor Pharmacy will be notified for implementation.

6.0. Emergency and After Hours Prescriptions for Narcotics and Psychotropic: Inmates developing acute symptoms after normal clinic hours that, in the opinion of the Vendor attending medical staff, are in need of psychotropic medications or controlled substances, CII- CV, will be referred to the appropriate Vendor Practitioner on-call for direction and a verbal order for medication if necessary. A verbal order for medication may be given for up to 4 days for psychotropic medications and up to 4 days for pain medications. Vendor health staff will obtain and document consent from the inmate before administering any psychotropic medication.

6.0. Insulin administration lines:

6.1. Insulin will be drawn up by the Vendor health staff.

6.2. The syringes will be checked out from the nurses supply inventory. In the interest of security, the syringe will NOT be handed to the inmate for self-injection. The syringe will be discarded by the staff member administering the injection in accordance with OSHA standards in an approved sharps container as soon as possible.

6.3. Medication refills and new medication orders may be picked up during this time ONLY if authorized by the Vendor FHA.

6.4. The only exception to the guidance in 6.2 above is in the case of discharge supplies and self-administration training for inmates within 30 days of being released.

7.0. INH medication must be administered as a DOT medication. The inmate will be seen on Vendor nurse's line once a month to be monitored for their chronic condition (positive PPD).

7.1. If the inmate is assigned to an off-site work crew, the unit Nurse is to provide initial education regarding adverse side effects when the medication is first ordered. The inmate must be instructed to notify the Nurse if they notice these signs and symptoms by submitting a HNR. The education and any report of signs and symptoms will be documented in progress notes. This group of patients is exempt from monthly nurses' line and DOT.

Chapter 5, Sec. 6.5 Narcotics Accountability

REFERENCES: Arizona Administrative Code R4-23-672
Arizona Administrative Code R4-19-207 and 208
NCCHC STANDARD P-D-01

PURPOSE: The purpose of this procedure is accountability of controlled substances (narcotics) within the prison environment.

RESPONSIBILITY: It is the responsibility of the Vendor complex Director of Nursing (DON)/Dental Director or designee to ensure that all licensed Vendor Nurses/Dental staff are trained in recording, counting, and verifying narcotics (controlled substances) for their assigned area.

PROCEDURE:

1.0. Narcotics will be counted every shift according to the following criteria:

1.1. A licensed Vendor Nurse will be accountable for the narcotic cabinet keys and will be the contact person for accessing narcotics. The larger facilities must control keys in a safe and logical manner. For example, if a large facility has three or less licensed Vendor's Nurses on duty for the entire complex after hours and on weekends, then each Nurse may be authorized by the Vendor FHA to carry a set of narcotic keys. This flexibility does not apply to smaller complexes such as Alhambra, Apache, Winslow, Fort-Grant, and Safford. A back-up should be maintained in accordance with complex security restricted key processes.

1.2. Narcotics will be counted at the end of every shift by two licensed Vendor Nurses. The two licensed Nurses shall count the narcotics upon arriving and departing from their assigned post of duty.

1.3. The health unit that is open for services will have a narcotic count prior to closing the unit for the evening or night shift.

1.4. Only exception to the rule of two licensed Nurses counting narcotics is that time when only one licensed Nurse is available, in this case then security person may count with the licensed Nurse.

1.5. If a closed health unit is opened for an emergency the licensed Nurse is to count the narcotics with another Nurse or security personnel only if the narcotics are accessed prior to departure.

2.0. Narcotic Storage and Access: All narcotics including Clinic Stock and individually prescribed medication are to be segregated from all other medications. The narcotics are to be under double lock and key. Narcotic must be stored in cool place/medication room. Only one designated licensed Vendor personnel will have access to the narcotics per shift. This designated licensed personnel who has access to the narcotics, is accountable for recording the administration of narcotics in the narcotic count book.

3.0. Narcotic Recording: A Narcotic count book shall be kept on every unit that has narcotics along with a narcotic log form for each individual narcotic. As narcotics are removed from the narcotic stock, or individual's narcotic prescription, the designated licensed personnel will enter in the inmate's name who is receiving the narcotic, the date, time, amount remaining via actual count, inmate ADCRR# and the Vendor Nurse's signature. Every shift that the health unit is open, counting of narcotics will occur with proper documentation of each narcotic amount, date, and time. The narcotics counting process is that one Nurse actually counts the pills and reports to the other Nurse the number of pills while the other Nurse verifies that the narcotic log form count matches the pills actually counted as being correct. Both licensed Nurses sign the narcotic log form with their signature stating the narcotics are accounted for.

4.0. Narcotic Accountability Error: If an error in the count occurs while narcotics are being counted, the counting process is to continue till the count is finished. The log sheet of the particular unaccountable narcotic will be pulled from the log book during the counting process.

4.1. The designated licensed Vendor Nurse who carried the keys for that particular shift will track the unaccountable narcotic.

4.1.1 The Nurse must identify those who were administering medication.

4.1.2 Identify the patient with the particular medication/narcotic prescription when it was last administered.

4.1.3 Check for misplacement of the narcotic in medication room.

4.1.4 If the medication is accounted for there is no further intervention needed. If the narcotic is not accounted for, a Medication Incident Report form and an IR will be completed.

4.1.5 The licensed Nurse is responsible to immediately report the incident to the Vendor complex DON.

4.1.6 The Vendor DON reports to the Vendor FHA, the FHA reports to the Vendor Pharmacy, ADCRR pharmacy Monitor and Vendor Pharmacy Director.

4.2. Narcotic Unaccounted for: The Vendor FHA will perform his/her own internal investigation and send final report to the Vendor Pharmacy Director. A final report is sent to the Vendor Regional Pharmacy Director, and MS Contract Monitoring Authority. In the case of lost or stolen Controlled Substances, regardless of quantity or circumstances, the Arizona State Board of Pharmacy as well as the DEA shall be formally notified of such loss or theft. A DEA 106 Form shall be completed for each loss or theft. Proof of formal notification to the respective governing authorities shall be supplied to the Department Pharmacy Contract Monitor.

Chapter 5, Sec. 6.6 Medication Error Reporting

REFERENCES: ARIZONA Administrative Code R4-23-672
NCCHC STANDARD P-D-01
NCCHC STANDARD P-D-02

PURPOSE: To ensure that all pharmaceuticals and the pharmacy inventory is accounted for and actively managed at each Facility Health Unit and Vendor Pharmacy at all times.

PROCEDURES:

1.0 When a Medication Incident Report is needed due to a nursing delivery/administration error or a pharmacy error discovered after the prescription has been dispensed), the following will be performed.

1.1 A Medication Incident Report (form 70400033) will be completed and submitted to the Vendor FHA who will provide a copy to the Vendor Pharmacy Director, complex Director of Nursing (DON), Vendor Regional Medical Director, ADCRR Pharmacy Monitor, and ADCRR MS Coordinator (Nurse Monitor). The Medication Incident report will include:

1) Inmate's name
2) Inmate's number
3) Date
4) Prescriber's name
5) Name or person that made the error
6) Name of person discovering the error
7) Description of error
8) Action taken after discovery of error, (patient and prescriber notification etc.)
9) Other relevant information to the incident

2.0. When an inmate has taken a medication that is in error, staff finding the error must ensure that the Vendor Pharmacy, ADCRR Pharmacy Monitor and MS Coordinator are immediately informed. The Vendor Pharmacist will notify the prescriber of the error and assist the Practitioner to perform any corrective action. The individual identifying and/or reporting the error must document the incident in the SOAPE notes.

3.0. The Vendor Facility Health Administrator will direct, via post order, which types of medication errors require staff to complete an Information Report (Form 105-2pf/40000029). Examples of possible reasons may include patterns, adverse outcomes, involvement of security in caring for the inmate, etc.

3.1. The individual identifying the error shall forward the Information Report and the Medication Incident Report to the Vendor Pharmacy Director, ADCRR Pharmacy Monitor and ADCRR MS Coordinator (Nurse Monitor) for review.

3.2. The Vendor Pharmacy will, utilizing existing protocols, review and act on the Medication Incident Reports. A copy of the Information Report will be kept on file indefinitely in the Pharmacy that fills prescriptions for the Facility.

Chapter 5, Sec. 7.0 Clinical Follow Up Requirements

REFERENCES: NCCHC STANDARD P-E-12

PURPOSE: To establish procedures for Vendor health staff to use when following pending health care issues.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Facility Health Administrator and Vendor Supervisory Staff to assure that Vendor staff complies with this procedure. Responding to and informing patients of outcome of clinical activity (especially abnormal results) remains the primary responsibility of the Vendor attending Physician, Vendor Nurse Practitioner, and Vendor Physician's Assistant.

PROCEDURE:

1.0 All Vendor Clinical Practitioner/Provider Staff or designee is responsible to track diagnostic reports and consultation requests for their patients. Vendor Medical Providers shall write orders for diagnostic tests and consultation requests as necessary and track these or by ordering appropriate and timely follow-up visits or chart review so that they can follow up to assure they receive results.

2.0 Diagnostic and consultation reports must be reviewed within 7 days of receipt at the facility and the review documented by the Vendor Practitioner/Provider, signed, stamped (if paper health record) and dated prior to input into the health record. Abnormal reports shall be acted upon by the Medical Practitioner within five calendar days of receiving the abnormal report.

2.1. If the inmate is being transferred to another unit, and the report has not been reviewed and signed, the report is to be transmitted electronically, or if paper records are being utilized, placed on top of the SOAPE divider so the transferring unit can route the chart. The information/chart transferred should be adequately available to prompt and support the Vendor Practitioner assigned to that unit to render treatment if indicated.

2.2. Vendor Dental Practitioner staff or designee shall track any Consultation Report that the Vendor Dentist submits to assure that the referral to the outside consultant occurs in a timely manner.

3.0. Vendor Lab staff shall collect specimens and send them to the Vendor's reference laboratory; follow-up on pending lab results with the reference laboratory; forward lab results to the appropriate Vendor Practitioner for review; and notify the Practitioner immediately of any critical results.

4.0. The Vendor Clinical Coordinator will follow up with the Vendor's approving authority on any outstanding Consultation Reports pending approval after FIVE BUSINESS DAYS and inform the Vendor FHA and complex Medical Director of these pending reports. Refer to MSTM 7.2.0 for specific guidance in Clinical Coordination of outside consultations**.** The Clinical Coordinator shall, in accordance with MSTM 7.2.0, place a medical hold on inmates who have a scheduled appointment with an outside consultant. They shall also follow up and remove these holds after the inmate's appointment with the consultant.

5.0 Vendor Nursing staff shall note orders from the Practitioners/Providers and follow through to assure that the order is completed as ordered by the Vendor Practitioner; follow up with the Practitioner, forward the appropriate information/request to the Vendor's Clinical Coordinator, or other responsible staff to ascertain the status of a pending order (e.g., status of medical shoes ordered for an inmate); track and place inmates with chronic conditions on the provider line to assure that they are seen every six months, or as ordered by the Practitioner; plan PPD testing as appropriate and read the PPD skin test at 48-72 hours (this includes assuring that an annual PPD test or follow-up is completed for each inmate on the unit).

5.1. Responsibility to notify a patient regarding abnormal laboratory/testing findings may not be delegated by the Vendor Practitioner to Vendor nursing staff.

6.0. Vendor Radiology Technologist shall maintain a tracking log of x-rays sent to the reference Radiologist that, at a minimum, notes inmate name, ADCRR number, date x-ray sent to the Radiologist and date report is received from Radiologist. The Radiologist Technologist shall follow up with the Radiologist if reports are not received within the amount of time specified by ADCRR MS Contract Vendor. Notify the Vendor FHA and Vendor complex Medical Director if any delays in receiving reports.

7.0. Upon receiving the appropriate order, Vendor Medical Records staff shall place a medical hold on inmates who have a scheduled appointment with an outside consultant. They shall also follow up and remove these holds after the inmate's appointment with the consultant.

Chapter 5, Sec. 7.1 Missed Appointments

REFERENCES: ARIZONA REVISED STATUTE 31-201.01
DEPARTMENT ORDER 1101
NCCHC STANDARD P-E-07

PURPOSE: This policy is provided to guide ADCRR MS Contract Vendor staffs' response to, and documentation of, medical or dental appointments that were not completed.

RESPONSIBILITY: The ADCRR Health Services Contract Vendor holds a responsibility to make every effort to ensure that inmates are provided required health care in a timely manner.

PROCEDURE:

1.0. Missed Appointments can occur for a variety of reasons as a result of inmate personal decision-making or security generated complications. As a general rule, any missed appointment needs to be reviewed to determine the need for rescheduling the appointment and to allow administration to consider modifications to processes. This evaluation must be performed on a comparative priority basis in order to determine whether the inmate should be seen prior to existing appointments or the appointment should be cancelled altogether.

2.0. If the ADCRR Health Services Vendor professional personnel are unable to see all of the inmates appointed on the day's appointment turnout list, any inmates that were not seen will be rescheduled to be seen as early as possible and at the next available appointment time.

3.0. If Security is unable to turn out the inmates as previously scheduled, an Information Report (or memorandum) will be written from the Vendor Facility Health Administrator to the Deputy Warden of the respective yard requesting an explanation of why Security was unable to turnout the named inmate to health services at the requested appointment time.

3.1. Repeated impediment to inmate-patient health care delivery on a yard will be referred to the Warden for review.

Chapter 5, Sec. 7.2 Appointment or Treatment Refusals

REFERENCES: ARIZONA REVISED STATUTE 31-201.01
DEPARTMENT ORDER 1101
NCCHC STANDARD P-E-07
NCCHC STANDARD P-I-06

PURPOSE: A process for documentation of an inmate's refusal to attend an appointment or accept treatment for a specific health issue.

RESPONSIBILITY: The ADCRR MS Contract Vendor is responsible to make every effort to ensure that inmates are provided required health care in a timely manner. It is the responsibility of the Vendor Supervisory Staff, to ensure pertinent Vendor staff obtains an inmates' refusal to accept recommended treatment for a known, potential, or suspected health problem.

GENERAL PROCEDURE:

1.0. Cancellation Acceptance:

1.1. An inmate may refuse an appointment that was created by his/her HNR for limited medical attention on the Nurses' line (such as cold symptoms that have improved since submitting the HNR). If the inmate later changes his/her mind, he/she may seek and be provided treatment again.

1.2. HNR requests that have resulted in scheduling with the Vendor's Practitioner/Provider, Mental Health Practitioners, and Dental staff, cannot be cancelled by the inmate without coming to medical to complete the Refusal to Submit to Treatment form. Vendor staff will document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.3. Requests for medical attention, that might suggest a serious medical condition, and is directed to the Vendor health staff, who is scheduled to see the patient, cannot be refused except by coming to the health unit to discuss the impact of refusing care and treatment for the identified medical issue. Vendor staff will document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.4. Appointments initiated by Vendor Nursing and/or the Vendor Medical Practitioner as follow up visits, counseling, additional procedures, lab testing, medication lines, immunizations, etc. cannot be cancelled by the inmate without coming to medical to sign a refusal. Vendor staff will document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.5. Appointments for telemedicine services may only be refused at the telemedicine location in order to permit full disclosure to the inmate by the medical Specialist of the medical consequences of his refusal.

Vendor staff will document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

1.6. Refusal of appointments for off-site medical care by specialists must be completed by the inmate, in person, AT THE INMATE'S TREATING HEALTH UNIT whenever possible based on availability of the Vendor health staff to take the refusal. Vendor staff will document their efforts to explain the consequences of this refusal including the potential delay in rescheduling the appointment.

2.0. Documentation: The inmate must document his refusal by properly completing and signing the Refusal to Submit to Treatment (Form #1101-4P) and submitting it to the Vendor health services.

2.1. If completed in the health unit, or before a Vendor Health staff member, the placement of the inmate's signature on the form or electronically, must be witnessed by one Vendor health staff member.

3.0. If an inmate refuses to accept treatment or sign a Consent to Treat form, Vendor Nursing staff will:

- 3.0.1. In language the inmate can understand explain the consequences of his/her refusal to accept the proposed procedure/treatment.
- 3.0.2. Document exactly what was told to the inmate regarding the refusal of the procedure/treatment on the Refusal to Submit to Treatment form (Form #1101-4P or 1101-4PS).
- 3.0.3. Request the inmate to sign and date the completed Refusal to Submit to Treatment (Form #1101-4P or 1101-4PS) form before two witnesses.
- 3.0.4. Have the witnesses sign the completed form.
- 3.0.5. File/place or scan the completed form in the Legal Section of the inmate's health record. The completed form is to be filed/placed or scanned in section three of the inmate's health record under the Consent Refusal of Treatment tab.
- 3.06. All cancelled or rescheduled lines must be documented by a qualified Vendor health care professional. The documentation shall show the reason for cancellation and rescheduling of line(s).

4.0. If the inmate refuses to sign the refusal form, the Vendor Nurse will:

- 4.0.1. Document the refusal on the Refusal to Submit to Treatment form.
- 4.0.2. Have two witnesses sign the refusal form.
- 4.0.3. File or scan the completed form in the health record under consents/refusal section.
- 4.0.4. Document the inmate's refusal to sign the refusal form in a SOAP form in the Health Record.
- 4.0.5. The completed form is to be filed/scanned in Section Three (3) of the inmate's health record under the Consent Refusal of Treatment tab.

5.0. If Security is unable to turn out the inmates as previously scheduled and a refusal is not received as required, the Vendor Facility Health Administrator will write an Information Report (or memorandum) to the Deputy Warden of the respective yard requesting a response as to why Security was unable to turnout the named inmate to health services at the requested appointment time. Repeated complications on a yard will be referred to the Warden for review.

6.0. If an inmate refuses treatment or service more than three consecutive times (e.g. FSBS, health care Practitioner ordered evaluation, etc.), the inmate will be counseled and documented by a qualified Health Care Professional. The patient's HCP will review the chart or see the patient for possible new orders. This is not meant to preclude earlier intervention as the attending Practitioner/Provider determines is necessary to protect the health of the patient.

7.0. If the inmate changes his/her mind, he/she may seek and be provided treatment again.

Arizona Department of Corrections Rehabilitation & Reentry	Health Services Fees	OPR: MS Contract Vendor Regional Director of Nursing (RDON) MSCMB MS Coordinator (Nurse Monitor) Auth: kc
Medical Services Technical Manual	MSTM Chapter 5 Section 8.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 5, Sec. 8.0 Health Services Fees

REFERENCES: Arizona Revised Statutes 31-201.01
DEPARTMENT ORDER 916

PURPOSE: To provide consistent criteria for charging for Health Services received by inmates within the Arizona Department of Corrections Rehabilitation & Reentry or other contracted facility. To ensure that medical visits by inmates who are exempt do not have fees deducted from their accounts.

RESPONSIBILITY: It is the responsibility of the Vendor Facility Heath Administrator to ensure Vendor health staff complete and forward original appointment lists to the business office each day. Vendor health staff will insure that inmates are being charged as authorized and directed in Department Order 1101 and ARS 31-201.

PROCEDURE:

1.0. AUTHORITIES: The authority to waive any charges other than those defined by ARS 31-201.01 is restricted to the Director of the Department of Corrections.

2.0. PROHIBITION OF CARE DENIAL: No inmate will be denied care due to lack of funds. No inmate will be denied care due to being indigent. He/she will be seen by Vendor health care staff. The Business Office will place a $4.00 hold on their bank account for the visit.

3.0. CHARGING PROCEDURES: (Refer to Department Order 1101). Inmates will be charged per Department Order 1101 and ARS 31-201. Inmates may be charged $4.00 co-pay for their health care visit.

3.1. The Vendor Nursing staff shall complete the Appointment List (# 1101-13P) prior to the visit. Upon completion of the Health Appointment List, Nursing shall indicate if the visit is a Charge or No Charge (in the appropriate column). If the visit is a No Charge, Nursing shall place the appropriate exemption code (below) in the charge column of the Health Appointment List. NOTE: If the Shift Supervisor has requested an unscheduled security-need-to-know examination the Health Appointment List will indicate a No Charge.

3.2. At the time of visit the charge status will be indicated and the inmate must sign before being seen for treatment.

3.3. The completed original of the appointment list will be submitted to the complex Business Office within **72 hours of completion** of the health services appointment and the copy retained on the Health unit for 1 year.

3.4. One of the most common inmate requests is to waive the charge. This may not be done. The Fee-For-Service is a Vendor Nursing procedure and a Mid-Level or primary care Practitioner (Provider) does not have the authority to alter a fee.

4.0. Should an inmate dispute any charge he/she can have it reviewed by submitting an Inmate letter to the Vendor FHA.

4.1. The following method shall be used by the inmate in accordance with Department Order 916. The inmate shall acquire a copy of his account report; highlight the disputed charges; and forward the report to the FHA with justification regarding why the account should not be charged.

5.0. FEE WAVIER PROCEDURE: Except as provided in this document, every inmate shall be charged a reasonable medical and health services fee for each medical visit an inmate makes pursuant to a health needs request form or for emergency treatment.

5.1. The ADCRR Director shall exempt certain inmates, or medical visits by inmates, from payment of medical and health services fees and fees for prescriptions, medication or prosthetic devices. The Director exempts the following inmates, or medical visits by inmates, from payment of health services fees and fees for prescriptions, medication or prosthetic devices:

5.1.1 Medical visits initiated by the Vendor Medical or Mental Health staff of the department.

5.1.2 Medical visits to a Vendor Physician by inmates who are referred by a Vendor Physician Assistant or Vendor Nurse Practitioner, or visits due to work related injuries.

5.1.3 Inmates at reception centers.

5.1.4 Juvenile inmates.

5.1.5 Pregnant inmates.

5.1.6 Seriously mentally ill inmates. For the purposes of this paragraph, "seriously mentally ill inmates" means inmates who as a result of a mental disorder as defined in section 36-501 exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the general prison population without supportive treatment or services of a long-term or indefinite duration and whose mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living, including interpersonal relationships, self-care, employment and recreation.

5.1.7 Developmentally disabled inmates who are housed in a special programs unit.

5.1.8 Inmates who are inpatients at the Alhambra prison facility special programs psychiatric hospital.

5.1.9 Inmates who are inpatients at the Flamenco prison facility mental health treatment unit.

5.1.10 Inmates who are undergoing administrative physical examinations for fire-fighting crews.

5.1.11 Inmates who are undergoing follow-up medical treatment for chronic diseases listed in DO-1101.

5.1.12 Any condition requiring regular examination, treatment or follow up as determined and documented by an ADCRR Contract Vendor Healthcare Practitioner/Provider.

5.2. Obviously many more disorders will be seen on a repetitive, persistent basis. As described above, the fee waiver will occur if a return visit is initiated by the Provider at the time of visit, e.g. a follow-up in 7 days, etc. Thus no Health Needs Request Form would be required. If an HNR (Form # 70400152 or 70400152ES) is needed to be seen, a charge may be indicated. The Vendor Nurse determines “Fee” status of the visit.

5.3. All visits in the IPC will be provided on a No Charge basis using the appropriate exemption code in the charge column of the Health Appointment List. Inmates assigned to C19, C42 and C44 at ASPC Florence; inpatients at the Alhambra Special Psychiatric Hospital and the Flamenco Mental Health Center at ASPC Phoenix. Per DO 1101.

6.0. The following Exemption Codes are authorized for entry into the appointment and charging documents and will be tracked via database processes:

NC-1 Medical visit initiated Vendor by Practitioners/Providers. (This does not include weights, blood pressure checks, or prn visits).

NC-2 Inmate processing through Reception Center

NC-3 Juvenile

NC-4 Pregnant
NC-5 Seriously Mentally III
NC-6 SPU SMI ONLY (Aspen and WTU at PV complex)
NC-7 HU8 ASPC-Florence
NC-8 Inpatient at ASPC-Phoenix (Mental Health Units)
NC-9 IPC Patient (ASPC-Florence, Tucson, Lewis and Perryville)
NC-10 Administrative Examinations (Food Service, Fire Crew, Parole, etc.) to include:
- 10.1 PPD's
- 10.2 Lab
- 10.3 X-Ray
- 10.4 Chronic conditions (as listed in DO-1101 or per NCCHC Guidelines)
- 10.5 Medication delivery
- 10.6 Vital signs
- 10.7 Medical record reviews
- 10.8 Physicals
- 10.9 Treatments
- 10.10 PREA evaluations
- 10.11 On the job injury unless determined to be due to personal negligence by the inmate

Note that NC-1 and NC-10 are not to include intakes, or CDU visits (Nurses Line).

Chapter 5, Sec. 9.0 Oral Health Care Services

REFERENCES: DENTAL TECHNICAL MANUAL
NCCHC STANDARD P-E-06

PURPOSE: To provide consistent guidance for providing quality oral health care to incarcerated patients.

RESPONSIBILITY: It is the responsibility of the MSCMB Dental Monitor to provide oversight guidance to ADCRR MSCMB in the monitoring of oral health care that is provided in ADCRR Department of Corrections by the MS Contract Vendor.

PROCEDURES:

1.0. The guidance is found in MSCMB Dental Technical Manual, dated June 2017.

Arizona Department of Corrections Rehabilitation & Reentry	Health Education and Promotion	OPR: MS Contract Vendor Regional Nurse Educator MSCMB Contract Evaluation Administrator MSCMB MS Coordinator Auth: kc
Medical Services Technical Manual	MSTM Chapter 6 Section 1.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 6, Sec. 1.0 Health Education and Promotion

REFERENCES: NCCHC STANDARD P-F-01

PURPOSE: The ADCRR Health Services Contract Vendor will provide information and services that promote health status, prevent disease, provide early detection and treatment of disease, and teach self-care.

PROCEDURE:

1.0. Inmates will be provided education and counseling for general health maintenance and self-care throughout incarceration.

2.0 Inmate newsletters, if available, shall regularly contain health related information.

3.0. Programs to improve the health status of inmates may be offered on an individual and group basis.

4.0. Inmates with chronic diseases will be provided with information that is designed to increase their ability to monitor and manage their health status.

5.0. Inmates will be informed at the end of the Intake Health Assessment of the recommended schedule for preventive health care exams.

Chapter 6, Sec. 2.0 Tobacco Use

REFERENCES: DEPARTMENT ORDER 109
NCCHC STANDARD P-F-05

PURPOSE: To provide guidance regarding tobacco use in ADCRR Health Facilities.

RESPONSIBILITY: Department Order 109 describes the Department policies regarding smoking. All Health Services Contract Vendor staff are responsible for monitoring and supporting the following regulations in all Department institutions and offices, including rental and contract properties.

PROCEDURE:

1.0. General Complex guidance: Smoking shall be limited to outside areas only. Outside smoking areas shall not subject normal traffic to second-hand smoke, e.g., smoking shall be prohibited near entrances to buildings.

1.1. All used smokeless tobacco (chewing tobacco, plug tobacco and/or snuff) shall be disposed of in a covered receptacle; i.e., an empty soda can or closed styrofoam cup.

2.0. Inmate Tobacco Use

2.0.1. Smoking cessation information shall be made available to inmates. The Vendor health staff will make information available to inmates who request assistance with cessation of use of tobacco products.

2.0.2. Inmates shall not smoke inside any building, including but not limited to the housing areas, visitation areas, kitchens and warehouses within the prison.

2.0.3. Smoking and the possession of tobacco and all smoking-related materials are totally prohibited by inmates placed in: Reception centers, Minors units, all detention units, including the detention section of Cellblock 6, Special Management Unit I and II, Santa Maria Special Management Area and all Medical Units.

3.0. All inmates will be advised of the tobacco policies by Operations Division staff during Orientation.

Chapter 6, Sec. 3.0 Exercise

REFERENCES: DEPARTMENT ORDER 804
DEPARTMENT ORDER 906
NCCHC STANDARD P-F-03

PURPOSE: To establish a procedure where inmates are offered exercise outside of their cell.

RESPONSIBILITY: It is the responsibility of the ADCRR Contract Vendor Facility Health Administrator and complex Supervisory Staff, to assure that all clinical and ancillary Vendor staff complies with policies that encourage exercise.

PROCEDURE:

1.0. Inmates will be offered exercise outside of their cells in an area large enough to accommodate the activity.

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

3.0. Vendor Practitioners/Providers should consider, if appropriate, exercise as an adjunct to any treatment plan.

4.0. Inmates who are under disciplinary sanctions may have modified exercise capabilities as outlined in the referenced Department Orders and Director's Instructions.

Chapter 6, Sec. 4.0 Personal Hygiene

REFERENCES: DEPARTMENT ORDER 704 DEPARTMENT ORDER 804
DEPARTMENT ORDER 811 DEPARTMENT ORDER 909
NCCHC STANDARD P-F-01

PURPOSE: ADCRR has established in Department Orders, specific guidelines so that inmates can take care of their personal hygiene. These guidelines are further outlined in the prison Complexes documents such as the inmate handbook, facility instructions, post orders, and standard operating procedures. These documents describe bathing schedules, clothing and bedding exchange, laundry facilities, haircuts and shaving arrangements, and the availability of personal hygiene products.

RESPONSIBILITIES: The Warden and MS Contract Vendor Facility Health Administrator hold joint responsibility to ensure that policies and procedures are in place that allows inmates to maintain at least a minimum level of personal hygiene.

PROCEDURES:

1.0. The need to escort segregation inmates for showering and the strain on resources to accomplish this are an important regulator of inmates' ability to shower. From a health aspect, showering every day is a best practice. However, correctional authorities retain final decision-making responsibility in this activity. The availability of a sink, hot and cold running water, wash clotMS, towels and soap in segregation cells does permit sponge bathing. Inmates will be allowed to take a shower in accordance with Department Orders 704, 804 & 811.

1.0.1 Inmates in Complex Detention Units, Security level 1-5, and non 1-5 inmates shall be afforded three showers per week.

1.0.2 Level 4 inmates under Department Order shall be afforded at a minimum three showers per week.

1.0.3 Level 3 inmates under Department Order shall be afforded a minimum of three showers per week.

2.0. Clothing:

2.0.1. In addition to clothing issued when the inmate is received at the institution, an inmate may exchange clothing on an as needed basis as supplies are available.

2.0.2. Laundered clothing is issued to inmates at least once per week if in house laundry facilities are not available for the inmate to launder their own clothes.

2.0.3. Inmates shall receive a change of outer clothing three times a week, a daily change of underwear, and a weekly bed linen and towel change.

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

3.1 Health Services shall write a Special Needs Order for inmates who need additional or alternative feminine hygiene products due to medical issues.

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

5.0. Vendor Medical Practitioners/Providers (through the Vendor Facility Health Administrator and Warden) may approve medical exceptions to laundering and shower frequencies. Exceptions must be documented utilizing the Duty/Special Needs Order.

Chapter 6, Sec. 4.1 Self-Catheterization and Colostomy Care

REFERENCES: Department Order 1101
NCCHC STANDARD P-A-08

PURPOSE: To ensure all inmates who need to perform intermittent self-catheterization or maintain and manage a colostomy, have access to a semi-private area and have been provided the necessary supplies.

DEFINITIONS: A **colostomy** is a surgical opening that is made in the large intestine (colon). After an opening is made, the colon is then brought to the surface of the abdomen to allow stools to leave the body. The opening at the surface of the abdomen is called a stoma. Stool leaves the colon through the stoma and drains into a flat, changeable, watertight bag or pouch. The pouch is attached to the skin with an adhesive (substance that seals the pouch to the skin).

Intermittent catheterization is the temporary placement of a catheter (tube) to remove urine from the body. This is usually done by placing the catheter through the urethra (the tube that leads from the bladder to the outside opening) to empty the bladder.

RESPONSIBILITY: The MS Contract Vendor complex Director of Nursing (DON) shall ensure the inmate's Unit Vendor Nursing Staff have instructed the inmate in proper technique of self-catheterization or colostomy care. The Unit vendor Nursing Staff shall provide the inmate with adequate supplies to meet his/her specific needs. The Vendor's DON shall ensure that the unit Deputy Warden is advised of the inmate's need for a semi-private area to perform intermittent self-catheterization of maintain or manage a colostomy and a Special Needs Order generated.

PROCEDURES:

1.0. Inmates will be afforded adequate supplies to meet their specific needs as ordered by an ADCRR Vendor Medical Provider. Upon the inmate's assignment to a prison unit, or upon his/her return from a medical specialist consultation or service, the Vendor Nursing Staff shall review the inmate's medical record and interview the inmate, determining the type, quantity of supplies, and products the inmate will require.

Chapter 7, Sec. 1.0 Facility Capabilities Supporting Special Needs and Services

REFERENCES: NCCHC STANDARD P-A-08
NCCHC STANDARD P-G-01
NCCHC STANDARD P-G-02

PURPOSE: To provide information in a cooperative effort between the facilities administration and treating clinicians regarding the inmates significant health needs that must be considered in those classification decisions that exist for purposes of preserving the health and safety of that inmate, other inmates, or staff.

RESPONSIBILITY: It is the responsibility of the MS Contract Vendor Facility Health Administrator to work with the Warden to jointly ensure that a cooperative relationship exists between correctional staff and Vendor healthcare staff in the dissemination of vital information relative to the special needs of the inmate population. In cases where those identified needs are of a mental health nature, the Vendor Mental Health Clinician shares that pertinent information with the Vendor Facility Health Administrator.

PROCEDURES:

1.0. Health care needs are to be considered in decisions regarding the inmate's assignment to institutions, work and programming. This consideration is to ensure that inmates with health care problems or limitations are not placed in facilities that are unable to provide health care appropriate for individual needs; and that an inmate who has restrictions is not assigned work or programming that presents a risk of further injury or physical/mental debilitation.

1.2. Correctional and Classification staff must be advised of inmate's special needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication must be documented and performed in such a manner that does not compromise confidentiality of health information.

1.3. Vendor Health and custody staff will communicate about inmates who are: chronically ill; on dialysis; adolescents in adult facilities; infected with serious communicable disease; physically disabled; pregnant; frail or elderly; terminally ill; mentally ill; suicidal; or developmentally disabled.

2.0. MSCMB Medical Program Administrator and Contract Vendor Regional Medical Director will approve for publication, a desktop reference put forth by the Contract Vendor, for use by Shift Supervisors to respond to inmates Chronic Condition Emergencies.

3.0. Information regarding an inmate's health status is found in the Adult Information Management System (ACIS) comments. A health status determination is to be completed when the initial Health Assessment is completed, and/or a new health condition is identified which results in the need for further diagnostic procedures, specialty consults, activity limitations, facility restrictions, health care follow-up, special

housing requirements, other special needs, or, work restrictions and/or an identified health condition is resolved or stabilized, or at the time a change in restrictions has been instituted.

3.1. Food allergies are to be entered into the ACIS to allow other Corrections Divisions (i.e., food service) to access this determination. All other allergies (drug/substance) will be tracked through the Health Problem Summary Listing, health record annotation, pharmacy databases, and red-ink chart entries if paper records are utilized.

3.2. ACIS comments will be documented in the ACIS system in accordance with MSTM policy.

4.0. The following criteria will help the reader to understand facility capabilities and clarify the level of wellness that is needed to assign an inmate to ADCRR complexes. These criteria are subject to change as deemed appropriate.

ASPC-Douglas: Min/Med/Max; Medical Score (Max) M-3; MH Score (Max)-MH-2; Nursing HRS 24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology Associate; Chronic Conditions-All; Corridor Status-No.

ASPC-Eyman: Custody Level-Med/Close/Max; Medical Score (Max) M-4; MH Score (Max)-MH-4; Nursing HRS 24/7; Physician and Mid-Level Providers; On site Dental; Mental Health Staffing – Psychology and Psychology Associates; IPC Beds-No; Chronic Conditions-All; Corridor Facility-Yes.

ASPC-Florence: Custody Level-Min/Med/Max; Medical Score (Max)-M-5; MH Score (Max)- MH-4; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology and Psychology Associate; IPC Beds-Yes; Chronic Conditions-All; Corridor Facility-Yes.

ASPC-Lewis: Custody Level-All; Medical Score (Max)-M-5; MH Score (Max)-MH-3; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology and Psychology Associate; IPC/Special Beds-Yes; Chronic Conditions-All; Corridor Facility-Yes.

ASPC-Perryville: Custody Level-All; Medical Score (Max)-M-5; MH Score (Max)-M-4; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; Onsite Dental; Mental Health Staffing-Psychology and Psychological Associate; IPC Beds-Yes; Chronic Conditions-All; Corridor Facility-Yes.

ASPC-Phoenix: Custody Level-All; Medical Score (Max)-M-4; MH Score (Max)-MH-5; Nursing HRS - 24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychologist and Psychology Associate; IPC Beds-No; Chronic Conditions-All; Corridor Facility-Yes.

ASPC-Safford: Custody Level-Min/Med; Medical Score (Max)-M-3; MH Score-2; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology Associate; IPC Beds-No; Chronic Conditions-All; Corridor Facility-No.

ASPC-Tucson: Custody Level-All; Medical Score (Max)-M-5; MH Score (Max)-MH-4; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Providers; On site Dental; Mental Health Staffing-Psychology and Psychology Associate; IPC Beds-Yes; Chronic Conditions –All; Corridor Facility-Yes.

ASPC-Winslow: Custody Level-Min/Med/Close; Medical Score (Max)-M-3; MH Score (Max)-MH-2; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology Associate; IPC Beds-No; Chronic Conditions-All; Corridor Facility-No.

ASPC-Yuma: Custody Level-Min/Med/Close; Medical Score (Max)-M-4; MH Score (Max)-MH-3; Nursing HRS-24/7; Medical Staffing-Physician and Mid-Level Provider; On site Dental; Mental Health Staffing-Psychology Associate; IPC Beds-No; Chronic Conditions-All; Corridor Facility-Yes.

Chapter 7, Sec. 1.1 Alcohol & Substance Abuse

REFERENCES: DEPARTMENT ORDER 917
NCCHC STANDARD P-G-06
NCCHC STANDARD P-G-08

PURPOSE: To provide appropriate management of inmates who are intoxicated or withdrawing from alcohol or drugs. The MS Contract Vendor is to provide medical support in drug and alcohol education and counseling efforts.

RESPONSIBILITY: It is the responsibility of each Vendor health staff member to evaluate every new intake or parole violator for signs and symptoms of drug or alcohol use or withdrawal symptoms.

PROCEDURES:

1.0 Intake and Assessment: Vendor Health staff will interview each new intake and obtain drug/alcohol use/abuse history, review corroborating documentation, assign drug/alcohol treatment needs score according to established criteria, enter score on classification profile and recommend an appropriate level of intervention and treatment required. (See Appendix E of this manual).

2.0. Vendor staff shall respond to any indication of alcohol intoxication.

2.1. Document observations of slurred speech, unsteady gait, odor of alcohol on the breath and level of consciousness. Then question the inmate to glean time of last drink, number and type of drinks per day, how many days he/she has been drinking. Also inquire about previous history of withdrawal symptoms. Vendor staff will identify any existing medical conditions that would be exacerbated by withdrawal of alcohol.

2.2. Intoxicated inmates will be placed where staff can observe them.

2.3. Inmates experiencing life-threatening intoxication are sent to a licensed acute care facility.

3.0 Alcohol Withdrawal:

3.1. Vendor health staff are to observe the inmate for alcohol withdrawal symptoms, (See Appendix E in this manual).

3.1.1 Mild to Moderate withdrawal symptoms include: tremors, agitation, irritability, anxiety, nausea, vomiting, diarrhea, profuse sweating, and inability to sleep or eat. Usual onset is 6-8 hours after the last drink but can occur sooner. Inmates experiencing mild to moderate signs and symptoms of withdrawal should be placed in a single cell and closely observed for increased severity of symptoms.

3.1.2 Major withdrawal symptoms include: confusion; disorientation; agitation severe enough to require restraints; hallucinations (olfactory, tactile, auditory or visual) and must be reported to

medical personnel immediately. Hospitalization is required to safely manage major withdrawal symptoms.

4.0. Drug Intoxication:

4.1. An inmate under the influence of drugs may present with many of the same behaviors as alcohol intoxication. Question the inmate to ascertain the amount, frequency and type of drugs being used. Obtain a medical history to identify any conditions that could be adversely affected by abrupt withdrawal of the drugs. Note that all inmates determined to be abusing drugs should be single celled and under observation.

5.0. Drug withdrawal: Withdrawal syndromes that follow abrupt cession of drug use require medical attention. Different drugs have different withdrawal phenomena that vary in their degree of risk and intensity. A Vendor Practitioner (Provider) should be contacted immediately upon suspicion of active drug withdrawal.

6.0. Vendor health staff are responsible as per this manual and other policies to complete appropriate physical clinical assessments of intoxication and withdrawal; and/or medical treatment of the physiological results of disorders associated with alcohol and other drugs; and/or prescription of psychoactive drugs as required.

Chapter 7, Sec. 1.2 Sun Exposure Protection

REFERENCES: NCCHC STANDARD P-B-02

PURPOSE: To ensure that vulnerable inmates who are at risk from exposure to the sun are provided proper medical clothing.

RESPONSIBILITY: It is the responsibility of the Contract Vendor unit Practitioner/Provider to determine an inmate's need for temporary or permanent assignment of a Special Needs Order for clothing suitable for blocking the harmful rays of the sun.

PROCEDURE: Once the determination has been made, based on clinical studies, that inmates who meet the following guidelines will be issued long sleeved orange t-shirts and wide brim hats to reduce their exposure to the sun.

1.0. The following diagnoses must be well documented (vs. reported) for an inmate to qualify for issuance of a long sleeved protection.

1.1 Documented history of Skin Cancer.

1.2 Rufous skinned (red-headed) inmates.

1.3 Inmates with past histories of actinic keratosis, squamous cell carcinoma or basal cell carcinoma.

1.4 Inmates with illnesses which can be exacerbated by exposure to sun such as discoid lupus or systemic lupus erythematosus.

1.5 Inmates on medications which have photosensitivity reaction to sun as a common adverse reaction, such as: sulfonylureas, some tetracyclines, phenothiazines, thiazide, chlorothiazides, diuretics, griseofulvin, or coal tar preparations administered topically.

1.6 Other somewhat uncommon illnesses may be considered for long sleeved shirt issuance, such as: erythema multiforme, pemphigus erythematosus, solar urticaria, scleroderma, dermatomyositis, erythropoetic protoporphyria, porphyrias including porphyria cutanea tarda, or albinism.

2.0. An undocumented history of photosensitivity is not a valid reason for issuance, unless alleged to be from a medication which the inmate is currently taking.

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

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

Chapter 7, Sec. 1.3 Therapeutic Diets

REFERENCES: DEPARTMENT ORDER 912
NCCHC STANDARD P-F-02

PURPOSE: A daily diet, which incorporates the USDA's Recommendations and Dietary Guidelines, is available to all inmates. Inmates whose medical or dental condition requires nutritional adjustment will be provided with a therapeutic diet according to orders of a prescribing practitioner.

RESPONSIBILITY: It is the responsibility of the Contract Vendor professional Health Service Practitioners/Providers to ensure that the nutritional needs of inmates are met. The contracted Dietitian is responsible to provide adequate foods to meet current industry standards of provision of nutrition). The ADCRR and MS Contract Vendor leadership retains joint responsibility to ensure that the food served will help inmates to be healthy. The inmate receiving a medically recommended/ordered diet has a responsibility to follow the clinical treatment plan.

PROCEDURES:

1.0. Medical Diets are special diets ordered for temporary or permanent health conditions that restrict the types, preparation, and/or amounts of food. Examples include restricted, low sodium, low fat, pureed, soft, liquid, and nutritionally supplemented diets. While medical diets may impact upon or be impacted by those diets which are of a religious or security nature, such impact is not the focus of this document.

1.1. Restricted Diets shall be evaluated by a Registered Dietitian at least annually to ensure nutritional adequacy. The review must also take place whenever a substantial change in the menus is made. The review may take place through a documented on-site visit or by written consultation. Either way, written documentation of menu reviews includes the date, signature, and title of the consulting dietician/nutritionist. The review shall be documented by a letter to MSCMB Medical Program Administrator or designee and the MS Contract Vendor Regional Medical Director or designee who will distribute copies to all Vendor FHAs for local files.

2.0. Inmates who may require therapeutic diets may be identified either upon the initial health screening and assessment process, by exam or changes in physical condition.

2.1. Restricted Diets shall be prepared as outlined in the Food Service Technical Manual and the Diet Guidelines Manual.

3.0. An order for a therapeutic diet must be consistent with the therapeutic diets listed in the diet manual and supported in the health record progress notes with SOAPE documentation by the prescribing Practitioner including diagnosis and treatment plan.

3.1. When inmates refuse prescribed diets for three consecutive days, follow-up nutritional/medical counseling shall be provided by a qualified Health Care Professional. Inmates who fail to adhere to medical diets are not disciplined, but counseled by health staff.

3.2. The Clinician's decision to stop medical diets is a therapeutic decision and shall be accomplished in accordance with the Food Service Technical Manual. The manual outlines a process for providing medically ordered and required diets. The manual establishes a process for obtaining Restricted Medical Diets, Diet terms and conditions, Diet Order/Diet Card issue, and Diet Order/Card revocation. The Food Service Technical Manual also provides requirements regarding an inmate's removal from a Restricted Diet, the Medical Diet Process, and the process for ensuring that inmates who are on a Restricted Diet and who transfer continue to receive the diet at their new location.

3.3. When an inmate agrees to and accepts a diet card, he or she has obligated themselves to follow the operational rules regarding diet management. If they do not follow ADCRR's rules, as outlined in the Food Services Operations Manual, they are subject to Departmental action. Mere refusal to follow a therapeutic diet is not subject to discipline. However, other actions involving diet trays or diet cards, or trading foodstuffs, which may call for discipline by the Department include; lying or presenting false or misleading information to staff, volunteers or others acting in official capacity, disobeying a verbal or written order, including Departmental and Institutional rules, policies, procedures, memoranda or other directives, fraud, or counterfeiting or forging any official document or currency.

3.4. As directed in the Food Services Technical Manual, the Dietary Services Manager is authorized to require the inmate to contact the Contract Vendor Health Services to continue a therapeutic diet. The authorization extends to an inmate's failure to follow administrative guidelines. The only individual authorized to cancel or discontinue a therapeutic medical/dental diet order is a Vendor Practitioner.

4.0. Upon receipt of the Vendor Practitioner's order, the health status will be updated on ACIS to reflect the order. Special diets are verified as needed through use of the health status program.

5.0. Food Services maintain a diet manual that contains the cyclical centralized menu and therapeutic diet menus. Therapeutic diets conform as closely as possible to the centralized menu. A registered dietitian evaluates all menus twice a year for nutritional adequacy.

5.1. Appropriate diets are served that incorporate the principles expressed in the United States Department of Agriculture and the Department of Health and Human Services Food Guide Pyramid and meet the current Recommended Dietary Allowances for appropriate age groups. Orders for medical diets include the type of diet, the duration for which it is to be provided as mandated by existing food service guidelines, and special instructions, if any.

5.2. Food Services Managers shall ensure that workers who prepare regular and medical diets are trained in preparing the diets, including appropriate substitutions and portions.

5.3. The Food Service Contractor shall provide the necessary supervision and training, ensuring that restricted diets are prepared and served in accordance with the Diet Guidelines Manual.

5.4. A Food Service Staff member or designee shall be responsible for obtaining the inmate's signature on the diet sign-in sheet when the inmate receives a diet tray or snack.

6.0. Special Populations: Basic nutrition is to be given to all inmates in administrative and punitive segregation, as well as to all others. Menus shall be reviewed and approved by the Nutritionist to ensure that the nutritional needs of adolescent inmates are met.

7.0. Any medical diets not listed in the Diet Reference Manual may be prescribed on a case by case basis by the Health Care Provider with the approval of the MSCMB Medical Director (or designee) in collaboration with the ADCRR Registered Dietician.

7.1. The following items must be addressed with that request:

7.1.1 Description of the desired diet, identification of the diagnosis that supports such a diet order. Include the negative impact seen as a result of lack of the special diet.

7.1.2 Describe all pertinent treatments to date provided to ameliorate the apparent negative impact of the current diet.

7.1.3 Validate that a discussion was held with the inmate regarding his diagnosis and that the inmate understands the need for compliance with the requested diet.

7.1.4 Provide any specialist or consultative documents that support the recommendation.

Chapter 7, Sec. 1.4 The Pregnant Inmate

REFERENCES: DEPARTMENT ORDER 705
DEPARTMENT ORDER 1101
NCCHC STANDARD P-G-07
NCCHC STANDARD P-G-02, 06
NCCHC STANDARDS P-A-08

PURPOSE: To assure that pregnant inmates receive comprehensive counseling and assistance in accordance with their expressed desires regarding their pregnancy, whether they elect to keep the child and place the child with a family member or friend, turn the child over to Child Protective Services or place the child for adoption.

RESPONSIBILITY: It is the responsibility of the Warden to ensure that pregnant inmates are transported and restrained in accordance with Director's Order 705. It is the responsibility of the Contract Vendor complex Medical Director (or designee)/Perryville and Vendor complex Director of Nursing (DON)/Perryville, to assure that the Vendor OB/GYN and Vendor nursing staff provide necessary counseling to pregnant inmates.

PROCEDURES:

1.0. Intake Counseling/Education for Pregnant Inmates

1.1. Newly committed inmates arriving from sending counties/jails, when identified as pregnant, will be provided counseling on the day of arrival by the Vendor intake Nurse. The counseling will consist of the following topics; Avoiding the use of alcoholic beverages; Smoking cessation; Restricting the use of caffeine; Avoiding risky behaviors such as tattooing, sharing dirty needles and other dangerous practices; Obtaining sufficient rest and sleep; Avoiding street drugs; Maintaining adequate nutrition; Ordering prenatal vitamin and iron supplementation; Discussion of the birthing process and signs/symptoms of labor; and other topics determined by the FHA to be in the best interests of the patients.

1.2. The complex Vendor OB/GYN Practitioner/Provider will ensure that pregnant parole violators returning to custody will discuss the above counseling topics at the first scheduled appointment.

1.3. All counseling/education provided by the Vendor OB/GYN, Nursing or other Vendor staff related to pregnancy will be documented in the SOAPE format within the inmate health record.

2.0. Ongoing Pregnancy Counseling

2.1. The Vendor OB/GYN Practitioner will meet on a scheduled basis with all pregnant inmates at a frequency determined by the progression of their pregnancy and special needs.

2.2. The Vendor Practitioner will assure that the inmate is provided an opportunity to ask questions about her pregnancy and questions are answered as comprehensively as possible. Topics that should be raised by the Practitioner if not asked by the inmate include:

2.2.1 Use of anesthesia and details related to the birthing process

2.2.2 Physical/sexual activity

2.2.3 Labor signs

2.2.4 Nutrition counseling

2.2.5 Breast/bottle feeding (dependent on release date)

2.2.6 Environmental/work habits

2.2.7 Tubal sterilization (following release)

2.2.8 Lifestyle choices during pregnancy related to the use of tobacco and alcohol

2.2.9 Discussion of choices related to placement of the child with family, Child Protective Services or adoption.

3.0. If the inmate is taking methadone during pregnancy due to a heroin addiction, the Vendor OB/GYN should discuss ongoing use and issues, as well as prepare the inmate for the cessation of the methadone following delivery. Close to the time of delivery, the OB/GYN should consult with other medical providers as necessary to establish a treatment plan for dealing with any serious withdrawal symptoms that may present themselves and share this plan with the inmate.

4.0. The newborn baby cannot return to the prison complex with the mother following birth. Therefore, the Vendor FHA will coordinate with the Warden in the development of a system wherein pregnant inmates are advised during their pregnancy to coordinate with the Correctional Officer III/IV staff at their housing unit. The inmate and CO III/IV must work together in arranging contacts with family, friends, and outside agencies that will be involved in placing the child after birth. The inmate and CO III/IV must establish contact with these individuals to finalize custody arrangements prior to delivery.

5.0. Abortion Counseling: The Vendor OB/GYN may discuss the process of abortion with all pregnant inmates with clarification of the following points:

5.1. Elective abortions are only performed if the inmate is able to pay for all costs related to the procedure. Related costs include all doctor and allied health clinician fees; all laboratory and diagnostic tests completed; all inpatient hospital costs, including surgery; all medication costs; all transportation costs to and from medical appointments related to the abortion procedure; all security costs including staff/labor costs; all follow-up medical/mental health costs following the completion of the procedure.

5.2. Necessary abortions will be performed as deemed appropriate by Department and contracted consultants when the mother's health and safety are jeopardized by the ongoing pregnancy.

6.0. Post-Partum Counseling: The Vendor OB/GYN will schedule the inmate for a follow-up appointment after delivery. In addition to evaluating medical needs related to post-pregnancy issues, the OB/GYN should be aware of any indicators of depression that would warrant a referral to mental health services for evaluation and treatment.

Chapter 7, Sec. 1.5 Tuberculosis Screening & Management

REFERENCE: NCCHC STANDARD P-B-02, Infectious Disease Prevention and Control
ACA STANDARD 5-ACI-6A-14 (M), Communicable Disease and Infection Control Program
DEPARTMENT ORDER 1102, Communicable Disease and Infection Control
Arizona Revised Statutes 36-738, Qualified Immunity
Arizona Department of Health Services Tuberculosis (TB) Program
Arizona Department of Health Services Tuberculosis Control Manual
Arizona Department of Health Services, Prevention Registry Form
https://azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-investigation-resources/tb-prevention-registry-form.pdf

PURPOSE: The purpose of this policy is to provide standard guidelines for the initial screening of inmates, management of latent tuberculosis infection (LTBI), and management of active tuberculosis (TB disease) including contact investigation, if indicated, and reporting requirements.

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

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

PROCEDURES:

1.0. TUBERCULOSIS (TB) SCREENING

1.1 Inmates shall be screened ANNUALLY for tuberculosis.

1.2 Inmates shall receive Purified Protein Derivative (PPD) skin tests based on the following time frames:

1.2.1 Upon arrival at the reception center, all inmates receiving their PPD (or Gamma interferon release assay (IGRA) blood test) shall remain at the reception center for a minimum of 48 hours so the test results may be obtained and documented in the medical record, prior to movement to their permanent facility.

1.2.2 Upon return to custody, an inmate shall receive the PPD at the receiving institution. A repeat PPD test is NOT required if less than 90 days have passed from the prior release.

1.2.3 Yearly thereafter from date of last PPD.

1.2.4 After exposure to any confirmed active TB disease.

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

1.3 Documentation of completed annual PPD shall include:

1.3.1 A completed TB symptomology/PPD/COCCI form filed in the lab/x-ray section of the paper health record or noted in the appropriate area of an electronic health record.

1.3.2 An updated Medical Work-Up form 1101-68 for facilities that utilize a paper record.

2.0. INITIAL SCREENING FOR TUBERCULOSIS (TB)

2.1 Symptom Screening: Nursing staff shall provide all inmates symptom screening for pulmonary TB within 24 hours of admission.

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

2.1.1.1 With Symptoms: Within 24 hours, evaluate for TB disease. Perform a tuberculin skin test and chest X-ray.

2.1.1.2 Without Symptoms: Within seven days, check for a documented history of a positive skin test.

2.2 TB Skin Testing: CHP Nursing staff shall perform skin testing on all inmates with no documented history of a positive skin test. Inmates vaccinated with Bacilli Calmette-Guerin (BCG) are not excluded from receiving a PPD test or an Interferon-Gamma Release Assay (IGRA). The skin test result (measured and documented in millimeters) must be read within 48-72 hours. NOTE: Gamma interferon release assays (IGRAs) were developed as an alternative to the tuberculin skin test (TST) for diagnosis of Mycobacterium tuberculosis infection. They do not help differentiate LTBI from tuberculosis disease. IGRAs are functional assays that measure T-cell response to mycobacterium tuberculosis-specific antigens in whole blood. These assays may be utilized as an alternative to TST.

2.2.1 A skin test ≥10mm is read as positive.

2.2.1.1 No documented history of a positive skin test: CHP Nursing staff shall administer a tuberculin skin test and read results within 48-72 hours.

2.2.1.2 Positive skin test: CHP Nursing staff shall refer inmate to CHP Practitioner (Provider) for Chest X-ray & evaluation for TB disease and therapy.

2.2.1.3 Documented history of a positive skin test: Nursing staff shall check for completion of treatment or a history of a BCG vaccine.

2.2.1.3.1 History of completed treatment: CHP Nursing staff shall perform symptom screening annually.

2.2.1.3.2 History of incomplete treatment: CHP Nursing staff shall refer inmate to CHP medical Practitioner/Provider for chest X-ray & possible initiation of therapy. CHP Nursing staff shall also perform symptom screening annually.

2.2.2 A skin test ≥ 5mm is read as positive if inmate has any of the following conditions: HIV, recent close contact of someone with TB disease, Chest X-ray (CXR) consistent with previous TB disease, organ transplant recipient, immunosuppression, or a history of injection drug use with unknown HIV status.

2.2.2.1 Negative skin test: CHP Nursing staff shall evaluate inmate's HIV status based on ADCRR Medical History Form (1101-29P).

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

2.3 A chest x-ray shall be performed on a patient with a positive PPD skin test or who has symptoms:

2.3.1 Negative PPD skin test but who have symptoms of TB (cough, anorexia, weight loss, fever and/or hemoptysis).

2.3.2 New converters (a newly positive PPD). (Old converters who are asymptomatic shall NOT have a CXR, unless there is a suspicion of TB or exposure).

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

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

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

2.4 If the chest x-ray is abnormal and/or symptoms are compatible with active TB:

2.4.1 The CHP Regional Medical Director or designee shall be notified immediately to determine if respiratory isolation and/or transfer to a hospital for evaluation and treatment is indicated. The CHP Medical Director or designee shall also notify the Department's Medical Director and the Department's Assistant Director for Medical Services. If the patient is transferred to the hospital he/she shall be masked with a paper mask en route.

3.0. ACTIVE PULMONARY TB OR TB DISEASE

3.1 Characteristics: Tuberculin skin test (TST) is usually positive. Chest radiograph is usually abnormal. Symptoms are present: at least one pulmonary symptom (i.e., cough greater than three week's duration, hemoptysis or chest pain) or at least three systemic symptoms (i.e., fever, night sweats, unexplained weight loss, fatigue, & decreased appetite). Respiratory (sputum or bronchial washing) specimens may be smear or culture positive for *M. tuberculosis.*

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

3.3 Medical Management and Case Control Measures:

3.3.1 The CHP Regional Medical Director or designee shall be notified immediately to determine if respiratory isolation and/or transfer to a hospital for evaluation and treatment is indicated. The CHP Medical Director or designee shall notify the Department's Medical Director and the Department's Assistant Director for Medical Services.

3.3.1.1 In the absence of an airborne infection isolation room within a facility, a TB case or suspect shall be sent to a contract hospital for airborne infection isolation & for appropriate medical treatment until no longer infectious.

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

3.3.3 CHP Medical Practitioner/Provider or CHP Nurse shall counsel the inmate on the findings and treatment.

3.3.4 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 health care facility with airborne infection isolation capabilities, until all the following conditions are met:

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

3.3.4.2 Anti-tuberculosis treatment is initiated.

3.3.4.3 Clinical signs and symptoms of tuberculosis are improved and all the criteria met for non-infectivity.

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

3.4.1 All TB medications shall be administered by direct observed therapy (DOT) to ensure adherence to therapy. This precludes these inmates from assignments to outside work crews.

3.4.2 A TB case or suspect on TB therapy shall be monitored by a CHP Nurse or medical Provider for signs and symptoms of adverse reaction.

3.4.3 A TB case or suspect shall receive thorough medical evaluation by a CHP Medical Provider if an adverse reaction or drug intolerance develops.

3.4.4 If a TB case or suspected case is released or transferred to an outside facility before completion of TB therapy, the public health department or receiving correctional facility shall be notified by the CHP Facility Health Administrator or designee no later than 24 hours of release or transfer to ensure appropriate placement and completion of treatment. For deportation cases, contact the Arizona Department of Health Services TB Program at 602-364-4750.

3.4.5 In the event the patient is non-compliant with TB therapy, counseling with the CHP Nurse and/or medical Provider shall occur and 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.

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

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

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

3.5.3 Transporting an inmate with confirmed or suspected TB disease.

4.0 REPORTING REQUIREMENTS:

4.1 Case Reporting: The CHP Facility Health Administrator or designee shall immediately notify the CHP Regional Medical Director or designee, Department's Assistant Director for Medical Services and Medical Director or designee, and the Department's Occupational Health Administrator of any TB case or suspected case. The Facility Health Administrator or designee, after consultation with the CHP Regional Medical Director, shall report the TB case to the Arizona Department of Health Services TB Control Program within one working day of receipt of diagnosis. Send the appropriate report to the ADHS. Refer to the Arizona Department of Health Services TB Control Manual for appropriate reporting forms.

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

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

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

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

5.0 Contact investigations of offenders diagnosed with active or suspected TB.

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

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

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

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

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

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

5.6.1 Arizona Department of Health Services TB Control Office
5.6.2 County Health Department TB Control Office
5.6.3 Department's CHP Regional Medical Director or designee
5.6.4 CHP complex health staff
5.6.5 CHP Facility Health Administrator
5.6.6 CHP complex Director of Nursing (DON)
5.6.7 Complex Warden or Deputy Warden
5.6.8 Department's complex Monitor
5.6.9 Department's Medical Director or designee
5.6.10 Department's applicable Program Evaluation Administrator or designee
5.6.11 Department's Occupational Health Administrator
5.6.12 Department's complex Occupational Health Nurse
5.6.13 Representative from Offender Classification

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

5.8 Close contacts (i.e. live, work or share air with an active case of TB), shall have a PPD skin test unless then have a known positive PPD.

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

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

6.0 LATENT TB INFECTION (LTBI)

6.1 Preventive therapy is recommended for inmates with latent TB infection (LTBI) to reduce the risk of becoming TB disease, which is highly infectious: Once the medical evaluation has ruled out TB disease, the CHP medical Provider shall order a treatment regimen by DOT based on current treatment guidelines to patients that meet the following criteria:

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

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

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

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

6.1.5 TB skin test result ≥ 10mm induration.

6.1.6 Note that DOT may not be possible for patients assigned to outside work crews, and KOP administration may be considered under these circumstances.

6.2 CHP Medical Practitioner shall order laboratory testing and follow up visits based on current treatment guidelines.

6.3 Inmates on INH with liver function tests greater than 3x normal values or with signs of hepatitis or other adverse effects of the drug shall have the medication discontinued and clinically evaluated promptly.

6.4 Inmates who refuse or are unable to complete a recommended course of preventive therapy shall be counseled to seek prompt medical attention if signs & symptoms suggestive of TB develop. These inmates shall also be required to document in writing their refusal for treatment and this shall be included in his/her health record.

6.4.1 Management of Missed Dose(s): For interrupted treatment lasting two or more months, TB disease should be ruled out before continuing LTBI treatment. For frequent or prolonged interruptions of more than three weeks, LTBI treatment should be restarted from the beginning.

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

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

7.0 Testing Inmates Who Refuse to Cooperate

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

7.2 If an inmate does not cooperate after receiving counseling, the CHP Director of Nursing shall notify the CHP Facility Health Administrator, who shall notify the Warden or designee.

7.3 After being notified by the CHP Facility Health Administrator, the Warden or designee shall:

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

7.3.2 If the inmate refuses to sign the Involuntary Tuberculosis Test form, note on the form the inmate refused to sign.

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

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

7.3.5 Ensure the entire procedure is video recorded by whatever means is available to Operations staff, including the instructions to the inmate and the application of necessary force.

7.3.6 Ensure the test is administered away from other inmates and not in an inmate housing area.

7.3.7 Ensure the inmate is escorted to the Health Unit at a prescribed time so healthcare staff can assess the skin test.

Definitions:

Classification of TB exposure/infection:

- Class 0 – No TB exposure, not infected
- Class 1 – TB exposure, no evidence of infection (Negative reaction to Tuberculin Skin Test)
- Class 2 – TB infection, no disease (Positive reaction to Tuberculin Skin Test)
- Class 3 – Tuberculosis, current disease
- Class 4 – Tuberculosis, no current disease
- Class 5 – Tuberculosis suspect

Contact – an individual (inmate or employee) who has shared the same air space as a person with TB disease for a sufficient amount of time that there is a probability that transmission of TB may have occurred.

Converter – a person who has, within two year period:

- Had an initial TB skin test without a "significant" reaction.
- Had a second skin test with a "significant" reaction.

Infectious – Inmates should be considered infectious if they are:

- Coughing or undergoing cough – induced or aerosol generating procedure or have sputum smears positive for acid-fast bacilli and they have not received therapy, has just started or has a poor clinical response to therapy.

Non-infectious – Inmates are not considered infectious if they meet all of these criteria:

- Adequate therapy for 2-3 weeks
- Favorable clinical response to therapy, and
- Three consecutive negative sputum smears from sputum collected on different days.

Purified Protein Derivative (PPD) – a combination of proteins that are used in the diagnosis of tuberculosis

Tuberculosis – an infectious disease caused by Mycobacterium tuberculosis and spread from person to person through air.

Chapter 7, Sec. 1.6 Suicide or Mental Health Watch

REFERENCES: DEPARTMENT ORDER 807
DEPARTMENT ORDER 1103
NCCHC STANDARD P-G-05
ADCRR Mental Health Technical Manual

PURPOSE: To establish consistent guidelines for placing an inmate on a suicide or mental health watch by Contract Vendor mental health, Vendor health care staff or the Security shift commander.

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

PROCEDURES: The direction for response to Suicide attempts and completion of a Suicide or Mental Health Watch are described in Department Order 1103.

1.0. Inmates are placed on continuous or 10 minute Suicide Watch when: The inmate's behavior is self-destructive; or the inmate is displaying suicidal behavior; or the inmate attempts suicide and/or has a documented history of attempting suicide, and there are situational warnings indicating an impending suicide attempt; or the inmate verbally threatens to commit suicide and/or to cause self-inflicted wounds.

2.0. Suicide and Mental Health watch Performance:

2.1. Quarterly inspections shall be performed by the head MH clinician and unit DW. These areas generally will not have fixtures, appliances or bars which could be used with the inmate's clothing in a self-harm attempt.

2.2. The inmate will be strip searched by security. All objects that may be used as a weapon for self-harm will be removed by security.

2.3. It is a combined effort of the Vendor Health staff, Mental Health staff, and Security staff to visually check the inmate for his/her welfare at random intervals, or as otherwise specified and record the observations on the appropriate record.

3.0. Suicide Watch and Mental Health Watch Support. All visits by health staff shall be documented on the health record. The Vendor Medical staff member performing this check will ensure that the inmate response verbally and/or is seen moving purposefully. The observing staff member will note that observation in the health record. Health staff shall visit those inmates on mental health watch on weekends and holidays if Mental Health staff are unavailable.

3.1. In the event that Mental Health staff are unavailable or during non-regular business hours, Health staff shall contact a Mental Health clinician for mental health watch orders. The inmate must be seen by Health staff. NOTE: INMATES CAN ONLY BE PLACED ON CONTINUOUS OR 10 MINUTE

WATCH IF THE INMATE WAS NOT EVALUATED IN PERSON BY A MENTAL HEALTH CLINICIAN OR PRACTITIONER.

4.0. Cervical spine injuries can occur during falls and when an inmate attempts suicide by hanging. The following is required for Vendor medical personnel when evaluating inmates who have fallen, or have attempted suicide by hanging, irrespective of level of consciousness.

4.1. Vendor medical personnel evaluating an inmate who has experienced a fall or who has attempted suicide by hanging will authorize movement of the inmate by security personnel only after the cervical spine has been immobilized.

4.2. Security personnel may cut an inmate down who is attempting suicide by hanging. However, the inmate will not be moved further unless authorization by medical personnel has been obtained, and the cervical spine immobilized.

Chapter 7, Sec. 1.6.1 Hunger Strike Clinical Support

REFERENCES: DEPARTMENT ORDER 1001.13
NCCHC STANDARD P-E-04

PURPOSE: To provide guidelines for the identification and management of inmate(s) on a hunger strike.

POLICY: It is the policy of the Arizona Department of Corrections Rehabilitation & Reentry through its MS Contract Vendor, to medically monitor inmates on a hunger strike.

PROCEDURES:

1.0. Evaluation and Documentation:

1.1. A hunger strike exists when an inmate communicates to staff that he or she is on a hunger strike, and/or has been observed by staff to be refraining from caloric intake for a period in excess of 72 hours.

1.1.1 If a hunger strike is communicated or observed by security staff, the inmate is to be referred to the Vendor Medical Staff for evaluation in accordance with Department Order 1101.

1.1.2 If an inmate that is housed in a contract hospital communicates their intent or the hospital staff report activity of a hunger strike, the Vendor Utilization Management staff will immediately inform the pertinent Vendor Facility Health Administrator, Contract Vendor Regional Medical Director, and ADCRR Health Services Assistant Director. The Contract Vendor health staff will follow the policy of the hospital located in the local area where the inmate resides.

1.2. The Contract Vendor Regional Medical Director or designee, Vendor Regional VP or designee, MSCMB Assistant Director or designee, and MSCMB Medical Program Administrator or designee is to be notified upon verification of any Hunger Strike.

1.3. The inmate may be placed in medically appropriate housing to monitor and measure solid and liquid caloric intake and output.

1.4. All commissary food and private food stock are to be removed, and commissary food purchasing privileges suspended for the duration of the Hunger Strike.

1.5. Upon referral to Vendor Medical staff, the medical staff is to arrange for the following initial assessment procedures:

1.5.1 General physical exam by an Health Care Practitioner within 24 hours for evaluation, including height, weight, and vital signs;

1.5.2 Dipstick Urinalysis;

1.5.3 Complete blood count and chemistry profile;

1.5.4 Serum pregnancy test on female inmates;

1.5.5 Psychological evaluation;

2.0. Monitoring and Support Activity

2.1. A "Clinical Staffing" (to include Operational staff and Vendor Mental Health staff) should be convened to assist in ascertaining the alleged purpose of the hunger strike. During this Clinical Staffing meeting, the inmate will be encouraged to cooperate with the monitoring efforts of the Vendor health staff as a method of keeping him/her informed of their current state. A verbal report to the Vendor Regional Medical Director or designee and Regional VP or designee, by the Vendor Facility Health Administrator, is required immediately upon completion of the clinical staffing. This is followed by a full clinical staffing written report sent to Vendor Regional VP, Vendor Regional Medical Director and ADCRR MSCMB Assistant Director, within the same working day (shift) of the FHA's notification of a hunger strike.

2.2. Vendor medical staff are to assess weight and vital signs at least every 24 hours while an inmate is on the Hunger Strike, and document such measurements in their medical record.

2.3. Intake and output (I&O) are to be documented at least every 8 hours. Uncooperative patient activity must be documented. If an inmate is uncooperative and/or the staff have documented difficulty acquiring valid I&O measurements, the attending Practitioner/Provider may order a urine specific gravity.

2.4. When valid medical reasons exist and are fully documented in the medical record, medical staff may consider using a urine specific gravity as an alternative to monitoring the I&O in accordance with the inmate's cooperation.

2.5. Additional medical actions should be carried out during the course of the Hunger Strike as determined by the Vendor facility Physician or other appropriate health care Practitioner/Provider and as permitted by the inmate.

2.6. Inmate on a Hunger Strike will be given an opportunity to partake in each scheduled meal and refusal documented in the medical record. The inmate is to be provided with adequate supplies of drinking water.

2.7. The Vendor Facility Health Administrator or designee is to be kept appraised on a daily basis of the inmate's general medical condition, particularly as regards to need for potential transfer to an acute care medical institution or consideration of forced feeding.

3.0. Refusal to Accept Treatment/Support

3.1. When, as the result of inadequate intake or abnormally low output and a Vendor medical professional determines that the inmate's life or permanent wellbeing will be threatened if treatment is not initiated immediately, the health care professional is to immediately inform the Vendor Facility Health Administrator or designee. The health care professional and Facility Health Administrator or designee will confer to determine whether to transfer the inmate to an acute care medical institution or if forced medical treatment should be recommended.

3.2. When, after reasonable efforts have been exhausted (or in an emergency preventing such reasonable efforts) a medical necessity for immediate treatment of a life threatening situation exists, the health care professional may inform the Facility Health Administrator that a court order compelling treatment should be sought. Forced medical treatment requires an order from a Court. If forced medical treatment is contemplated, the Vendor Regional VP, Regional Medical Director and ADCRR Health Services Assistant Director must be notified. Note that the earlier the Regional Medical Director and Regional VP are notified of an impending decision to recommend court ordered treatment, the better chance there is that timely intervention can be ordered by the court.

3.3. Prior to forced medical treatment being recommended, the Vender health staff should make reasonable efforts to convince the inmate to voluntarily accept treatment. Medical risks faced by the inmate if treatment is not accepted are to be explained to the inmate and documented in the medical record.

3.4. Vendor medical staff shall continue clinical laboratory monitoring as well as medical and psychiatric/psychological follow-up as long as necessary.

3.5. Each complex facility will produce a post order which provides specific guidance for the complex with particular attention given to the process to follow to meet the communication requirements above and to identify the preferred housing location of inmates on hunger strikes.

4.0. Release from Hunger Strike Status

4.1. Only a Vendor Medical Provider may order that an inmate be released from Hunger Strike evaluation and treatment. This order must be documented in writing in the health record of the inmate.

Arizona Department of Corrections Rehabilitation & Reentry	Americans with Disability Act (ADA) eligible inmate Management	OPR: MS Contract Vendor Regional Director of Nursing MS Contract Vendor Medical Records Supervisor MSCMB Medical Records Monitor MSCMB Medical Program Administrator (Physician Monitor) Auth: kc
Medical Services Technical Manual	MSTM Chapter 7 Section 1.7	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 7, Sec. 1.7 ADA Eligible Inmate Management

REFERENCES: DEPARTMENT ORDER 108
NCCHC STANDARD P-A-08-ac

PURPOSE: To require removal of barriers to programs, services and processes for inmates with qualifying disabilities pursuant to title II of the Americans With Disabilities Act (ADA) and consistent with reasonable accommodation and security requirements. This policy is focused only on the ADA as it relates to inmate services.

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

DEPARTMENT **PROCESSES**:

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

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

HEALTH SERVICES **PROCEDURES**:

2.0. Procedures at the Reception Center and the subsequent transfer of an inmate with disabilities to an ADA-accessible facility are provided in Department Order 108.

2.1. In general, Vendor health staff shall complete a nursing assessment within 24 hours after the inmate arrives. Additionally, the staff shall ensure that the inmate is scheduled to see the Vendor Health Care Provider, for continuity of care, within 7 workdays after arrival at the new facility.

2.2. During processing at a reception center, a Vendor Medical Provider identify inmates who meet the designated criteria for transfer/placement of disabled inmates, perform a functional assessment examination on the ADCRR form, and offer the inmate an opportunity to sign a voluntary "ADCRR Waiver of Liability by an Inmate with a Disability." The Medical Practitioner/Provider shall assign a medical and health care needs (M) score and ensure the score and related disability needs information is relayed to the Offender Services Division and to the Vendor Health Records Librarian in accordance with the policy on Inmate Classification. This information will be entered into the ACIS in an acceptable

format to communicate the special needs of the patient. The Vendor Medical Provider shall enter the disability needs information on the problem list of the health record. The Vendor complex supervising Medical Records Librarian will ensure that a system is in place at the facility that will ensure that the assigned M score and related disability needs information is relayed to the Offender Services Division and to the Health Records, in accordance with Inmate Classification policy.

2.3. The Vendor Facility Health Administrator or designee will immediately forward all related documentation to the Regional Director of Nursing (RDON), for review by the Vendor Regional Medical Director to verify that the criteria is met.

2.4. If criteria are met, the Vendor RDON or designee will complete a request for Inmate Transfer for Medical Reasons. Upon approval, the RDON will forward the request to Central Classification for transfer orders.

3.0. Upon the inmate's arrival at the new facility, the complex Director of Nursing (DON) or designee shall (because of the inmate's special needs) instruct the inmate on how to obtain health care services, and document this instruction in the health record and ensure the inmate is scheduled to see the Vendor Health Care Provider, for continuity of care, within 30 days after arrival at the new facility.

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

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

4.2 Ensure the revised disability needs information is entered on the inmate's problem list in the health record and the information is relayed to the Vendor Medical Records Librarian (for sites w/o EHR).

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

4.4 If called for by the reassessment, the RDON or designee shall complete the Transfer for Medical Reasons, and forward the form to Central Classification.

5.0. Recommending transfer/placement of disabled inmates from one facility that is not ADA-accessible to another facility that is ADA-accessible.

5.1. The Vendor complex Medical Director or complex DON shall identify inmates who may meet the designated criteria for transfer/placement of disabled inmates following recommendations of subordinate staff.

5.2. The complex DON or designee shall ensure completion of a Functional Assessment examination (and form/documentation) within seven workdays after the inmate is identified or a request is received for evaluation, and

5.2.1 Determine if the inmate has a disability that requires the inmate to be transferred to an ADA-accessible facility or if the inmate will sign an ADCRR Waiver of Liability.

5.2.2 Immediately after completing the assessment, forward all related documentation to the RDON for review to ascertain if the criteria's are met.

6.0. Auxiliary Aids and Services

6.1. As described in Department Order 108, as consistent with security requirements, ADCRR Contract Vendor shall provide or allow auxiliary aids and services to individuals with disabilities to enable them to communicate effectively and to participate in or to receive services, programs, and activities, provided that doing so will not result in undue hardship or cause a fundamental alteration to a service, program or activity.

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

6.3. Vendor Practitioner/Providers, in considering work restrictions are informed that ADA-qualified inmates 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.

7.0. Transfer from non-accessible to accessible institution

7.1. Department Order 108 requires that authorized Vendor health staff identify inmates who meet the designated criteria for transfer/placement of disabled inmates. It also allows institutional staff to request a reassessment. The request must be routed through the Vendor Facility Health Administrator to initiate assessment.

7.2. Within seven workdays after the inmate with disabilities is identified or the request is received, a Functional Assessment in accordance with local post orders shall be completed to determine whether the inmate meets the criteria and has a disability that requires transfer.

7.3. The ADCRR Contract Vendor Regional Director of Nursing (RDON) or designee retains the responsibility to review all documentation. A recommendation will be made to the Vendor Regional Medical Director or designee for decision on transfer/placement of disabled inmates. If a move or change in location is found to be clinically indicated, the case will be presented to the Vendor Regional VP/Administrator for action.

Chapter 7, Sec. 1.8 Clinical Staffing of Special Problems

REFERENCES: NCCHC STANDARD P-A-08
NCCHC STANDARD P-G-01

PURPOSE: To provide a mechanism and forum to ensure a cooperative effort between the facilities administration and Vendor treating clinicians in responding to a specific inmate's health needs especially in situations of treatment refusals.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Health Practitioners/Providers to work with the operations and security staff to jointly ensure that every possible avenue is explored to encourage cooperation by inmates in completion of their own care. This policy is provided to enable communication to and with the inmate-patient.

PROCEDURES:

1.0. Clinical Staffing Reasoning: Inmates who present with a complex issue(s) or series of health issues should receive care through the methodologies described in the Department Order 1100 series. However, the Vendor Practitioner/Provider must have an ability to access other professional comments and recommendations regarding the inmate's care.

1.1. To access this support the Practitioner of record may request a Clinical Staffing by a written request to the Vendor FHA including the name and ADCRR number of the inmate, and a history of the issue to be addressed. The request should also include a recommendation from the provider regarding any perceived need for immediacy of the Staffing meeting.

1.2. This action must not take the place of any clinically required specialty consultation. It may be useful in situations such as; hunger strikes, inmates with multiple and incessant medical complaints, etc.

2.0. Membership: The Vendor FHA shall convene the Staffing and include the following members:

2.0.1 The Vendor Practitioner(s)/Provider(s) of record will present the case.

2.0.2 The FHA will coordinate the conduct of the Staffing and documentation of the outcome.

2.0.3 The Vendor complex DON or designee will provide Nursing observations and recommendations.

2.0.4 The Vendor Psychologist or Psych. Associate will provide Mental Health observations and recommendations. If appropriate, a Mental Health Practitioner shall participate.

2.0.5 The Unit Deputy Warden will serve as a member of the Staffing Committee to provide Operational and Security observations and recommendations on a case by case basis.

2.0.6 The Vendor Unit Medical Records Librarian or designee will take minutes and collect the individual Case Worksheets after completion of the meeting.

2.0.7 Others as deemed appropriate.

3.0. Conduct of the Staffing:

3.1. The Staffing will be scheduled to last approximately one hour and, unless otherwise indicated, will proceed as follows:

3.1.1 The FHA will provide general directions to the other members, paying particular attention to the need for confidentiality and the reason and authority for including a non-medical individual in a meeting which will most likely reveal clinical information.

3.1.2 The unit Practitioner will present the case to the committee paying particular attention to his/her observations, laboratory, and other clinical findings.

3.1.3 The remainder of the members will query the Practitioner, seeking to determine the current status of the inmate and developing a base of information.

3.1.4 The inmate will be brought into the meeting room and the FHA will describe the clinical staffing process. The attending Practitioner will provide the issue(s) to be discussed.

3.1.5 The inmate will be asked to provide their concern(s) relative to the clinical staffing topic.

3.1.6 Upon completion of the inmate's presentation, the FHA will provide a synopsis of the problem and the inmate will be asked to leave while the clinical staffing members discuss their case. The inmate shall be called back and the consensus statement arrived at for resolution of any issues and/or improved treatment(s) will be provided to the inmate. A statement of understanding or misunderstanding (refusal) shall be included in the minutes of meeting as well as a S.O.A.P.E. entry.

3.1.7 The attending Practitioner shall provide a "S.O.A.P.E" note entry as to the staffing and recommendations.

3.1.8 A copy of the minutes shall be forwarded to the Vendor Regional Medical Director, MSCMB Assistant Director and MSCMB Medical Program Administrator.

4.0. Documentation:

4.1. The committee is to document the discussions and outcome of the meeting as follows:

4.1.1 Inmate Name

4.1.2 DOC# Unit

4.1.3 Date: Case Reviewed by (names of committee members)

4.1.4 I. Case Overview

4.1.5 II. Labs/X-rays/Observations/Testing

4.1.6 III. Inmate Statement

4.1.7 IV. General Findings

4.1.8 V. Recommendations

4.2. The Vendor Unit Practitioner will also document the outcome of the Staffing in health record in a S.O.A.P.E. format ensuring that the Plan is clearly documented.

4.3 The Vendor Regional VP/Administrator or designee shall perform periodic reviews of clinical staffing to ensure compliance with Department Orders and MSTM.

Chapter 7, Sec. 1.9 Special Needs Considerations and Orders (SNO)

REFERENCES: NCCHC STANDARD P-A-08
NCCHC STANDARD P-G-01
NCCHC STANDARD P-G-02

PURPOSE: To provide information in a cooperative effort between the facilities administration and Contract Vendor treating clinicians regarding the inmates significant health needs that must be considered in daily processing and correctional management and to preserve the health and safety of that inmate.

RESPONSIBILITY: It is the responsibility of the Vendor Health Care Practitioner/Provider to consider the physical needs and limitations of inmates and to share that pertinent information with correctional staff.

PROCEDURES:

1.0. Health care needs are to be considered in decisions regarding the inmate's management and assignment to work and programming. This consideration is to ensure an inmate who has restrictions is not 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 inmate's special needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication must be documented via an approved Special Needs Order form and performed in such a manner that does not compromise confidentiality of health information.

2.0 The Contract Vendor Health Services support of the needs of the body should not be interpreted to be understood as all issues related to the body are health issues. Many issues brought to the Health Practitioner are related to comfort and the patient's interpretation of potential harm. In addition, the inappropriate issuing of items may also represent a potential security problem. The below examples are provided to guide Health and Operational staff in determining accountability to respond to an inmate request:

2.0.1 A proper fitting shoe size is often a comfort issue.

2.0.2 An uncomfortable mattress is often a comfort issue.

2.0.3 A desire by the inmate to be cuffed in front vs. behind his back is often a comfort issue.

2.0.4 A desire to stay in a specific location is often a personal desire.

2.0.5 A desire to have a bed wedge assigned is often a comfort issue.

2.1. While the above are general issues, there may be aggravating circumstances that may bring the issue into the Vendor health services responsibility (to order and/or provide). Vendor health staff are prohibited from providing clinical services to increase comfort unless there is a direct, foreseeable, and documentable relationship to the patient's clinical state of health. Such individual circumstances must

be fully evaluated and documented as having negative clinical impact on this specific inmate. An example of this is lower bunk assignment request that is based on clinical necessity and not on the inmate's preference.

3.0. The following guidance is provided in consideration of bed wedges prescribed for adjunctive treatment of Gastroesophageal Reflux Disease (GERD) and is effective upon publication of this policy:

3.0.1 ADCRR Contract Vendor Medical Practitioners will not prescribe a Bed Wedge via the Special Needs Order process or renew a Special Needs Order for a bed wedge for the treatment of GERD without the authorization of the Vendor Regional Medical Director or designee.

3.0.2 ADCRR Contract Vendor Nursing personnel will not renew an expired or expiring Special Needs Order for a bed wedge that has been previously prescribed for the treatment of GERD.

3.0.3 Bed wedges that have been previously prescribed for the treatment of GERD and are confiscated by operations personnel will not have a bed wedge SNO renewed.

3.0.4 Bed wedges MAY be prescribed for documented, current, symptomatic congestive heart failure with orthopnea or severe symptomatic Chronic Obstructive Pulmonary Disease (COPD).

3.0.5 Any other consideration of bed wedge prescription must be approved by the Vendor Regional Medical Director or designee in accordance with the Vendor's established procedures.

4.0. Alternative methods of restraint are not to be directed by Vendor Health staff. ADCRR Contract Vendor Medical Practitioners will no longer issue a Special Needs Order (SNO) authorizing alternative methods of restraint. Correctional Officers will restrain an inmate appropriately based on a variety of factors, including observation of the inmate which may suggest an alternative method of restraint is necessary. Pregnant females will be cuffed in accordance with Department Order 705.14.

5.0. Metal Detector use on inmates with pacemakers or ICD's (implantable cardioverter- defibrillator). There are two concerns regarding the use of walk-through metal detectors on inmates with pacemakers or ICDs. The first is the possibility of "false alarms" where the pacemaker sets off the metal detector. The second is the erroneous concern that the pacemaker or ICD will be adversely affected by passing through the metal detector, causing potential harm to the inmate.

5.1. There is no scientific evidence to support a claim of harmful interactions between this equipment and metal detectors. Nonetheless:

5.1.1 It is common community practice to have patients with pacemakers bypass metal detectors.

5.1.2 Inmates who happen to pass through walk-through a metal detector do not need a medical evaluation.

5.1.3 Security concerns are to be of primary importance when faced with an inmate claiming to have lost his/her SNO. When an officer is in doubt, the inmate may be passed through a walk-through metal detector. If the officer wishes, he/she may visually inspect the anterior (front) chest wall, usually on the left side, above the breast and below the collar bone, for a hard, Zippo lighter sized device visible just under the skin. The officer may also contact the appropriate medical facility for confirmation of the presence of a pacemaker/ICD.

5.2. Inmates with a properly documented existence of either a pacemaker, or an ICD (implantable cardioverter-defibrillator) who inform the correctional staff will not be required to pass through walk-through metal detectors. Alternate methods of search will be utilized by security personnel such as, but not limited to using a hand held metal detecting wands, pat searches, etc.

5.3. Inmates with either a pacemaker or ICD will be provided with a Special Needs Order (SNO) stating "I/M has a pacemaker/ICD. Hand wanding or other alternatives to walking through a metal detector should be utilized if available." The SNO will be written by a medical Practitioner/Provider, and should be written on intake if the pacemaker/ICD is present, or on return from the hospital after one of these devices has been implanted in the inmate. The duration of the SNO can be written "for the duration" or "indefinite."

6.0 Continuous Oxygen delivery equipment poses safety and security risks in an open yard environment. Therefore, inmates requiring continuous use of Oxygen shall be housed in a sheltered housing or in the IPC.

7.0. It is the inmate's responsibility to keep and protect his/her copy of the SNO. "Worn out" SNOs can be returned to the health unit for replacement. Vendor health staff should be vigilant regarding the susceptibility of SNOs to be sold or transferred between inmates. Therefore, requests to make copies of the SNO to replace a "lost" SNO should be minimized and carefully scrutinized.

8.0 Medical Shoes as prescribed treatment shall be provided to inmates with the following conditions:

8.1.1 Diagnosed Type 1 & Type 2 diabetics with loss of toes due to diabetes, foot ulceration, poor integrity of feet, circulatory compromise or peripheral neuropathy.

8.1.2 Diagnosed Perpheral Vascular Disease.

8.1.3 Inmates possessing prescribed orthotic inserts that require tennis shoe or other accommodating foot wear which cannot be appropriately utilized in a deck shoe.

Chapter 7, Sec. 2.0 Outside (Specialty) Care and Clinics

REFERENCES: NCCHC STANDARD P-A-01
NCCHC STANDARD P-D-05
NCCHC STANDARD P-E-12

PURPOSE: To ensure that the inmate's serious medical needs are met by providing for specialty care beyond the medical capabilities of the Contract Vendor prison staff by providing a system of efficient management of requesting, deliberation, monitoring, and tracking proposals for specialty services via outside consultations. This process will aid in ADCRR's Vendor delivery of medical services that are comparable with a community standard of care. Consultations may be performed in-house, at an outside location, or by way of video conferencing/telemedicine.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Facility Health Administrator to develop processes for smooth management of specialty clinical support. It is the responsibility of the individual Vendor Practitioner/Provider and Vendor Clinical Coordinator staff to monitor their orders and requests to ensure successful coordination of local and regional access to community Practitioner/Providers for specialty care. It is the responsibility of the attending Vendor Physician or Mid-level Practitioner, in coordination with the Clinical Coordinator, to follow their requests for specialty care to ensure that the needs of the patient are met. It is the responsibility of the Vendor complex DON to monitor Vendor Nursing staff compliance.

PROCEDURES:

1.0. General Authorities:

1.1. The Vendor Facility Health Administrator: It is the responsibility of the FHA or designee and the individual Vendor Practitioner, to ensure that all requests for medical services submitted are accurate and complete. The Vendor FHA neither approves nor denies any requests for medical services.

1.2. Clinical Coordinator (CC): It is the responsibility of the Vendor CC to serve as the facilitator and to utilize a system that tracks and monitors the requests for outside specialty care. The CC is also responsible for all travel arrangements and appropriate documentation preparation to accompany the inmate for any consultations. While the CC is responsible to ensure that pertinent medical holds are entered, local policy must be developed that ensures that inmates who are scheduled for a necessary specialty visit or treatment remain in the current location, regardless of who actually makes the entry. Regular outside consult request meetings shall be held and documented. Minutes of these meetings shall be made available to the ADCRR Compliance Monitor upon request.

1.3. Interstate Compacts: The Vendor FHA, Vendor MRL personnel, and Clinical Coordinator should jointly be monitoring the existence of interstate compact inmates within their complex. In the event that a costly medical procedure becomes necessary, the sending State should be consulted ahead of the appointment. This will be accomplished through the FHA sharing information with the Interstate Compact Administrator in Phoenix, Central Office. The FHA will determine local responsibility for maintaining and updating the list produced by ACIS (see MSTM 7.8.0.)

2.0. Outside Consult Committee meetings:

2.1. An example of a functional Outside Consult Committee meeting membership consist of the Vendor FHA, the Vendor facility Medical Director or designee, the Vendor facility DON or designee and the Vendor facility Clinical Coordinator meeting on a regular basis. ADCRR Contract Monitor shall attend the Outside Consult Committee meetings as necessary.

2.2. At the time of approval of an outside consult, a case appropriate "medical hold" will be placed on the ACIS system in accordance with MSTM guidance and complex procedures to guarantee that the inmate is not moved to another facility prior to the outside consultation appointment.

2.2.1 All pending consult requests and those requests that are approved are entered into a database by the Vendor CC. The database is reviewed periodically (at least weekly) by the CC for review of decisions assuring that appropriate feedback has been received and provided to the appropriate complex Vendor health staff.

2.2.2 The Vendor CC will follow up with the Vendor UM approving authority on any outstanding Consultation Requests that remain in a "pending approval" status after 5 business days and report on those outstanding Consult Requests at the next outside consult meeting.

2.2.2.1 Urgent specialty consultations and urgent specialty diagnostic services, shall be scheduled and completed within 30 calendar days of the consultation request from the medical Practitioner.

2.2.2.2 Routine specialty consultations shall be scheduled and completed 60 calendar days of the consultation request from the medical Practitioner.

2.2.2.3 Documentation of consult approval(s) or denial(s) including reasons for denial for specialty consultations shall be sent to the requesting Practitioner in writing within 14 calendar days and documented in the health record.

2.3. The MS Contract Vendor shall ensure each complex outside consult meeting complies with Department Orders and Medical Services Contract Monitoring Bureau Technical Manual guidance and shall ensure further consistency in the procurement of health related goods and services delivered to the inmate population among complexes within the region.

2.4. This shall be accomplished through the required statistical reports as defined in the Contract.

3.0. Medical Records and Documentation Requirements to ensure that pending appointment information is transferred from the sending facility to the receiving facility.

3.1. The Vendor complex DON shall monitor Nursing staff for ensuring that the systems that are in place are followed in order to provide the necessary information and to convey inmates to specialty appointments. In addition, the Contract Vendor shall coordinate the necessary in-service training to accomplish this process in an accurate and timely manner.

4.0. Medical Record Scheduled Appointment Format will be used for Outside Referrals.

4.1. Format Management—on-site specialty appointments: Inmates are to be scheduled for appointments as indicated by the specific discipline providing the required service or exam. Upon completion of the scheduled appointment any subsequent appointment that is scheduled shall be noted in the appropriate health unit appointment register. The scheduled appointment shall be noted on the "Scheduled Appointment" register. The documentation shall note:

4.1.1 The date the inmate was seen;

4.1.2 The date of the scheduled appointment;

4.1.3 The appointment location;

4.1.4 The appointing discipline; and

4.1.5 The indicating reason for the specific health care appointment.

4.2. In the event that an appointment is to be scheduled and there are compelling reasons that cannot be scheduled at the time of the initial appointment, documentation as to the reason shall be completed. The author of the initial appointment or the staff member noting the order shall document in the progress note the reason for the postponement of the next scheduled appointment.

4.3. When the determination has been made that the appointment, as noted above, is to be made; a member from the respective discipline shall place the appointment date in the unit appointment register and on the Scheduled Appointment register.

4.4. Upon completion of the scheduled appointment the actual date the inmate was seen shall be documented.

4.5. If the initial date of the scheduled appointment is changed the unit appointment register shall reflect the rescheduled date. In addition "Rescheduled" shall be documented in the Scheduled Appointment register and a new and total entry shall be completed.

5.0. Process Management: Community Appointments: Upon the Vendor's Clinical Coordinator's receipt of the approval of an outside consultation, the Clinical Coordinator shall: Arrange for the outside appointment as directed by local post orders; and contact the sending medical unit Vendor Nursing staff with the specific information as outlined in this document. The unit Nursing staff is responsible for the completion of this document.

6.0. The Nurse noting the orders of the Vendor Medical Practitioner/Provider is responsible to enter the proper information noting the actual date the inmate was seen upon the inmate's return from the outside consultation. Subsequent follow-up appointments on or off the prison complex must be documented as directed in this document. The Scheduled Appointment register shall be maintained and be readily obvious in the health record.

7.0 Prisoners who are military veterans shall be provided care within Arizona Department of Corrections Rehabilitation & Reentry medical system and shall not be referred out to VA Hospitals or clinics for medical care. The Veterans Administration Representatives may be authorized, (with the appropriate security clearance); to provide on-site benefits evaluation or delegate such benefits evaluations to the Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contractor.

Chapter 7, Sec. 3.0 Outside Hospitalization

REFERENCES: DEPARTMENT ORDER 711
DEPARTMENT ORDER 1101
NCCHC STANDARD P-D-05
NCCHC STANDARD P-E-13

PURPOSE: To ensure that the inmate's serious medical needs are met by providing a pre-arranged plan for hospitalization beyond the confines and medical capabilities of the prison complexes utilizing the existing community resources.

RESPONSIBILITY: It is the responsibility of the, ADCRR Contract Vendor to be aware of both local and regional options available in the community to accept continued medical care of incarcerated inmates.

PROCEDURES:

1.0. Regional Hospitalization: ADCRR Contract Vendor will coordinate the development and maintenance of written contracts for hospitalization of inmates beyond the confines of the prison complexes. The contract documents will specify the agreed upon reimbursement arrangements and billing practices. Services will consist of Level One Trauma, intensive care, and routine hospitalized care for all anticipated medical conditions.

1.1. Responsibility for medical care will be transferred to the Medical Practitioners licensed to practice medicine in the state and credentialed in good standing by the contracted hospitals.

1.2 Admission of the inmate to the hospital may be arranged in advance through a Direct Admission process and/or through the hospital's Emergency Department.

1.3. The Vendor is responsible to brief the MSCMB (Medical Services Contract Monitoring Bureau) Assistant Director or designee, MSCMB Program Evaluation Administrator and MSCMB Medical Program Administrator on issues of impending death, unusual medical complications, end of life treatment issues, and public or high profile cases.

1.4. Local hospitals closer to the individual locations of each prison complex may be utilized for emergency services and routine care.

2.0 The Vendor will define service requirement and assure the smooth transition of care and admission for the inmates.

2.1. Copies of contracts detailing local arrangements shall be provided to the MSCMB Assistant Director.

2.0. Incarcerated ADCRR inmates require the same commitment of hospitalization and specialty care for all contracted facilities, both in-state and out of state.

3.0. Hospitalization of Inmates

3.1. Hospital admissions may occur from pre-scheduled surgeries or procedures, from emergency department follow up, and/or from immediate admission/referral from a consulting Physician/Licensed Practitioner of the inmate who may have been seen as an outpatient visit on a particular day.

3.1.1 Direct Admission to the hospital may also be made in an urgent situation by the Vendor Practitioner/Provider on the prison complex working directly with the hospital-based Specialist to admit the patient under the care of the Specialist directly to the hospital, thereby, circumventing a clinically unnecessary stop in the Emergency Department.

3.1.2 Emergent admissions may be made by transporting the inmate 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.

3.2. For pre-scheduled admissions with sufficient time for one-on-one discussions, the Vendor Medical Practitioner shall, in language the inmate can understand, explain the hospitalization, procedure, test, treatment, etc., to include: the nature and purpose of the referral; the risks/side effects and benefits; alternative methods/options that were or can be considered. This does not lift the responsibility that the surgeon bears to acquire informed consent. The Vendor Practitioner (Provider) or Vendor Nursing personnel who discusses the admission must document the discussion on the Consent Form signed by the inmate. In some medically complicated cases, the unit Practitioner may deem it appropriate for the Specialist to obtain the Consent Form and if necessary, complete a Refusal of Treatment form (if the inmate refused care) following the appointment and discussion by the inmate with the Specialist.

3.3. As a general rule, inmates will not be transported off-complex to outside hospitals without the acknowledgment and/or direction of a Vendor medical Practitioner employed by ADCRR Contract Vendor. The Vendor FHA or designee will be contacted by either the Vendor Nursing staff or the Vendor Practitioner of any "send outs" to the hospital or emergency facilities. In medical emergencies, where time is of the essence, the FHA, in consultation with the nursing staff, may authorize a medically-related transport to the hospital if a continued delay in waiting for an after-hours response from the Practitioner would likely have a negative impact on the appropriate care of the inmate. At the time of the Send Out, Vendor Nursing personnel will initiate and send with the inmate to the hospital, the Outside Consultation Request; pertinent recent Progress Notes, and a list (or printout) of the inmate's current medications. The Continuity of Care document may also be completed for significant other medical issues. The FHA, or his designee, will provide notification to the appropriate individual of any non-scheduled transports for medical care in accordance with the Vendor current Communications policies. In emergency situations, the Vendor Practitioner (or attending Vendor Nurse) will contact the receiving hospital facility to advise of the impending transfer.

4.0 Hospitalization

4.1. Once hospitalized, the Contract Vendor Utilization Management staff will monitor the inpatient care of the inmate and will determine authorization of any additional procedures that the hospital and/or Specialist may propose following admission.

4.2. Daily reports will be required to be provided by the Contract Vendor to the Central Office MSCMB.

4.3. The Vendor FHA or designee will continue telephone contact with the inmate's designated emergency contact following the initial notification provided by the complex chaplain in accordance with Department Order 711.

5.0. Visitation: Hospital visits by the relatives of a hospitalized inmate will be coordinated by the sending complex Vendor FHA according to the seriousness of the medical condition and the restrictions required by Security. In no case, will safety for the public be diluted to allow a visit.

6.0. Return to the Prison Complex

6.1. Discharge planning, and the return of the inmate to the sending complex, will be coordinated by the Contract Vendor Utilization Review staff. Decisions about the need for additional medical needs, post-

hospital discharge, may determine alternate placement in an IPC special needs bed, and/or considerations relative to special mobility issues.

6.2. Discharges from the hospital will be coordinated by Contract Vendor UM staff with the hospital and the receiving facility.

6.3. Security will return the inmate directly to the HEALTH UNIT of the housing yard of the inmate upon his/her return to permit, the Vendor Nursing staff to: Assess the inmate following transport, determine any continuity of care issues, identify any medications the inmate may have been sent back, obtain new prescriptions from the Vendor Practitioner for any changes in medications, evaluate the need for current insulin injections of known diabetics, schedule an encounter with the Vendor Practitioner to occur within 24 hours of return, identify any follow up and/or return visits to the Specialist, and identify any special needs for continued recovery, such as crutches, wheelchairs, dressing changes, elastic supports, and oxygen therapy.

6.4. Appropriate discharge information and follow-up plans will be provided by the hospital and made available to the inmate within the requirements of control of information.

6.5. Inmates returning after regular health services clinic hours will be taken directly to the facility's identified health unit for evaluation and review of discharge paperwork.

Chapter 7, Sec. 4.0 Infirmary (IPC)

REFERENCES: DEPARTMENT ORDER 1101
NCCHC STANDARDS P-G-02
NCCHC STANDARD P-G-03

PURPOSE: To facilitate timely and appropriate care to meet the serious needs of inmates assigned to inpatient components sheltered housing/Assisted Living units, special needs unit, located at Florence, Tucson, Perryville, Lewis and observation beds located at the private prisons.

RESPONSIBILITY: It is the responsibility of all Vendor Health staff to facilitate the transfer of inmates requiring more definitive or supportive care to an appropriate housing placement.

POLICY:

1.0. Medical Segregation in an inpatient setting may occur due to an inmate's medical condition requiring more definitive and supportive levels of nursing care than an inmate can receive in general housing areas. ADCRR Contract Vendor maintains several specially designed and Vendor staffed areas to provide for this level of care. These medical areas can be identified as: Inpatient Components (IPCs) that function like a medical infirmary with overnight bed accommodations, Special Needs Unit (SNU), Sheltered/Assisted Living and Observation Beds. Any change to the above structure shall require a written plan with appropriately assigned patient acuity (medical score), appropriate patient selection and appropriate staffing levels, and require 24 hour nursing care coverage.

1.1. Movement in and out of the IPCs is controlled and directed by Vendor medical personnel and is based upon medical conditions. IPCs are NOT to be used for detention or other security purposes.

1.2. Consideration must be given for careful coordination between custody vs. care. Medically appropriate inmates must be placed in the open and proper IPC bed locations while security and safety for staff and inmates must be maintained.

2.0. Inpatient Components

2.1. Admission Procedure: Admissions to the IPC must be coordinated by the Vendor Facility Health Administrator of the unit where the IPC is located. Admissions requiring movement from one complex to another must be submitted through Contract Vendor designated personnel. An Inmate Transfer for Medical Reasons Form #108-3(e) must be completed or submitted electronically by the Vendor Utilization Management Nurse or designee. The request shall be forwarded to Central Classification. Implementation of this transfer requires the signature of the Vendor Utilization Management MD or designee or the Vendor UM Nurse or designee. Upon request for movement into IPC, an Inmate Transfer for Medical Reasons Form #108-3(e) shall be completed or electronically submitted by the UM Nurse and forwarded to Central Classification.

2.2. Requests for transfers will be forwarded to Central Classification by the Vendor UM Nurse. The inmate's health records will be transferred to the receiving IPC by the sending facility.

2.3. When the admission comes following a hospitalization, the sending facility will transfer the health records after thirty days or immediately upon request.

2.4. All medical visits in the IPC will be provided on a No Charge basis using the appropriate exemption code of the Health Service Appointment List.

3.0. Level and scope of care:

3.1 Acute care: any combination of frequent observation, assistance with care activities, dressing changes, IV fluids or medications, self-care instructions or pain management.

3.2 Complete care: unable to perform any self-care, needs to be turned, may need suctioning, oxygen-dependent, bowel and bladder care, tube feedings.

3.3 Supportive: able to perform own care but needs constant supervision and verbal cueing.

3.4 Convalescent: can do own care but lacks stamina to function in general population.

4.0. Clinical Responsibilities:

4.1. In patients arriving from a hospital prior to 1630, the Vendor IPC Practitioners/Providers will review the discharge orders before the end of that IPC Practitioner's shift if on site. The IPC Practitioner will, also before the end of that shift, write admitting orders that comply with Vendor's formulary. If the patient arrives after 1630, the admission orders must be obtained by the Vendor duty nurse from the discharging facility as soon as possible.

4.2. No more than 72 hours will elapse between Vendor Medical Practitioner visits to the IPC units. In the absence of the assigned medical Practitioner, another Vendor Practitioner will be assigned the responsibility of the visits. On weekends/holidays after normal duty hours, the Vendor medical Practitioner designated on the urgent notification roster will be called for orders when needed. Medical orders from the hospital for medications and treatments may be continued. The medical Practitioner will rewrite the orders on the next normal work day.

4.3. Inmates admitted to the IPC will have a history and physical completed by the Vendor Medical Practitioner within 72 hours of arrival. Inmates housed in the IPC will be evaluated by the Vendor Medical Practitioner at minimum every 72 hours. The medical Practitioner will utilize the SOAPE progress note format for their visits.

4.4. If the assigned Practitioner will not be on duty for 72 hours or more (i.e. vacation) the Practitioner shall ensure the inmate is followed by another Vendor Practitioner for continuity. In the event the Vendor Practitioner is unexpectedly unavailable for duty, the inmate will be followed by the Vendor Practitioner on call.

4.5. Vendor nursing personnel will observe the assigned inmates/patients frequently during each shift. Inmates in IPCs will be visited/assessed by Nursing on a q shift basis. Daily health assessments, each shift vitals and care provided will be documented in SOAPE format in the health record.

5.0. Non-IPC, Sheltered Housing/Assisted Living Units, and Special Needs Units, are utilized for inmates with health related issues that do not require the level of care in the inpatient area. They may or may not be in the same housing area as an IPC. Special Needs Unit provides care to patients with an illness or diagnosis that may require monitoring, medication and/or therapy less frequently than an IPC setting, or may require assistant with activities of daily living. Assisted Living provides care to patients whose health needs require a protective environment than in the general population housing areas. The inmates in this area require assistance with some of their care. Often they require cueing for some activities and medication administration.

5.1. Admissions must be coordinated through the Vendor Facility Health Administrator of the facility where the sheltered housing is located. Screening must be accomplished to prevent housing of inmates who would pose a danger to the others assigned to the unit.

5.2. Guidelines for the management of chronic conditions will be maintained. Vendor Medical Practitioners will provide ongoing visits weekly for the inmates housed in the unit. Vendor nursing staff will make visits to the unit at least every shift and more often as needed for the health and welfare of the assigned inmates.

5.3. A weekly documented nursing assessment shall be performed. All assessments shall include complete vital signs and weights with documentation.

5.4. Vendor Practitioner follow-up will be weekly for inmates housed in Special Needs Unit.

5.5. When an inmate must be transferred from one complex to another, it must be coordinated by the Vendor UM Nurse or designee with notification to Central Classification.

6.0. Staffing requirements

6.1. IPC Staffing: A Vendor Registered Nursing Supervisor will be responsible for the daily activities of the nursing staff on the unit. Each shift will have a minimum of two Vendor Registered Nurses assigned (at all times in Tucson & Florence IPC). A Vendor Licensed Practical Nurse (LPN) may be assigned to augment the activities of the RN. Vendor Nursing Assistants (NAs) can be utilized to provide assistance with activities of daily living and routine care such as monitoring vital signs. Mid-level Vendor Practitioners may be used to provide care on a temporary or intermittent basis but may NOT be assigned as attending Practitioner.

6.2. Special Housing Unit Staffing: A Vendor RN shall be assigned to monitor the care provided in the unit. Vendor LPNs may be assigned to provide the nursing care in the unit with a RN on-site for consultation when needed. Vendor CNAs may be used to assist with personal care if needed by the inmate. Vendor Mid-level Practitioners may be assigned to provide the medical care.

6.3. In situations where a staffing decision is being made between LPNs and RNs, Registered Nurses are the preferred level of staffing for inpatient components. LPNs shall NOT be the supervising care giver in an inpatient component.

7.0. Record keeping: The Vendor Practitioner and the Vendor Nursing staff will use the SOAPE format in the health record. An IPC chart will be initiated on every new admission to the IPC. The same chart will be used for the inmates who return from the hospital after being admitted for more treatment/testing. The Practitioner will complete a discharge summary when the inmate is discharged to return to his sending unit.

7.1. The IPC chart will be incorporated in the permanent record. The Physician's/Practitioner Order, Admitting/Discharge Summary, Nursing care Plans should be filed/scanned under the Hospital Records Tab with the Admission/Discharge summary placed on top. The other portions of the IPC record should be filed/scanned under the appropriate tab (SOAPE notes, lab, and med sheets). If the record has not been developed with a Hospital Records Tab, the information will be temporarily filed/scanned under the Consultation Tab until the Hospital Records Tab separator can be acquired.

7.2. A separate chart does not need to be created for Medically Segregated/Special Housing Unit inmates.

7.3 All inmates in sheltered/Assisted Living, special needs unit, and observation beds or in the IPC with a medical score of M-3 or above shall be supervised or assisted in the shower for bathing by medical personnel as necessary based on mobility, fall risk or medical need.

7.4 Observation bed(s): are designated for medical/mental observation for specific stated purposes including any medical/mental condition that warrants observation and can safely and appropriately be carried out in facility medical observation. Examples include the following: watching the inmate/resident patient's response to a change in medication regimen, to prevent an inmate/resident patient from eating or drinking before a medical test that requires such restriction, to allow inmate/resident patients to recover from day surgeries or medical procedures, or to watch the general behavior of inmate/resident patients whose mental stability appears questionable. No inmates are to visit other inmates.

7.5 Placement Criteria: inmate/resident patients may be placed in an observation bed by a medical Practitioner/Provider; however, a Practitioner/Provider order is required for observation to continue beyond a twenty-four (24) hour period.

7.5.1 Criteria for placing inmate/resident patients in an observation bed may include, but is not limited to:

a) Convalescent care,

b) Post-seizure activity;

c) Objective weakness;

d) Observation for simple allergic reactions;

e) Flu symptoms;

f) Diabetes management and or

g) Any medical condition that warrants periodic observation

7.5.2 Health staff is available to assist patients housed in the observation unit 24 hours per day, seven days per week.

7.5.3 A health care provider is on-call 24 hours per day, seven days per week.

7.5.4 Patients are always within sight or hearing of a qualified health care professional.

7.5.5 The number of sufficient and appropriate qualified health care professionals is based on the number of patients, the severity of their illnesses, and the level of care required for each.

7.5.6 A supervising registered nurse is on site at least once every 24 hours.

7.5.6.1 A manual of nursing care procedures is consistent with the state's nurse practice act and licensing requirements.

7.5.7 Admission to and discharge from the IPC (infirmary) occurs only on the order of a medical Practitioner (or other clinician where permitted by virtue of his or her credentials and scope of practice).

7.5.8 Medical Practitioner orders direct the care provided to patients housed in the infirmary, observation unit or sheltered housing.

7.6 If at any time the inmate/resident patient's condition deteriorates or is identified as requiring nursing care beyond the facility's capability, the medical Practitioner will be immediately notified and an appropriate transfer will be initiated. If the inmate/resident patient exhibits significant life or limb threatening deterioration, the inmate/resident patient may be transferred to the ER immediately.

7.6.1 A medical Practitioner's order is required for the release from observation.

7.6.2 Observation beds are not intended to be used during a census crisis. During extreme cases of census crises, observation beds may be utilized with the prior written approval of the Managing Director, Facility Operations and Regional Director, Health Services, Written approval must be obtained for each occurrence.

7.7 A health record is kept for each patient and includes:

a) Admitting order that includes the admitting diagnosis, medication, diet, activity restrictions, diagnostic tests required, and frequency of vital sign monitoring and other follow-up.

b) Complete documentation of the care and treatment given

c) The medication administration record and

d) A discharge plan and discharge notes

7.7.1 Observation patients may be placed by a qualified health care professional other than a physician; however, a physician's order is needed to keep them longer than 24 hours.

7.7.2 When a patient is admitted to an observation bed for mental health reasons, the patient's mental health care is supervised by mental health clinicians.

7.8 Inmates shall not be admitted to an IPC bed for mental health watches.

Chapter 7, Sec. 5.0 Emergency Medical Transportation Services

REFERENCES: NCCHC STANDARD P-E-08
NCCHC STANDARD P-E-10

PURPOSE: To assure that a written plan is in place pertaining to the emergency transport of an inmate from a facility to a hospital, and that medical or prison personnel involved in the transport as well as receiving hospital professionals are advised of all medical needs and issues.

RESPONSIBILITY: The Contract Vendor Facility Health Administrator or designee and the Vendor complex Medical Director or designee, jointly bear the responsibility to create systems that support emergency medical transportation services at each respective prison. The Vendor complex Director of Nursing (DON), is accountable for assuring that Vendor Nursing staff in preparing inmates for transport; adequately inform involved Vendor medical and security personnel of pertinent data; as well as organizing and sending necessary written documents.

PROCEDURES:

1.0. Arranging for Emergency Medical Transportation Services: For the purposes of this policy, Emergency Medical Transportation Services will be defined as either ground-transport ambulance or air ambulance.

1.1. During regular business hours, the Vendor Nurse and or on-site Vendor Practitioner (Provider) will evaluate medical emergencies and determine if ground ambulance or air ambulance services are necessary. If a medical emergency is considered life-threatening, 911 should be immediately contacted.

1.2. After hours, nursing personnel shall immediately ask that 911 be called if an emergency medical condition is determined to be life-threatening. If the medical emergency is not immediately life threatening, the Nurse will contact the Practitioner (Provider) assigned on the Urgent Response List to obtain orders for off-site use of an ambulance.

2.0 The Vendor Nurse coordinating off-site emergency transfers will assure that the unit shift commander is immediately informed of the emergency so that security escort staff can be assigned.

2.1. Security will provide the required number of escorts for all send outs. In general: Security will provide two escorts and a chase vehicle to accompany the ambulance services that have been requested by Vendor medical to transport an inmate to a selected hospital and/or medical facility. Escorts will be staged by Security as quickly as possible to avoid any delay in the initiation of the offsite emergency send out. Radio contact will be maintained between the officer riding in the ambulance and the officer in the “chase” vehicle. On air transports, the security team will also be staged similar to that of ground transportation, i.e., one officer will accompany the patient being flown out. Death row inmates and high risk inmates may have a second set of escorts staged by Security, but without delay to the medical

urgency of the transport. The Vendor unit Nurse will continually monitor and attend to the needs of the inmate in an emergency.

3.0. Notifications:

3.1. Any upgrading, or changing, of the medical destination by Vendor Health staff or by the accepting provider will be communicated to the chase vehicle officer who will advise the sending complex of the altered change in plans. This could also involve an upgrade to a helicopter transport if the patient's condition becomes more critical.

3.2. Any significant delay in the transportation of an emergency send out will be reported to the complex Warden for follow up and review of circumstances to determine appropriate steps that might be taken to minimize any future events of a similar nature.

3.3. The Vendor Facility Health Administrator will be immediately contacted by the Nurse if the following conditions occur related to an emergency medical transport: Emergency medical personnel (fire or paramedics) determine that an inmate must be flown by air ambulance to a destination hospital, or the inmate expires after off-site medical transportation is initiated.

3.4. After hours, following the departure of an inmate by emergency medical transportation, the Vendor nurse will contact the Vendor Facility Health Administrator or designee and leave documentation for the review on the following workday by the Vendor Clinical Coordinator and the Vendor DON (as designated by each facility). If the Vendor Nurse cannot make contact with the Vendor FHA, leave a voice or e-mail message regarding the Name and ADCRR number of inmate; Housing location; Medical condition requiring transport; Type of emergency transport, Destination hospital, Date and time of transport.

4.0. Emergency Medical Record package

4.1. Specific portions of the medical records must be transported with an inmate when emergency transportation is utilized. The following will be packaged: Transfer Summary Continuity of Care (1101-8P); Request for Medical Records (1104-1); Outside Consult Request (1101-63P); Declaration of Intent to Limit Life-Support Procedures-copy, if established (1101-9P); For pregnant inmates, copies of the Pregnancy Packet.

4.2. After hours, assistance may be rendered by security staff (including medical liaison) in obtaining medical records not immediately available to Vendor Nursing personnel, as well as copying and other administrative duties that need to be completed prior to the arrival of emergency transport.

5.0. Medical Equipment

5.1. All efforts should be taken by the Vendor Nurse to retain equipment that is the property of ADCRR/Contract Vendor. This includes full and half-back boards, wheelchairs, stretchers and any other equipment that could be utilized by emergency transport services. In the event such equipment is taken, the Nurse will complete an Incident Report noting the agency that took the equipment, and submit to the Vendor Facility Health Administrator.

5.2. Effective chest compressions during Cardio-Pulmonary Resuscitation (CPR) cannot be accomplished when the patient is on a bed or a gurney. Medical personnel, performing or supervising the performance of CPR should ensure that CPR is performed on a solid surface. A backboard is required when performing CPR on a bed, gurney, or other transport device.

Arizona Department of Corrections Rehabilitation & Reentry	Segregation (Lockdown status)	OPR: MS Contract Vendor Regional Medical Director MS Contract Vendor Regional Nursing Director MSCMB Medical Program Administrator MSCMB Health SVS Coordinator Auth: nt
Medical Services Technical Manual	MSTM Chapter 7 Section 6.0	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 7, Sec. 6.0 Segregation (lockdown status)

REFERENCE: DEPARTMENT ORDER 804
DEPARTMENT ORDER 1103
NCCHC STANDARD P-E-09
NCCHC STANDARD P-E-10
Mental Health Manual

PURPOSE: To provide continuity of care for all inmates who may be transferred into a housing area that has been designated for isolation and/or segregation of inmates. To ensure that the inmate's medical record is reviewed upon placement/transfer to the special area. To assess an inmate's medical issues and needs relative to any complications arising from a new housing area and to assure that the inmate has continuing access to health care.

RESPONSIBILITY: It is the responsibility of the Contract Vendor complex Director of Nursing (DON) to assure that inmates are not transferred to alternative housing areas where their medical needs cannot be accommodated or met.

PROCEDURES:

1.0. Special housing may be referred to as Protective Segregation (PS), DI67, Detention, Central Detention Unit (CDU), Administrative Detention, Lockdown Status, Special Management Areas, Special Management Units or similar terms. The term "Segregation" will be used to refer to all of these areas and functions. This policy does not apply to short term holding cells used by security, nor to suicide or mental health watches, nor to hunger strikes which are addressed elsewhere.

1.1. Detention Rounds must be conducted by Vendor health staff a minimum of 3 days per week on non-consecutive days.

1.2. In accordance with the guidance contained in MSTM Chapter 5 Section 3.1 security will support Vendor Health Services by assure appropriate portable collection boxes are available for inmates on a daily basis. In the lockdowns areas, the collection of HNRs will be done in such a manner as to assure medical confidentiality for the inmate.

1.3. Inmates in a "Lock-down/lockup" status will be instructed on local health care access procedures. Facility/complex post orders will include the following minimum elements of direction to Vendor staff:

1.3.1 Specifying how the HNR forms are made available to inmates.

1.3.2 Specifying how the forms are collected by health staff. Vendor health staff will gather those HNRs that Security has collected in the lockdown units.

1.3.3 Specifying that Correctional Officer (non-health services staff) are not authorized to directly handle the HNRs.

2.0. Security will notify Vendor Health Services of placement of an inmate in Segregation within one hour after an inmate is placed in detention. (Department Order 804).

2.1. Upon notification of an inmate's transfer a Nursing staff member shall perform an immediate chart review to ascertain if any medical, dental or mental health issues exist that would contraindicate the placement or require accommodation to the inmate's lockdown status, document findings including the date and time of the "lock down" in the Progress Notes of the inmate's health record.

2.2. When the notification includes information that the inmate is injured or appears to be ill, Vendor Nursing staff shall conduct an immediate hands-on assessment (for which there is no health care fee).

2.3. During the first visit, nursing staff shall complete an initial assessment to include vital signs and weight, any physical abnormalities, including bruises or abrasions.

2.4. Any suicide ideation is to be brought to the attention of the Vendor Mental Health Staff or the Vendor Practitioner (Provider) immediately with documentation in the Mental Health Progress Notes.

2.5. Keep On Person (KOP) medications will be allowed to continue to be in the possession of the inmate providing there is no indication of anticipated abuse. Direct Observation Therapy (DOT) medications will be retained by Nursing and administered by nursing service, as prescribed.

3.0. Ongoing Medical Care

3.1. Inmates will have access to sick call, based upon a schedule established by the facility throughout their segregation.

3.2. The HNR system will be monitored by the Vendor FHA to ensure that inmates have access to care in accordance with the basic requirements: routine, urgent, and emergent care is available to the inmates; and inmate patient (condition and records) confidentiality is respected.

3.3. Every inmate must have access to health care/sick call seven days per week.

3.4. When an inmate's housing or custody status precludes physically reporting to the Health Unit, a Vendor health services staff member will visit the housing area a minimum of three times per week to observe the segregated inmates' health status and coordinate any treatment required. There will be no health care fee for these observation visits as the visit was initiated by the vendor health services staff.

3.5. Should an extreme shortage of staff or a disturbance, preclude Nursing staff from making a required visit, security staff shall provide the escort and supervision necessary to ensure access to health care.

3.6. Necessary clinical encounters do not take place cell side, but must occur in an appropriate clinical setting. This requires coordination between the Vendor FHA and Warden.

3.7. Vendor nursing staff will assure that necessary referrals to the Vendor's Practitioner/Providers are scheduled on the Provider's Line.

3.8. Vendor Nursing staff will obtain monthly weights (or witness refusals) and document those in the health record. If an eight percent loss in weight or greater occurs from baseline measurements, the inmate must be seen by a Vendor Practitioner/Provider within five working days of the documented weight loss.

4.0. Documentation of Care-in-Detention rounds must occur at least 3 times per week.

4.1. Vendor nursing staff will record, in SOAPE format, all of the health encounters in the Progress Notes of the inmate's Health Record.

4.2. Detention rounds are to be documented on ADCRR produced rosters or count sheets obtained for each scheduled date of detention rounds. Specific guidance must be included in a Post Order or Institution Order. The Vendor health staff member is to place their initials by each inmate's name as rounds are conducted cell by cell. Detention rounds documentation is considered completed upon the health staff member signing and dating at the bottom of the roster or count sheet(s).

4.3. The Vendor Facility Health Administrator is responsible to ensure that these records are maintained in a complete form and are available for auditing. The documentation may be retained in the FHA's administrative offices or in the Detention Unit's files. The file location must be reasonably accessible to

health and operations staff performing audits to ensure that inmates placed in segregation maintains their medical health while physically and socially isolated. These files will be maintained for a minimum of three years.

4.4. Due to the extensive documentation of activities with segregated inmates required by policy and sound medical practices, the documentation described in this section will meet the requirements and serve as the documentation of a Health Services visit required under Department Order.

5.0. Extreme isolation refers to situations in which inmates are seen by staff or other inmates fewer than three times a day, and have little or no contact with other individuals. ADCRR does not have any authorized permanent housing in this category. However, should an inmate be placed in a temporary situation with these criteria, the inmate will be monitored by medical staff on a daily basis.

6.0. Medical segregation may occur due to an inmate's medical condition requiring more definitive and supportive care than an inmate can receive in general housing areas. These inmates may be transferred to an Inpatient Components (IPC). IPCs are not to be used for detention or other security purposes. Medical Segregation is not considered a security decision. Therefore, while there is no automatic reduction in inmate property or inmate privileges, the Vendor FHA must coordinate with the Warden to ensure the best level of health care response and care is provided to aid the patient's recovery while ensuring safety.

Arizona Department of Corrections Rehabilitation & Reentry	Management of Terminal Illness	OPR: MS Contract Vendor Regional Medical Director MS Contract Vendor Regional Director of Nursing MSCMB Medical Program Administrator MSCMB Health SVS Coordinator Auth: dr
Medical Services Technical Manual	MSTM Chapter 7 Section 7.0	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 7, Sec. 7.0 Management of Terminal Illness

REFERENCES: ARIZONA REVISED STATUTE § 36-3231
DEPARTMENT ORDER 1101.08
NCCHC STANDARD P-A-08
NCCHC STANDARD P-G-01
NCCHC STANDARD P-G-03
NCCHC STANDARD P-D-05
NCCHC STANDARD P-G-12
NCCHC STANDARD P-I-04

PURPOSE: To establish guidelines that ensure consistent management practices in providing end-of-life care for inmates with terminal illnesses who resides in ADCRR/Vendor's IPCs.

RESPONSIBILITY: It is the responsibility of all Contract Vendor Health Care staff assigned to provide care to the terminally ill to provide a supportive environment which preserves dignity and provides pain control measures to the terminally ill inmate. Inmates are informed of their rights to access to care as well as their right to limit life support measures at intake.

PROCEDURES:

1.0. Living Will/End of Life Care, dated 12-19-12. Should a terminally ill inmate, residing in an IPC desires to limit life support efforts and/or to enter into a DNR agreement in future emergent situations, they must document their directive to the Vendor Health Staff. At intake orientation, as described in MSTM 5.2.0. Inmates are informed of their right to implement a declaration via Form 1101-98.

1.1. The inmate must express this desire by documenting the request on an Inmate Letter (Form 70501168-A) to the Vendor's Facility Health Administrator. This letter may be written by the inmate; or dictated to a Vendor employee if signed by the inmate; or verbalized to a Vendor employee (and one witness), who will document the request on an IM letter form. An HNR may be accepted in lieu of an inmate letter.

1.2. The Vendor attending Health Care Practitioner will review the declaration with the inmate and sign the declaration as one of the two required witnesses. If the inmate is not deemed oriented, arrange for a psychiatric evaluation. The Health Care Practitioner shall discuss the inmate's illness, alternative treatment plans, and expected outcomes with the patient.

1.2.1 The Vendor FHA will arrange for a meeting with a Health Care Practitioner to determine if the inmate is alert and oriented prior to signing the declaration.

1.2.2 The FHA will schedule a face-to-face discussion with the inmate. At the meeting the FHA will explain the form and ensure that the inmate expresses understanding of the Declaration of Intent to Limit Life Support Procedures (Form 1101-9P). The FHA will sign as the second required

witness after the Vendor Medical Practitioner/Provider or Mental Health Practitioner/Provider signs the declaration and will ensure that the declaration is placed in the health record and copies are provided for the institutional record, master record, and to the inmate.

1.2.3 The Vendor Practitioner/Provider should write on the Problem list the Date and "DNR" and the front of the chart will need to be marked "DNR" under the name label. The forms should be filed in Legal section.

1.3. A Pre-hospital medical care directive will be completed at this time and kept in the Vendor Nursing office. The inmate will be advised that he may revoke the declaration at any time by verbally advising any member of the ADCRR staff, or contract vendor staff.

1.3.1 The Vendor Practitioner/Provider must enter the date and identity of "DNR" on the inmate's "Problem List"

1.3.2 The Vendor Health Staff must mark "DNR" on the front of the record, under the name label.

1.3.3 The forms should be filed or scanned in Legal section of the Health Record.

1.4. Extraordinary Life Support Measures: All Correctional staff are obligated to engage in life-saving measures for any inmate in physical distress regardless of the cause. An inmate's Pre-Hospital Care Directive or "Do Not Resuscitate" (DNR) request does NOT apply to security staff. A DNR is for use only by outside Health Care Providers, hospitals and/or hospice facility, or for use by MEDICAL STAFF ONLY, or while housed in the IPC.

1.4.1 Inmate patients' DNR requests will be honored only by contracted ADCRR medical staff.

1.4.2 Correctional staff shall engage in life-saving measures for any inmate in physical distress unless or until directed otherwise by contracted ADCRR medical staff.

1.5. Tape the orange DNR sheet to wall in each nursing station of IPC.

1.6. An inmate may revoke a declaration at any time verbally or by submitting an inmate letter or HNR stating his/her decision. All DNR identifying papers, cards, dots, or other labeling method, shall be removed from the inmate's area. The paperwork shall be placed in the legal section of the inmate's health record and be duly annotated as "WITHDRAWN". All medically indicated procedures shall be resumed as though the DNR had never been initiated. The inmate may re-instate the DNR directive by requesting a new declaration.

1.7. The Contract Vendor Regional VP/Administrator shall ensure that hospitals providing services to the Department are required by the contract to provide the Department with copies of their "Do Not Resuscitate" policy and procedures at the time the contract is approved. Inmates shall be afforded the opportunity to complete a Pre-Hospital Medical 'Care directive (Form 1101-83P):

1.7.1 Upon return from a community hospital.

1.7.2 Subsequent to admission to an In-Patient Component Unit or similar medical unit.

1.7.3 The directive shall be witnessed and have the inmate's picture attached.

1.7.4 Displayed in a prominent place in the unit nursing station.

1.7.5 Copied and placed in the inmate's health record.

1.8. If an inmate is determined to be unable to make or communicate health care treatment decisions a reasonable effort will be made to contact a surrogate who has been identified by the inmate. In the absence of a surrogate who has been identified by the inmate, contact will be attempted in accordance with the guidance contained in Arizona Revised Statutes; specifically A.R.S. § 36-3231 which states in part:

1.8.1. If the patient has a health care power of attorney that meets the requirements of § 36-3221, the patient's designated agent shall act as the patient's surrogate. However, if the court appoints a guardian for the express purpose of making health care treatment decisions, that guardian shall act as the patient's surrogate.

1.8.2 A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall

not make decisions to admit the patient to a level one behavioral health facility licensed by the department of health services, except as provided in § 14- 5312.01, 14-5312.02 or 36-3281.

1.8.3 If the admitting officer for a Mental Health Care Practitioner/Provider has reasonable cause to believe after examination that the patient is incapable as defined in § 36-3281, and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in a level one behavioral health facility based on informed consent given by the agent or guardian. The patient shall be discharged if a petition for court ordered evaluation or for temporary guardianship requesting authority for the guardian to consent to admission to a level one behavioral health facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.

2.0. Pain Control. All patients diagnosed terminally ill will have a care plan. Physical measures, such as ice packs, heat, position changes and air mattresses will be used as needed to enhance the comfort of the inmate. Medications will be given as ordered by the Vendor Health Care Practitioners/Provider to achieve maximum comfort for the inmate. Food and fluids will be provided as tolerated by the inmate.

3.0. General policies for hospice type services. Terminally Ill/Hospice care will be provided for inmates who are in the last stages of a diagnosed terminal illness. Hospice care focuses on the achievements the patient is able to make in face of physical deterioration. Terminally ill patients will be provided support in a manner that is consistent with the basic medical doctrines of comfort support for the dying.

4.0. Responsibilities of certain Health Care Practitioners/ Providers during terminally ill care:

4.1. Medical: The Vendor complex Medical Director or designee will complete a symptom or system specific examination and develop a plan of clinical care detailing treatment, pain control and resuscitation status for consideration within 48 hours of admission. The Practitioner/ Provider will have regular contact with and make complete progress notes on all terminally ill patients. He/she will note all changes in plans of care in the progress note. Physician orders will be written as indicated.

4.2. The Vendor Facility Health Administrator or designee will coordinate with security for special visits when appropriate, remain administratively responsible for ensuring that all aspects of supportive care are carried out. The FHA will arrange for the utilization of a private room for the terminally ill patient when appropriate.

4.3. Consistent with state regulations, the FHA will facilitate the potential early release of terminally ill inmates in a timely manner when appropriate.

4.4. After each patient's death, the FHA will arrange for health services staff involved in the patient's care to access Employee Assistance and Support services through the CISD team.

5.0. The Vendor Inpatient Component Nurses are responsible for ensuring that the Vendor/Health Care Practitioner/Provider orders are processed and carried through; completing a daily nursing assessment, take vital signs every shift and make an entry on the patient's progress note at least every shift or as ordered by the Vendor Practitioner; notifying the Vendor complex Medical Director or treating Practitioner of any significant changes in the patient's condition; ensuring that treatment orders, medications, etc. are administered as prescribed and documented and that activities of daily living are met; providing at the end of each shift, a report to be given to the oncoming infirmary Nurse; and reporting all patient deaths per Department Orders and this manual.

6.0. Monitoring and Review: Terminally ill admissions and assignments to the infirmary shall be monitored by the Vendor complex Medical Director and Vendor Facility Health Administrator for clinical appropriateness, quality of care and pain management.

Chapter 7, Sec. 7.1 Inmate Mortality

REFERENCES: DEPARTMENT ORDER 601, Administrative Investigations and Employee Discipline
DEPARTMENT ORDER 1105, Inmate Mortality Review
2018 NCCHC STANDARD P-A-09, Procedure In The Event Of An Inmate Death
2020 ACA Standards:
5-ACI-6A-36, Suicide Prevention and Intervention
5-ACI-6C-03 (M), Confidentiality
5-ACI-6C-16, Offender's Death
5-ACI-6D-02, Internal Review and Quality Assurance

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

RESPONSIBILITY: The Department's Contract Healthcare Provider (CHP) Regional Medical Director retains responsibility to administer death events. It is the responsibility of all CHP clinical staff to understand and comply with this policy in supporting the reviews of deaths to validate the quality of care and to apply lessons learned in future mortalities.

PROCEDURES:

1.0 Pronouncement:

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

1.2 Although Criminal Investigative Unit officers are authorized to pronounce death due to their status as a peace officer, they will not pronounce deaths on inmates that are within the confines of the Department's prison system.

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

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

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

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

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

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

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

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

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

2.3 Psychological Autopsy

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

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

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

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

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

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

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

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

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

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

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

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

2.5 Joint Mortality Review Committee (JMRC)

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

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

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

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

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

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

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

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

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

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

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

Chapter 7, Sec. 7.2 Paper Health Records Transfer Process – Deceased Inmates

REFERENCES: NCCHC STANDARD P-A-09, Procedure In The Event Of An Inmate Death
NCCHC STANDARD P-A-08, Health Records
ACA STANDARD 5-ACI-6D-05, Health Records

PURPOSE: To provide a uniform system to prepare paper health records for transfer of the records of deceased inmates to Medical Services Contract Monitoring Bureau (MSCMB) at the time of the death of an inmate.

RESPONSIBILITY: The Contract Healthcare Provider (CHP) complex Medical Records Librarian is responsible for health records review and updates when an inmate departs the prison system due to death.

PROCEDURE: DECEASED INMATES

1.0. When an inmate has expired:

1.1. The CHP Medical Record Librarian at the unit housing the inmate at the time of his death must secure all volumes of the health records, any "loose sheet" filing, Medication Administration Records, and any diagnostic reports that have not been signed by the provider.

2.0. The date of death and complex shall be marked on the front of each volume. The date shall be located (under Allergies) on the Name/ADCRR # Label. The date shall be hand written in RED MARKER as shown: EXPIRED: ___/____/_____ Complex/Unit name: _____

2.1 Complete columns 4, 5, and 6 of the Inmate Chronological Movement Record to document the date deceased.

3.0 If any volumes are missing, every effort shall be made to locate the missing volume. MSCMB – Department's Medical Records Monitor shall be notified to search the database to see if it is in storage. If in storage, the health record shall be ordered from storage and kept at MSCMB for placement with the current records/or sent to CHP Facility Health Administrator (FHA) at complex. If the record is not in storage, the Medical Record Monitor will email all CHP Medical Record Librarians to conduct a thorough search of all units to locate the missing volumes.

4.0 The health record(s) should be taken to the CHP FHA and a Mortality Review Committee meeting will be scheduled within seven business days of death.

5.0 The health record(s) shall be sent by the CHP Medical Record Librarian II via Fed EX, UPS, or other acceptable certified package postal system to either the CHP for the State Complexes or for the Private Prison complexes to MSCMB – Department's Medical Records after the second mortality review has been completed.

6.0. Charts MUST NOT be sent to MSCMB via the interdepartmental mail unless approved by the Department's Medical Record Monitor.

Chapter 7, Sec. 7.3 Hospice Services Support Organization

PURPOSE: To provide basic responsibilities and foundational outlines to guide in the development of a Hospice program in support of inmates with terminal illnesses.

RESPONSIBILITY: It is the responsibility of all Contract Vendor Health staff, when authorized; develop Hospice services in accordance with the guidelines contained in this document and in the Contract.

PROCEDURES:

1.0. General guiding principles for hospice care. The Contract Vendor has a responsibility and a goal of providing Terminally Ill/Hospice care for inmates who are in the last stages of a diagnosed terminal illness. Hospice care focuses on the achievements the patient is able to make in face of physical deterioration. It encourages the patient to come to terms with his or her physical, mental, spiritual and emotional capacity, while providing a safe, pain-controlled and comfortable environment. Those who may be asked to participate in the hospice care team include: direct care Vendor health services staff, Religious Services, Mental Health personnel, and off-site consulting Practitioners.

1.1. Hospice care will be provided to ADCRR inmates as appropriate.

1.2. Family involvement will be encouraged and information provided to them during the terminal stages of the illness.

1.3. Vendor medical personnel will deliver direct physical care and medication administration.

1.4. Volunteers may be used for spiritual and emotional support.

1.5. Adequately trained and screened inmates may be used as volunteers.

1.6. All measures will be taken to preserve the inmate's dignity while in terminal/hospice care.

1.7. The hospice system will be administered through the support of a multi-disciplinary team. The team may consist of a Chaplain, a representative from Mental Health, the Program Counselor assigned to the patient, Vendor health staff, Vendor complex Medical Director, other Vendor health care or non-health care Practitioners (Providers) as deemed necessary by the Vendor Facility Health Administrator, and Security staff designated by the Warden.

2.0. Admission to Hospice Program

2.1. The Vendor Facility Health Administrator will, with a supporting inter-disciplinary team, develop admission criteria. The following elements are the administrative actions to be taken for admission. Patients become eligible for hospice care when they are diagnosed with a terminal disease and a prognosis of one year or less to live. The treating Practitioner shall inform the patient of the prognosis and treatment options, which include hospice care. Vendor health staff will make a referral to the institution Vendor Facility Health Administrator (FHA) or designee for the admission to the hospice care

program. The FHA or designee will request from the treating Practitioner the patient's diagnosis and estimated prognosis. If the patient's medical condition meets the admission criteria, the Facility Health Administrator or designee shall meet with the patient to inform him/her of the care that is available and to determine if the patient wishes to participate in hospice care.

2.2. The Facility Health Administrator or designee will notify the Vendor complex Medical Director or designee and schedule an interdisciplinary care conference within seven days to review the patient's condition and level of care needed.

2.3. The interdisciplinary care conference will include all members of the hospice care team which consists of, but is not limited to: the Vendor complex Medical Director, Vendor treating Practitioner, Mental Health Vendor, Facility Health Administrator, Vendor Clinical Coordinator, Vendor complex DON or designee, and security representative.

2.4. Upon placement of the patient in the hospice care program, the FHA or designee will identify progress "Hospice Care" to indicate the admission of the patient into the hospice care program and will review the hospice treatment plan which will be placed in the front of the patient's health care record. The Facility Health Administrator or designee will make an entry in the patient's progress note acknowledging the start of hospice care within 24 hours of the interdisciplinary team meeting.

3.0. The infirmary location of the Hospice Program will be staffed by adequate Vendor nursing personnel. The number of patients and care requirements will be considered by the Facility Health Administrator or designee when staffing for hospice care.

3.1. Nursing care is to be provided according to procedures outlined in written instructions. These must be developed by the Vendor Facility Health Administrator, in consultation with the Vendor Regional Medical Director and the Vendor Regional Nursing Director (RDON). The written Instructions will be maintained in identified Hospice areas.

4.0. Responsibilities of certain Vendor health care Practitioners/Providers during terminally ill/hospice care:

4.1. Medical: Admitting Provider will discuss DNR with patient. Patent will have DNR in place upon admission to hospital. The Vendor complex Medical Director or designee will complete a symptom or system specific examination and develop a plan of clinical care detailing treatment, pain control and resuscitation status for presentation at the interdisciplinary case conference within 48 hours. The Vendor Practitioner/Provider will have regular contact with and make complete progress notes on all hospice care patients. He/she will note all changes in plans of care in the progress note. Physician/Practitioner orders will be written as indicated. The Practitioner/Provider will attend and participate in the interdisciplinary team hospice care meetings on all hospice care patients.

4.2. The Facility Health Administrator or designee will schedule interdisciplinary team meetings, coordinate with security special visits when appropriate for hospice care patients and their family, remain responsible for ensuring that all aspects of care are carried out and that goals of the interdisciplinary treatment plan are met. The FHA will arrange for the utilization of a private room for the hospice patient when appropriate.

4.3. Consistent with state regulations, the FHA will facilitate the early release of terminally ill inmates in a timely manner when appropriate.

4.4. At the time of hospice patient's imminent death, the FHA or designee shall notify the Warden and coordinate a hospice vigil.

4.5. After each patient's death, the FHA will arrange for Vendor health staff involved in the patient's care to access Employee Assistance and Support services through the CIRT team and arrange for the inmate orderlies to access counseling and other bereavement services as necessary.

5.0. Vendor Hospice Nurses are to be responsible for ensuring that the Health Care Practitioner/Provider orders are processed and carried through; completing a daily nursing assessment, take vital signs every shift and make an entry on the patient's progress note at least every shift or as ordered by the Practitioner; notifying the Vendor complex Medical Director or treating Practitioner of any significant changes in the patient's condition; ensuring that treatment orders, medications, etc. are administered as

prescribed and documented and that activities of daily living are met; providing at the end of each shift, a report to be given to the oncoming infirmary Nurse; and reporting all hospice patient deaths per Department Orders and this manual.

6.0. Monitoring and Review: Terminally ill/hospice admissions and assignments to the infirmary shall be monitored by the Vendor complex Medical Director or designee and Vendor Facility Health Administrator for clinical appropriateness, quality of care and pain management. Hospice admissions, average daily census and average length of stay shall be tabulated and included in the Inpatient Component monthly statistical report.

7.0. Visits from significant others to terminally ill patients in the infirmary will be coordinated through the Contract Vendor, Security, Religious Services, and Mental Health.

8.0. Memorial remembrance services for deceased inmates may be coordinated and conducted by Religious Services. Attendance at these memorials will be open to inmates and staff.

Chapter 7, Sec. 8 Medical ACIS Entries

REFERENCES: DEPARTMENT ORDER 901

PURPOSE: To provide a system whereby authorized ADCRR Contract Vendor Health staff can enter pertinent medical, dental, or mental health information into the Adult Information Management System (ACIS) described in Department Order 901. Entry is to assist Prison Operations staff in decisions for appropriate placement of inmates.

RESPONSIBILITY: It is the responsibility of the Vendor Facility Health Administrator or designee to ensure that proper entries are made by Medical Records, Dental, Mental Health and Nursing staff. Medical Record staff is responsible to monitor and maintain ACIS data, either by direct entry, or verification that information is transferred through the electronic health record.

PROCEDURES:

1.0. MEDICAL RESTRICTIONS

1.1. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff may enter information regarding the need for an offender to be housed only at specific ADCRR prison facilities due to special medical or mental health needs, which are usually permanent in nature. This special need is termed a Medical Restriction.

2.0. MEDICAL HOLDS

2.1. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff shall enter information regarding the need for an offender to be retained at an ADCRR prison facility due to special medical or mental health needs, which are usually temporary in nature (e.g. – pending appointments for outside consultation, postoperative recovery, etc.). This delay of an offender's transfer is termed a Medical Hold. Medical Holds are for 90 days or less.

3.0. SPECIAL DIETS

3.1. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff shall enter information regarding the need for an offender to receive a Special Medical Diet required because of medical diagnoses and/or conditions.

4.0 SPECIAL NEEDS RELATED TO MEDICAL/MENTAL HEALTH ISSUES

4.1. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff shall enter information regarding special considerations required because of medical &/or mental health issues (e.g. special duty status; special housing considerations; lower bunk; extra mattress/pillows/wedges; shaving waivers; Americans with Disabilities Act (ADA) status, etc.) which may be permanent or temporary in nature. These are termed Medical Special Needs.

5.0. MEDICAL AND MENTAL HEALTH SCORE (Privates Only)

5.1. Using ACIS data entry procedures as outlined in the ACIS User Transaction Security Procedure, authorized health staff shall enter information regarding Medical and Mental Health scores, as determined by medical and mental health providers.

6.0. INTERSTATE COMPACTS: The Vendor's FHA, MRL II, and Clinical Coordinator should jointly be monitoring the existence of interstate compact inmates within their complex. In the event that a costly medical procedure becomes necessary, the sending State should be consulted ahead of the appointment.

Chapter 7, Sec. 9.0 Medical Classification Scores

REFERENCES: Department Order 801

PURPOSE: To provide guidance for a uniform system whereby inmates arriving into the custody of Arizona Department of Corrections Rehabilitation & Reentry, are assigned accurate and pertinent medical scores corresponding to the inmate's health condition.

RESPONSIBILITY: It is the responsibility of ADCRR Contract Vendor with oversight by MSCMB staff to ensure that the Vendor's medical Practitioners assign accurate medical and scores to all inmates that are being processed into the Arizona Department of Corrections Rehabilitation & Reentry (ADCRR) and also for those inmates that are already housed in ADCRR and whose medical condition warrants an updated medical score reflects a change in their health condition.

PROCEDURES:

1.0 MEDICAL NEEDS ASSESSMENT: Correctional and Classification staff must be advised accurately of inmate's medical and mental health scores as these reflect special needs that may affect housing, work, and program assignments, disciplinary measures and admissions to and transfer from other institutions.

1.1 The following medical scoring system with the accompanying guidance and examples shall be utilized in the medical evaluation of the inmate.

The following may require placement in medical sheltered housing at the discretion of the health care practitioner:

M-4 Limited Physical capacity and stamina.

Severe physical illness or chronic condition.

The following requires placement in the IPC or medical sheltered housing:

M-5 Severely limited physical capacity and stamina.

Requires assistance with Activities of daily living.

1.2. Updating of ADCRR inmates Needs Assessment Scores shall be the responsibility of ADCRR Vendor Health Care Practitioners and a number score will be annotated on each inmate health record Problem List. Each inmate Medical Needs Assessment Score will be updated whenever there is a change in the inmate's medical condition that warrants a change in their medical score.

Chapter 7, Sec. 10.0 Sexual Assault

REFERENCES: Department Order 125
Public Law 108-79 (Prison Rape Elimination Act of 2003)
NCCHC STANDARD P-G-09
NCCHC STANDARD P-I-03

PURPOSE: Inmates who report or seek health care attention as a result of sexual assault during incarceration shall receive prompt attention for treatment and evidence gathering as required. The Arizona Department of Corrections Rehabilitation & Reentry policy encourages victims of sexual assault to report the assault and the Department encourages cooperation in its investigation and prosecution. The identity and dignity of the victim will be protected to the fullest extent possible.

RESPONSIBILITY: It is the responsibility of the Vendor health staff to provide supportive care to the individual.

PROCEDURE:

1.0. Department Order 125 directs that after the investigator has completed the suspect(s) interview, the inmate suspect(s) shall be taken to the medical unit for evaluation and documentation.

2.0 In potential cases of sexual assault, the reported victim shall be escorted for medical assessment and treatment. At no time will staff leave the victim alone until evaluated by Vendor Mental Health staff.

3.0. It is the shift commander's responsibility to ensure that the inmate victim is escorted to the Health Unit for examination, treatment and evaluation, and if determined appropriate by the Vendor Medical and/or Mental Health Practitioner/Provider, transported to the hospital emergency room for the collection of forensic evidence and medical treatment.

4.0. ADCRR Contract Vendor health staff shall not conduct forensic examinations. If a forensic examination is appropriate the suspect shall be taken to a hospital emergency room for such an examination.

Chapter 7, Sec. 11.0 Orthotic and Prosthetic Aids

REFERENCES: NCCHC STANDARD P-G-11

PURPOSE: Medical and Dental orthoses, prostheses, and other aids to impairment will be provided when the health of the inmate would otherwise be significantly adversely affected, as determined and ordered by the responsible Vendor Practitioner or Dentist and approved by the appropriate Vendor Approving Authority. Inmates will not be denied prostheses, orthoses, or other aids that are medically necessary because of lack of funds. This procedure specifies the method to provide these aids to inmates.

RESPONSIBILITY: It is the responsibility of the Vendor Facility Health Administrator to develop and monitor systems to support provision of medically necessary orthotics and prosthetics.

PROCEDURE: Orthotics and Prosthetics

1.0. Definitions and Standards for Aids: Orthoses/ Prosthetic Devices/ Mechanical Aids are specialized mechanical devices used chronically to support or supplement joints or limbs, or are artificial devices to replace missing body parts.

1.1. Appropriate but elective orthoses, prostheses, and aids to impairment are those services/devices which are not essential to prevent significant deterioration in the essential health of the patient, but nevertheless are reasonably expected to significantly improve the quality of life for the patient as it relates to a proven chronic or ongoing medical condition. These items are generally for chronic use and become the personal property of the patient. These items include, but are not limited to; dentures, dental prosthetics such as partials, flippers, etc., glasses, contact lenses, artificial eyes, artificial limbs, certain knee/ankle/foot braces, hernia support belts, hearing aids, special support hose, TENS units, non-institution issue shoes, suspenders, batteries for hearing aids and other battery operated devices, and include maintenance and/or repair of any such device.

1.2. There are certain items that though they may be available in the community, or are used for certain conditions, are of minimal proven medical value, requests to health services to authorize special items must be weighed against the concerns of running a safe and secure institution, and appropriate institution routine. There are many items in this category that are not generally considered or approved by the Vendor Health Services as rising to a level of need to create a medical exception to institution rules, policies, and standards, some examples are; high top tennis shoes, soft pillows, heating pads, knee sleeves for sports, etc.

1.3. Medical aids issued by Vendor Health Services as part of acute treatment for a limited medical condition such as casts, splints, ace wraps, short-term usage of canes/crutches/braces, etc., are routinely authorized and not generally charged to the inmate.

1.4. Hardware that is an essential part of a medically necessary procedure such as, heart valves, cardiac stent at time of angioplasty, intraocular lens implants at time of cataract surgery, etc., are routinely authorized and not generally charged to the inmate.

1.5. Inmates may also in certain circumstances obtain prostheses that the Practitioner or Dentist has determined are elective, which are medically appropriate, but are not medically necessary. This procedure establishes the mechanism for inmates to obtain these prostheses, orthoses, or other aids.

1.6. Most aids, prostheses, orthoses become the personal property of the inmate to emphasize the inmate's responsibility to care for the item(s) properly.

2.0. Footwear: The institution is responsible for the style, quality and fitting of standard issue clothing and footwear. Inmates with medical disorders for which special, non-standard footwear is a recognized and appropriate part of the medical treatment program and for which no reasonable treatment alternative exists will be prescribed special footwear. Footwear prescribed as "medically necessary" will be provided regardless of the inmate's ability to pay.

2.1. Patients with medical disorders, which may require special foot care, may be scheduled with a Vendor Practitioner for evaluation of the medical problem.

2.2. Inmates with a complaint about shoes and the complaint is not clinically related to an existing medical disorder, should be directed to appropriate operations staff for assistance. A complaint of shoes being uncomfortable is not, in and of itself, a medical problem.

2.3. The Vendor Practitioner doing the examination is to determine and document by history and objective examination: whether an inmate has a formal medical disorder for which non-standard or modified footwear is a recognized and appropriate part of the medical treatment plan, and without which there is likely to be serious deterioration in, or significant risk to, the inmate's basic health, and for which no appropriate alternative exists.

2.4. A Vendor Practitioner order for specialty shoes must be supported in the progress notes including diagnosis and treatment plan according to the criteria above.

2.5. After authorization, the order for modified or specialty shoes will be implemented by the Vendor Facility Health Administrator or designee and sent to the appropriate purchasing agent.

2.6. Shoes authorized by the above process and deemed "medically necessary" will not be denied due to inmate indigence.

2.7. Requests for specialty athletic shoes are not a medical issue and should not be scheduled for practitioner examination.

3.0. The Vendor Reviewing/Approving Authority shall consider the following in determining the relative need of a prostheses, orthoses, or other aid; urgency of need, time left on sentence, overall necessity, morbidity, mortality, functional disability and expected improvement, alternatives, risk/benefit, cost/benefit, and security concerns. Based on these factors a decision is then made as to whether the exception for the elective item should be allowed for the patient.

4.0. Glasses: The lack of vision correcting eyewear does not cause deterioration in a person’s general state of health. Health Services Contract Vendor does, however, recognize that corrected vision may promote participation in education, programming, or work assignments, it may increase comfort, or otherwise contribute to quality of life, therefore, Vendor Health Services will offer support on an as needed and as requested basis.

4.1. Unless there is a clear clinical indication to do otherwise, Vendor Health Services will offer refractive eye examinations for each inmate a maximum of once every three (3) years. Eyeglasses become the inmate’s real property and are handled according to the procedure outlined by Department Order 909. Medical eye examinations will not be denied due to indigence. Willful destruction or mistreatment of glasses will be responded to in accordance with Department guidance regarding destruction of state provided or state owned property.

4.2. Specialty optical aids, such as photo gray glasses, sunglasses, or contact lenses are considered medically optional unless ordered by an ophthalmologist as part of a medical treatment plan and not based on the inmate’s desire.

4.3. Eyeglass frames will be provided in accordance with the styles and material described by individual optician contract. Inmates may not choose different styles of frames beyond that offered by the optician in accordance with the ADCRR contract.

4.4 Bone Stimulators, when ordered by a specialist as part of a treatment plan, shall be made available to the inmate. The device shall be the property of ADCRR Health Services Vendor. The ordered treatments shall occur in the Health Unit. If the inmate is released while utilizing the bone stimulator, Health Services Vendor shall supply the device to the inmate upon release.

Chapter 8, Sec. 1.0 Establishment of Health Record

REFERENCES: NCCHC STANDARD P-H-01

PURPOSE: To provide a uniform documentation, by either paper or electronically, in which a record of an inmate's health status, diagnosis(es), examination(s), evaluation(s), treatment(s) and response(s) to treatment(s) can be recorded and maintained.

RESPONSIBILITY: The establishment of the Health record is the responsibility of the Contract Vendor Medical Records staff. The Medical Services Contract Monitoring Bureau (MSCMB) Medical Records Monitor may change, or revise the establishment of the health record as may be required by statute, regulation, Department Order or procedural changes.

PROCEDURES: Paper Health records (current volume and previous volumes) are kept on file in a designated area of the prison health unit(s) in numerical order as defined by the individual ADCRR numbers.

1.0. ESTABLISHMENT OF THE ADCRR HEALTH RECORD

1.1. Origination of Health Records: Upon arrival at any of the following designated Reception Centers Vendor medical record staff shall originate the documentation which becomes the inmate's health record:

1.1.1 Alhambra Reception & Treatment Center (ASPC-Phoenix-ARTC): Adult male Inmates

1.1.2 Lumley Reception & Assessment (ASPC-Perryville): Female Adult or Female minor Inmates

1.1.3 Browning (ASPC-Eyman): Death Row Male Inmates

1.1.4 Rincon Minors Unit (ASPC-Tucson): Male minor Inmates adjudicated by the courts as adults.

1.2. Organization of All ADCRR inmates Health records shall be in accordance with MSTM Chapter 8.

2.0. Inmate Identification Information: If paper records are being utilized, the health record jacket shall contain the following information in the upper right hand corner of the file jacket: Inmate's full name (last name, first name) and ADCRR Number (which becomes the health record file number).

2.1. Information regarding any allergies the offender may have will be annotated in red on the Front of the file jacket.

2.2. The ADCRR Number will be adhered to the bottom edge of the back cover of the jacket utilizing the following color system:

3.0. ADCRR INMATE NUMBER TERMINAL DIGIT will be utilized to identify the medical record for organized filing.

1- LT BLUE	2- RED	3- LT GREEN	4- GRAY	5- GOLD
6- DK GREEN	7- BLUE	8- ORANGE	9- BLACK	0- YELLOW

4.0. All forms contained in the health record must contain the following identifying information, and be entered in chronological order, with most current on top:

4.0.1 Inmate's full name, and

4.0.2 Inmate's ADCRR Number, and

4.0.3 Inmate's Date of Birth, and

4.0.4 Inmate's current location (Prison, Unit).

Chapter 8, Sec. 2.0 Consent to Treat/ Informed Consent

REFERENCES: DEPARTMENT ORDER 1101.03
NCCHC STANDARD P-I-05

PURPOSE: To inform Vendor health staff on the requirements that all examinations, treatments, and procedures are governed by regulations and compliance with informed consent requirements.

POLICY:

1.0. Consent to Treat/Informed Consent: The Contract Vendor Health Care Practitioner/Provider performing the procedure/treatment/test shall explain the procedure/treatment/test in language and terms the inmate can understand. The explanation shall include what is to be done and the reason for doing the procedure/test/treatment. The benefits of the treatment must be explained as well as any risks and possible side effects. The Vendor Provider is responsible to explain the existence of any alternative test, treatment or procedures.

2.0. The Provider shall document exactly what was explained to the inmate regarding the procedure/treatment/test on the Consent to Treat Form (Form #1104-4).

2.1. Request the inmate to sign the completed Consent to Treat Form before two (2) witnesses that he completely understands what has been told him/her. The two (2) witnesses shall also sign the completed form.

2.2. Document in the Health Record that the Consent to treat document has been signed.

2.3. The completed document will be placed or scanned in the inmate's Health Record.

3.0. 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 inmates who do not have the capacity or ability to understand the information given or if a court order to treat has been obtained.

4.0. The completed form will be placed or scanned in the inmate's Health Record in Section 3: Under Consents/Refusals tab.

Arizona Department of Corrections Rehabilitation & Reentry	Release of Medical Information	OPR: MS Contract Vendor Medical Records Supervisor Medical Services Contract Monitoring Bureau (MSCMB) Medical Records Monitor Auth: cp
Medical Services Technical Manual	MSTM Chapter 8 Section 2.1.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 8, Sec. 2.1 Release of Medical Information

REFERENCES: DEPARTMENT ORDER 1104
NCCHC STANDARD P-H-02

PURPOSE: To provide for the protection and confidentiality of the medical information and health records of inmates remanded to the custody of the ADCRR. To provide guidelines for the release of medical information and copies of health records of inmates remanded to the custody of the ADCRR and inmates who have been released. To provide guidelines for charging reasonable fees for the production of copies of health record.

RESPONSIBILITY: The Vendor Medical Records staff must adhere to the strict rules of release of information. The Vendor Medical Record Supervisor will instruct and guide the Medical Record staff when processing requests for medical information.

PROCEDURE:

1.0. Release of Health Record copies to outside parties: Health records may be released upon receipt of a valid authorization from the inmate or released offender, upon receipt of an Authorization to Release Copies of medical records, a validly served and appropriate Subpoena, or upon receipt of a Court Order. Situations not requiring a valid authorization from the inmate or released offender for valid release of the health record include:

- 1.0.1 Court Order
- 1.0.2 For Law Enforcement agencies; i.e. FBI, Federal Marshall, police department, sheriff's office, jails, prisons
- 1.0.3 Medical Examiner
- 1.0.4 Public Health Department
- 1.0.5 For Emergency Treatment at a hospital
- 1.0.6 State Licensure board (i.e., Board of Medical Examiners or State Board of Nursing)

1.1. When releasing information pertaining to an inmate's care, the requesting party must produce verifiable identification and that the information is to be used only for:

- 1.1.1 The attending Medical Practitioner or Medical Practitioners responsible for the inmates care.
- 1.1.2 Health care facilities requiring information in order to care and treat the inmate.
- 1.1.3 Medical Practitioners who have a legitimate or academic interest in the case.

1.1.4 Vendor Medical staff and/or peer review committees who are responsible for monitoring and evaluating care in the health care setting, to the extent necessary to carry out their duties.

1.1.5 Insurance companies or others responsible for payment of charges, to the extent they relate to the charges.

1.1.6 The Industrial Commission, employers of patients filing industrial injury clACIS or the legal representatives of those employers, to the extent they relate to the claim.

1.2. The release of mental health records is addressed in ARS 36-509. Records and information contained in records may only be disclosed to Governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing evaluation and treatment or to report a crime on the premises or to avert a serious and imminent threat to an individual or the public.

1.3. Release of Health records via written Authorization: Health record copies may be released upon the written authorization of the inmate. Although ADCRR and the contract vendor has its own Authorization to Release Health records form, any authorization meeting the following requirements shall be acceptable for release of health record copies:

1.3.1 Signed by the inmate/or released offender (If active inmate, must be either witnessed by an ADCRR staff person or non-family member or can be notarized by a Notary Public).

1.3.2 Specifies copies requested with dates of service.

1.3.3 Gives the full name and address of the person to whom the health record copies are to be released.

1.3.4 Note that the Authorization must be dated within 60 days of the release request.

1.4. In cases where health records contain information related to diagnosis & or treatment for Mental Health, HIV+/AIDS, or Alcohol/substance abuse, the authorization must specifically note the exact information to be released (e.g. Mental Health, HIV, substance abuse).

1.5. Upon receipt of an Authorization to Release Health records (hereinafter-called Authorization), the Vendor Medical Record staff (or designee) shall verify the signature of the inmate by comparison with other examples of inmate signature contained in the health record (ex: on the Initial/Intake Assessment form or History form).

1.5.1 If the inmate is housed at a Private Prison or has been released from ADCRR and is required to sign the Authorization, MSCMB Medical Record Monitor in Central Office will complete an Authorization form and electronically send with Medical Record Request to the appropriate location. MS Contract Vendor Medical Records Supervisor or designee will otherwise complete the authorization form. The Vendor MRL will have the inmate called to the Health Unit to sign the Authorization. Vendor MRL, medical staff person, or Correctional Officer will sign the witness portion.

1.6. Charges for copying are assessed at $.50 per page when the request comes from an Attorney, Federal/Public Defender, family member, Subpoena ($.25 per page and $25.00 per hour for clerical fee, $1.00 per Declaration fee), Court Order, or in rare cases, when an inmate is authorized by Legal Services to obtain health records when a valid lawsuit has been served.

1.6.1 For the Private Prison Facilities: COPIES ARE NOT TO BE MADE UNTIL MSCMB MEDICAL PROGRAM MONITOR IN CENTRAL OFFICE NOTIFIES THE PRIVATE PRISON MEDICAL RECORD LIBRARIAN VIA EMAIL THAT PAYMENT HAS BEEN RECEIVED, or unless directed by the Medical Record Monitor to copy prior to payment.

1.6.2 For MS Contract Vendor: COPIES ARE NOT TO BE MADE UNTIL VENDOR MEDICAL RECORDS SUPERVISOR OR DESIGNEE NOTIFIES THE VENDOR MEDICAL RECORD LIBRARIAN VIA EMAIL THAT PAYMENT HAS BEEN RECEIVED. Note: The Public Defender Offices may receive the copies of medical records with the invoice.

1.6.3 For Private Prisons Facilities: If a charge is required, the MRL shall count the number of pages to copy and write on the MRR the number of pages.

1.6.3.1 The MRL shall forward the Medical Record Request Worksheet (MRR) including the page count and the Authorization to MSCMB Central Office Medical Records.

1.6.3.2 Upon notification from Central Office (via phone or e-mail) that payment has been received, make pertinent copies of the health record as stipulated in the Authorization and record the following information on the Medical Record Request (MRR) form: Date Mailed to Central Office; Number of pages that were copied (number of pages must be the same number that were faxed to Central Office for the invoice); Documents copied by (Signature/title of person making/releasing the copies); Make a copy of the MRR and send with copies to Central Office; File all documents in Section IV under the Legal/Administrative tab.

1.6.3.3 If there is no charge for the copies, (for requests for Continuity of Care, DES, Value Options) Central Office Medical Record staff shall email the Request for Copies to the complex MRL to copy the requested records and fax or mail the copies to the requesting party. A copy of the Request for Copies and Authorization form is retained in the Legal/Administrative section of the health record in Section IV of the health record.

1.7. Processing

1.7.1 MSCMB Medical Records Monitor or Contract Vendor Medical Record designee shall: Compute the charges; prepare a statement of charges; and mail or fax an invoice to the requestor. Notify the Medical Records Librarian via email once payment has been received and to copy records and forward to Central Office.

1.7.2 The complex MRL shall: Copy the records and confirm that the count is the same as was quoted for the invoice and record the following information on the Medical Record Request form.

1.7.3 Date Mailed to Central Office or Contract Vendor Regional Office.

1.7.4 Number of pages sent.

1.7.5 Documents copied by (Signature/title of person making/releasing the copies)

1.7.6 The complex MRL shall then make a copy of the Medical Record Request and send with copies to Central Office and file all documents under Section IV Legal/Administrative tab.

1.8. MSCMB Medical Records Monitor or designee shall: Confirm correct number of pages (follow-up with MRL if incorrect); Compute a statement of charges for the health record copies as appropriate; Complete information on the appropriate Tracking Log in the database. Close out tracking # in database; Attach a copy of the Authorization to the copies; Accept payment for the copies; Complete receipt form; Close out in invoice database; Mail copies to requesting party; Send a copy of the Authorization, original copy of receipt, and health record copies to the requester; and Send the payment check attached to the copy of the Receipt to the Budget/Business Office.

1.8.1 The MS Contract Vendor Medical Records Supervisor or designee shall follow the procedures outlined in section 1.1 to 1.7.1 when responding to release of medical information.

2.0. SUBPOENAS AND COURT ORDERED REQUESTS FOR COPIES OF RECORDS: Patient authorization IS NOT REQUIRED FOR COURT ORDERS. However patient authorization IS REQUIRED FOR SUBPOENAS. When pertaining to Private Prison Facilities, the MSCMB Medical Records Monitor shall contact the requester to advise that Authorization is needed (if not provided). When pertaining to MS Contract Vendor, the Vendor Medical Records Supervisor or designee shall contact the requester to advise that Authorization is needed (if not provided) No further action shall be taken until/unless Authorization is received.

2.1. Health records may be released in response to a Subpoena or Court Order, which has been validly served upon the Custodian of health records. The Custodian of health records in the Private Prison Facilities is the MSCMB Medical Records Monitor. The Custodian of health records in ADCRR is the MS Contract Vendor OR vendor Medical Record staff assigned to the various ADCRR facilities/complexes.

2.2. Subpoenas or Court Order may be served in Civil Cases in person on the Custodian of health records. Subpoenas or Court Order may be served in Criminal Cases either in person OR via United States Mail. Out of State subpoenas will not be accepted per Legal Services Bureau.

2.3. Acceptance of a Subpoena or Court Order: Medical Record Staff (Custodians of health records by MS Contract Vendor or ADCRR Private Prison Facilities) shall document the following information on the face of the Subpoena and then send a copy to the Discovery Unit:

2.3.1 Date and time of the of receipt of the Subpoena,

2.3.2 Manner of Services (in person or via mail),

2.3.3 Signature and title of Custodian of Medical Records

2.4. If neither the State of Arizona, the Department of Corrections, nor the inmates are parties to the case involved, unless an Authorization from the inmate accompanies the subpoena, the matter shall be referred to the Discovery Unit for advice as to how to proceed. No further action shall be taken until that advice is received.

2.5. Processing Private Prison Facilities and MS Contract Vendor:

2.5.1 The facility MRL shall: Count the number of pages to copy and forward the Medical Record Request Worksheet to either MSCMB Medical Records Monitor or MS Contract Vendor Medical Records.

2.5.2 The MSCMB Medical Records Monitor (Private Prisons) and Vendor Medical Records Supervisor or designee shall: Compute charges; Prepare a statement of charges for the health record copies as appropriate; Mail or fax invoice to the requestor; Notify Medical Record Librarian that payment has been received and to copy records and forward to the appropriate Office of Responsibility; accept payment; Complete a Receipt; Send a copy of the Authorization, and health record copies to the requester; Send the payment check attached to the copy of the receipt to the MSCMB Medical Records Monitor, who in turn will approve and forward to the Budget/Business Office; Complete information on the appropriate Tracking Log in the database.

2.5.3 The Facility MRL shall: Copy the records and confirm that the count is accurate; Number each page of copied material in the lower right-hand corner of the page, assuring the applied number shall not obscure the documentation on the page; complete a Declaration Statement that verifies authenticity of the health record. The Declaration Statement must include:

2.5.3.1 Inmate name

2.5.3.2 Inmate ADCRR #

2.5.3.3 Date range for records (i.e. January 1, 2004 – May 12, 2004)

2.5.3.4 Number of pages

2.5.3.5 Signature and title of Medical Record staff

2.5.3.6 Date completed

2.6. The Facility MRL shall: record the following information on the Medical Record Request form:

2.6.1 Date Mailed to the appropriate Office of Responsibility

2.6.2 Number of pages sent

2.6.3 Documents copied by (Signature/title of person making/releasing the copies)

2.6.4 Make a copy of the Medical Records request and attach to authorization and send with medical records to C.O.

2.7. The Facility MRL shall forward the health record copies, with a copy of the Subpoena or Court Order and Declaration on top to the Central Office Medical Records Monitor if a Private Prison Facility or to MS Contract Vendor Medical Records Supervisor or designee. 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.

2.8. Upon receipt of the health record copies, MSCMB Medical Records Monitor (Private Prisons) or MS Contract Vendor or designee shall: Call the requestor for receipt options: Pick up records or mail. If mailing, send documents to the requester via U.S. Registered Mail, Return Receipt requested as follows:

2.8.1 Package shall be arranged in the following order:

2.8.1.2 Copy of receipt that contains charges for document copies

2.8.1.3 Copy of Subpoena or Court Order

2.8.1.4 Original of Declaration Statement

2.8.1.5 Copies of numbered health record

2.8.1.6 Package shall be placed in a sealed manila envelope, marked "Confidential", on which is recorded the title of the action/case involved, the Case Number, the name of the inmate whose health records are enclosed.

SAMPLE:

John Q. Inmate v. American Widgets

CIV No.99-XXX-XX (XX) Medical Record Copies:

John Q. Inmate, ADCRR No. 999999

3.0. Health record copies requested by Discovery Unit (ADCRR Legal Services): The Discovery Unit may request copies of health records for use of the Attorney General's Office or other ADCRR legal counsel in representing the Department in lawsuits &/or clACIS. The MSCMB Central Office Medical Records Monitor shall include CIPS profile and any outside previous records in the package.

3.1. Upon receipt of a request for documents and valid authorization signed by the inmate/released offender from the Discovery Unit, MSCMB Central Office Medical Record Monitor shall: Relay the request via e-mail to the health record staff at the facility/unit where the health record requested is maintained. Facility MRL staff shall:

3.1.1 Make the appropriate copies of the health record

3.1.2 Number each page of the copies in the lower right-hand corner

3.1.3 Prepare a Declaration Statement of authenticity of the copies

3.1.4 Send the copies to MRPM or designee along with the copy of the Discovery Unit request if the records are for the Phoenix AG Office or if Tucson AG office is the requesting party, mail to the Tucson Attorney General.

3.1.5 File copies of all documents in Section IV under the Legal/Administrative Tab.

3.2. Once copies are received at Central Office, staff will send via interdepartmental mail to ADCRR Legal Services to forward via courier to the Discovery Unit with a copy of the Discovery Unit request.

3.3. When a MRR is received that has been initiated by the Attorney General's Risk Management Office (Tucson), the Private Prison MRL or MS Contract Vendor MRL will be instructed by the MSCMB Medical Record Monitor or MS Contract Vendor Medical Records Supervisor to send the records directly to the Tucson AG's office. The Facility MRL will notify the appropriate Office of Responsibility with the date that the record was sent and the number of pages copied. The Medical Records Monitor will notify Legal Services office that the MRR has been completed.

4.0. Tracking Logs: Tracking Logs of all information related to requests for Release of Medical Record Copies shall be kept by health record staff both at the facility and at Central Office. This Tracking Log can be either electronic or manual but must contain the following information:

4.0.1 Date of Request/Date Received at Unit

4.0.2 Inmate/Inmate Number Inmate/Inmate Name Facility

4.0.3 Requester

4.0.4 Type of Request: Authorization, Subpoena, or Court Order

4.0.5 Copies Requested

4.0.6 Date Request Relayed/To Whom/How

4.0.7 Date Copies Made

4.0.8 Date Copies Received in Central Office

4.0.9 Date Charges Relayed to Requester

4.0.10 Date Payment Received

4.0.11 Date Copies Mailed to Requester

4.0.12 Comments

5.0. Charges for copies of Health Records: ADCRR may charge a reasonable fee for the production of the health record copies.

5.1. Reasonable fees are set as:

5.1.1 By Subpoena: $.25 per page and $25.00 per hour for preparation time (minimum time 1 hour) (A.R.S. 12-2295), Declaration charge: $ 1.00.

5.1.2 By Court Order: $.50 per page. Declaration charge: $1.00.

5.1.3 Record By Authorization: $.50 per page; no charge for preparation time.

5.1.4 X-ray Film By Authorization: $15.00 for each "sheet".

5.2. Authority to Assess Charges and Collect Fees: Only the MSCMB MEDICAL RECORD MONITOR or VENDOR MEDICAL RECORD OFFICE STAFF may assess charges for health record copies and collect the fees.

5.3. A cashier's check or money order shall be the only forms of payment that are accepted. Law firm checks shall be accepted. No cash/debit payments will be accepted.

5.4. There is no charge for copies of the health record released for the following purposes: Continuity of care (doctor's office, hospitals, or Mental Health Practitioner) or to other government agencies/programs (e.g. Department of Economic Security, Vocational Rehabilitation Services, Social Security, other correctional facilities, Legal Advocate or to Discovery-ADCRR Legal Services/Attorney General's office

6.0. Individual Staff member named in a lawsuit:

6.1. When a Department of Corrections MSCMB staff member or previous ADCRR Health Services employee or MS Contract Vendor employee is named in a lawsuit and served with a subpoena to answer interrogatory questions, the Medical Record Monitor shall be informed and will provide decision whether the staff can review the health record or if copies of the health records need to be made. **.**

6.2. Staff are not permitted to copy any medical records without the approval of the Medical Record Monitor and the FHA.

6.3. Medical Records Librarians may be called upon to testify in a court of law regarding status or maintenance of medical records. The best support for this activity is to ensure, on a daily basis, that;

6.3.1 Record management is performed in accordance with policy and

6.3.2 Accuracy in copying of records in response to subpoenas and

6.3.3 Ensuring that each copy is legible and straight on the page and

6.3.4 Accuracy in accounting for, counting, and numbering pages and

6.3.5 Preparation of declarations of specified date ranges on the MRR.

7.0. Deceased Inmate's Records release. Records may be released to inmates' family (next of kin) with the approval of the Division Administrator.

7.1. Authorization to Disclose Copies of Medical Records must be completed by next of kin and witnessed by a Notary.

7.2. Family shall provide verification of relationship:

7.2.1 Death Certificate

7.2.2 A copy of Driver's License required prior to the release of health records.

7.2.3 Payment is required before copies are released.

7.2.4 Invoice will be mailed/faxed to requestor.

7.3. The MSCMB Medical Record Monitor is responsible for processing the copies of a deceased inmate's medical records when the records are at the MSCMB office. The MRL 2 is responsible for processing records requests if the chart is still at said complex.

Arizona Department of Corrections Rehabilitation & Reentry	HIPAA Ruling	OPR: MS Contract Vendor Medical Records Supervisor MS Contract Vendor Regional VP/Administrator MSCMB Medical Records Monitor Auth: cp
Medical Services Technical Manual	MSTM Chapter:8 Section: 2.2	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 8, Sec. 2.2 HIPPA Ruling

PURPOSE: To educate the Contract Vendor health staff regarding the impact of the Federal Health Insurance Portability and Accountability Act requirements, and the proper authorities surrounding use and release of information.

POLICY:

1.0 The first comprehensive set of Federal Regulations of Health Information, the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), came into effect in April 2003.

2.0. The Arizona Department of Corrections Rehabilitation & Reentry is a non-covered entity and therefore not subject to many of the privacy requirements of HIPAA. (45 CFR Parts 160 and 164). Under the Privacy Rule, protected health information (PHI) is defined very broadly. PHI included individually identifiable health information related to the past, present or future physical or mental health or condition, the provision of healthcare to an individual.

3.0. 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.

Arizona Department of Corrections Rehabilitation & Reentry	Request for Medical Records from outside Healthcare Practitioner/Provider	OPR: MS Contract Vendor Medical Records Supervisor MSCMB Medical Records Monitor Auth: cp
Medical Services Technical Manual	MSTM Chapter 8 Section 2.3	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 8, Sec. 2.3 Request for Medical Records from outside Healthcare Practitioner/Provider

REFERENCES: NCCHC STANDARD P-E-12

PURPOSE: To obtain previous medical records from outside Healthcare Practitioners, hospitals, jails, prisons, and other healthcare agencies to use for continuity of care purposes. This policy also refers to MSTM 8. Section 2.2

RESPONSIBILITY AND PROCEDURE:

1.0. It is the primary responsibility of the MS Contract Vendor Medical Practitioner/ Provider upon Intake to inquire whether the inmate was provided with medical care prior to incarceration. Form 1104-1 REQUEST FOR MEDICAL RECORDS is to be completed by the Practitioner/Provider.

1.1. The Request for Medical Records form #1104-01 specifies that an authorization is not required from an offender for ADCRR to obtain past health record.

1.2. This form is then electronically sent or mailed to obtain previous records by the Medical Record Librarian at the inmate's unit.

1.3. A copy of the form is then filed in the Previous Records section with the fax confirmation notification or if mailed, date mailed and signature of MRL is marked on the form.

2.0. Once the requested health records are received at the unit, they are forwarded with the health record to the Vendor Practitioner/Provider for review.

2.1. After the Practitioner/Provider reviews the records, he/she is to sign their name and use name stamp, and write the date reviewed.

2.2. These records are then filed under Section I, Previous Records (green tab).

Chapter 8, Sec. 3.0 Retention of Paper Health Records

REFERENCES: NCCHC STANDARD P-H-06

PURPOSE: To establish a procedure for the control and retention of health records to assure that the safety and confidentiality of the medical information and records is maintained according to Retention Schedules as filed with the Arizona Department of Library, Archives and Public Records (hereinafter called ADLAPR). To assure that medical information and records of inmates and former inmates are available for continuity of medical care and legal/administrative purposes. To provide a mechanism for the re-activation of the health records of released inmates in the event of their return to the ADCRR.

RESPONSIBILITY: The Contract Vendor Medical Records Librarians are responsible to ensure that the records of medical care are maintained and properly protected from unauthorized release. The Vendor Medical Records Supervisor is responsible to coordinate archiving of health records with MSCMB Medical Records Monitor, in accordance with professional librarian standards.

PROCEDURES:

1.0. RETENTION SCHEDULE FOR HEALTH RECORDS OF RELEASED OFFENDERS

1.1. Following an inmate's release from ADCRR, health records are sent directly to the ADLAPR for retention. In accordance with the Retention Schedule on file with ADLAPR and contract vendor, health records of released offenders shall be kept a minimum of 6 years past the date of last contact with the released offender.

1.2. According to procedures established by ADLAPR, at the end of the 6 year retention of the health records, ADLAPR staff shall destroy the health records upon written notification from Health Services.

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

1.4. The medical records of minors are processed in the same manner as the Adult Inmate. The medical records will be destroyed after the Minor has reached 24 years of age (unless the record has been folded into a re-incarceration medical record).

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

2.0. USE OF ADLAPR FACILITY

2.1. Storage of health records at the ADLAPR Health records is located in the ADLAPR storage facility for the remainder of the retention period unless otherwise noted.

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

2.2.1 Record Series Code: (i.e., number 496 (Adult) and 497 (Minor)) Note: If records are not in numerical sequence, individual health record numbers must be listed on a Detailed Box Contents Form (Single Box Report)

2.2.2 A copy of the completed Transfer Manifest and Boxed Records Data Entry Form is retained in Medical Services Contract Monitoring Bureau.

3.0. USE OF ADLAPR STORAGE FACILITY:

3.1. Health records processed for storage will be boxed, information stored in the IHAS Medical Record Inventory system database, and sent to ADLAPR for storage. The health records shall be arranged in numeric sequence in the specific storage containers required for storage. Health records must be placed in the storage box leaving at least 2" of space in the box.

3.2. Storage boxes are prepared for transmittal:

3.2.1 One Data Entry Bar Code Label is prepared for each box.

3.2.2 One label is affixed to the storage box approximately 2" below the handle; contracted label is affixed below.

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

3.2.4 A coversheet must be provided with each box listing the name of the unit and the date sent.

3.2.5 Information to be included in the box is as follows

3.2.5.1 Packing List inventory sheet of medical records contained in the box.

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

3.25.3 Signature of the MRL and the date must be written on the inventory sheet.

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

4.0. See MSTM 5. 1.2.1. for MRL responsibilities in identifying released inmates.

5.0. REACTIVATION OF HEALTH RECORDS FOR INMATES RETURNED TO ADCRR CUSTODY:

5.1. If an offender returns to the ADCRR system within the 6 year retention time period set with ADLAPR, the receiving facility shall contact the Medical Services Contract Monitoring Bureau to obtain the old volumes of the offender's health record.

5.2. Upon notification from the Vendor Medical Records Librarian at the facility health unit to the ADCRR Central Office staff of the return to custody of a previous ADCRR offender, the Central Office health record Monitoring staff shall order the medical records and they will then be forwarded to the appropriate ADCRR facility where the inmate is housed. If the inmate was released and the health record is still at that unit he was released from, the Vendor Medical Record Librarian at the facility health unit is responsible for contacting the previous health unit to obtain the health records.

5.3. Health record shall be securely packaged and addressed to be sent to the appropriate facility health unit/health records office using the ADCRR Mail Code. The package must clearly identify the contents as health records and shall be marked "**CONFIDENTIAL**."

5.4. The complex Medical Record Librarian will notify the Central Office Medical Record Monitoring staff of the need to request health records that are in the ADLAPR.

Arizona Department of Corrections Rehabilitation & Reentry	Inmate Access to Health Record Information	OPR: MS Contract Vendor Medical Records Supervisor MSCMB Medical Records Monitor Auth: cp
Medical Services Technical Manual	MSTM Chapter 8 Section 4.0.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 8, Sec. 4.0 Inmate Access to Health Record Information

REFERENCES: ARIZONA REVISED STATUTES 31-221
DEPARTMENT ORDER 1104

PURPOSE: To coordinate the right of an inmate to access his/her own health record information. This access includes Health Record Chart Reviews and the approval of inmates receiving copies of health records to be used for lawsuits.

RESPONSIBILITY: The Vendor Medical Record staff is responsible for arranging the appointment for the inmate to review his health records after receiving the request from the inmate. The Contract Vendor Medical Record Manager is responsible for notifying the inmate via Inmate Letter Response if he is approved or denied copies of his medical records.

PROCEDURES:

1.0. Record Review: The inmate is allowed to review portions of the health record during the Inmate Medical Record review. The inmate shall submit an Inmate Letter to the Vendor Medical Record Librarian to request an appointment to be scheduled by Medical Records staff. If the inmate submits his request to review his health record on the HNR form the MRL shall respond that the review will be scheduled but future requests for reviewing health records should be written on an Inmate Letter. The Medical Records Librarian will schedule Inmate Health Record Reviews for the maximum allotted time of forty five minutes as set by the MSCMB Assistant Director. The review of a health record is a labor intensive and time intensive activity. Therefore inmates are authorized to review their records no more than once per quarter. If they require additional appointments to review the records the inmate must be informed by the Vendor MRL that they must submit an Inmate Letter to the Vendor FHA explaining their justification for a review before 3 months have expired since the last review. Justification must include a reasonable explanation such as conduct of multiple laboratory tests that have not been discussed with the Practitioner/Provider, change in diagnosis of primary illness, recent admission/discharge, etc. For inmates who have their records on the electronic health record system: the inmate should be called up ahead of the review to be asked what records he wants to review so the appropriate records can be printed from the EHR.

1.1. In accordance with guidance provided by Legal Services and the Health Services Monitoring Bureau Assistant Director, the Vendor Medical Record Librarian is to remove the following sections of the health record chart folder prior to the review

1.1.1 Section 1: Previous records: All Mental Health records must be removed. The inmate is allowed to review his previous medical records if he specifically requests.

1.1.2 Section 4: Mental Health tab: Remove Mental Health records

1.1.3 Section 4: Legal/Admin tab: remove Legal/Administrative

1.2. Refer to form #1104-11 Guidelines for Inmate Medical Records Reviews. Once completed, the form is filed in Section IV, under Legal/Administrative tab.

1.3. Inmates who cannot read or write English may have a translator assigned in accordance with Department Order 704 and local procedure.

2.0. For review of Mental Health records: The inmate needs to submit an Inmate Letter to the Vendor Mental Health staff to request an appointment to be scheduled by Mental Health. Mental Health may answer any questions that the inmate may have at that time.

3.0. Inmates requesting copies of their health records; that are for use in litigation of medical issues, and upon receipt of a subpoena or Court Order or an Inmate Letter that identifies the specific portions of the Unit Health Record to be copied, the Medical Records Monitor shall:

3.1. Forward the letter to Legal Services.

3.1.1 Legal Services will review the Attorney General's database of valid lawsuits and coordinates with the Office of the Attorney General for advice as to whether the following requirements have been met in relation to the case:

3.1.2 The court has stipulated that the inmate may act as his own attorney.

3.1.3 The request is related to a bona fide lawsuit that has been validly served on the Department or other defendant.

3.1.4 The request for discovery has been filed.

3.1.5 The Office of the Attorney General has not filed, in court, an objection to the production of the records.

3.1.6 Staff shall not relinquish medical record copies to any inmate unless authorized by the Medical Records Monitor.

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

3.2.1 For the Private Prison Facilities, MSCMB Medical Record Monitor or Contract Vendor processes the Medical record request in the database, faxes the authorization and the medical record request to the MRL with an identification of which records to copy.

3.2.2 The inmate has signed the Inmate Medical Record Waiver of Liability.

3.2.3 Vendor Health staff who provided the copies to the inmate sign the Inmate Medical Record Waiver of Liability form as witnesses to the inmate's signature and file/scan the form in the inmate's Unit Health Record.

3.3. Charges for Copies: The Contract Vendor Medical Records Supervisor (for private prison facilities, MSCMB Medical Records Monitor), shall charge the appropriate fee for the information copied from a Unit Health Record, as follows:

3.3.1 An inmate who is not indigent shall be charged 50 cents for each page.

3.3.2 An indigent inmate who submits a copy of the approved Application for Indigent Status shall not be charged for copies.

3.4. When the inmate is approved or denied copies of his medical records, the MSCMB Medical Record Monitor or the Contract Vendor shall write the Inmate Letter Response informing of the outcome.

4.0. The Request for Medical Records (Form #1104-01) specifies that an authorization is not required from an inmate for ADCRR to obtain past medical record from non-ADCRR providers.

4.1. This form is then faxed/ mailed to obtain previous records.

4.2. The form is then filed or scanned in the Previous Records section.

4.3. Once copies are received the MRL will forward to the Provider to review and sign/date the documents. The "outside" records are then filed or scanned in Previous Records after the provider reviews them.

5.0. The Health and Medical Records are State Property. Inmates caught tampering or destroying information contained in the health medical record will be referred for disciplinary action and will forfeit their automatic right to future reviews of their medical records.

5.1. If an inmate is found guilty of tampering or destroying information, any future reviews of the Medical Record must be approved by the Assistant Director.

6.0. In accordance with ARS 31-221 and Department policy, inmates are not allowed to possess nor view the records of other inmates. Any release to view a record that names another inmate will not be honored and must be forwarded to the MSCMB Medical Record Monitor or Vendor for review and action if appropriate.

Arizona Department of Corrections Rehabilitation & Reentry	Release of Information to family members, attorneys, or family designees	OPR: MS Contract Vendor Medical Records Supervisor MSCMB Medical Records Monitor Auth: cp
Medical Services Technical Manual	MSTM Chapter 8 Section 4.1.	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Chapter 8, Sec. 4.1 Release of Information

REFERENCES: NCCHC STANDARD P-H-04

PURPOSE: This policy provides instructions for The Contract Vendor's Medical Record Professionals and Facility Health Administrators to respond to Inmate requests from Family Members/Designees/Attorneys to: review health records, receive copies of health records, and/or allow a verbal exchange of medical information.

RESPONSIBILITY: The Vendor Facility Health Administrator (FHA) is the single individual that is authorized to initiate action in response to requests from Family Member/Designees/Attorneys for access to inmate health information. The FHA will appoint an individual to act on these requests in the case of absence. The FHA shall ensure that processes are in place to allow release of information only in those cases where the proper authority has been given and/or wherein the request has been properly prepared and recorded. The Vendor Medical Records Librarian staff shall ensure compliance with this policy.

PROCEDURES:

1.0. Authorizations:

1.1. Family members/designee or Attorney will be permitted to come to the prison complex to review the inmate's medical and mental health records upon written authorization from the inmate.

1.2. The authorizations under this policy include only those ADCRR records possessed or accessible within the ADCRR Medical Records Library.

1.3. The authorizations do not extend to releasing information from community-based hospitals, medical offices, physician's offices or any other site where inmate's temporary medical records may be located.

1.4. In accordance with ARS 31-221 and Department policy, inmates are not allowed to possess nor view the records of other inmates. Any release to view a record that names another inmate will not be honored.

1.5. All requests from Central Office for copies of records must be copied or responded to within the time frame identified.

2.0. General Guidance for On-site Reviews

2.1. All reviews are generally authorized to be performed on-site at the prison complex where the inmate is housed (unless directed by MSCMB Medical Records Monitor to be performed at Central Office for a released offender).

2.2. If family or family designee is reviewing the Mental Health records, a Vendor Mental Health practitioner will be required during the review. If an attorney is reviewing the Mental Health Records, a Vendor Mental Health Practitioner is not required during the review.

2.3. Notes may be taken but copies may not be made during this examination of the record. If copies are desired following the review, the Family Member/Designee/Attorney will list the specific pages or sections that are desired as copies, sign that request, and give it to the Vendor attending Health Services staff member for later action.

2.4. If copies are made, 20 pages or less, any required payment must be made at the conclusion of the review.

2.5. When sending copies of medical records via interdepartmental mail, Vendor MRLs are to date stamp the date the records are being sent out on an attached note card and send with the Medical Records Request (MRR) and copies as proof that the records were sent out that date.

3.0. When a Family Member/Designee contacts the Vendor FHA requesting written or verbal information about the health record or requesting review of the health records and /or copies of health records, the Medical Records staff will be consulted to ensure the Authorization has been properly executed to allow that specific Family Member/Designee to receive any information or copies of records.

3.1. All Family Member/Designee/Attorney requests for verbal medical information and/or requesting review of the health records and /or requesting copies of health records will be forwarded to the complex Vendor Facility Health Administrator.

3.1.1 If the inmate has been recently released and the chart(s) is still at the prison, the chart will be sent to Health Services Medical Records Monitor for the review if the family member/designee or attorney wishes, otherwise, the review will be conducted at the prison.

3.1.2 For Private Prison: If the inmate is deceased, all records will be sent to the MSCMB Medical Records Monitor and the review will be conducted at Central Office Health Services.

3.1.3 For MS Contract Vendor: If the inmate is deceased, all records will be sent to the Vendor and the review will be conducted at the Vendor's Regional Office.

4.0. The Vendor FHA will direct the unit Vendor Medical Records staff to verify that an Authorization Form (ADCRR #1104-2) has been properly executed and filed in the Legal/Administrative Section of the Medical Record that allows the named specific Family Member/Designee/Attorney to receive the desired/requested verbal information or copies of records. These requests should be processed the same day as they are received in order for them to get to C.O. by the due date.

4.1. If a properly executed Authorization is in the medical record file the FHA will be advised:

4.1.1 That the inmate is allowing information to be released.

4.1.2 The date that the Release Authorization form was executed.

4.1.3 That the requesting Family Member/Designee/Attorney is or is not listed.

4.1.4 What (if any) restrictions are listed on the information release form.

4.2. If a properly executed Authorization is not in the medical file, the inmate will be called to the Health Unit and will be:

4.2.1 Informed of the request for information from the Family Member, Designee, or Attorney.

4.2.2 Informed that the request is for viewing, discussing, and/or receiving copies of the inmate's record.

4.2.3 Asked if they want to sign an Authorization form listing the interested individual.

4.2.4 The authorization may be signed (or refused) by the inmate and witnessed by an officer or Vendor Health staff person.

4.2.5 Upon the proper execution of the Authorization, the Vendor FHA will be notified.

4.3. If the inmate refuses to execute the Authorization,

4.3.1 Vendor Medical Records staff will write "Refused to Sign" and sign their name/title, use name stamp, and date refused on the Authorization.

4.3.2 The refused Authorization will then be filed in the Legal/Administrative section of the inmate's medical record.

4.3.3 The FHA will be notified.

5.0. Administration of the Authorization

5.1. A signed Authorization to Disclose Copies will be Valid for the time-frame up through the date the authorization was signed by the inmate. i.e.: 1/1/14-5/6/14. Records, for example, will not be copied for documentation written after 5/6/14.

5.2. Form #1104-2 will be filed under the Legal/Administrative tab of the Medical Record.

5.3. No more than **two** authorizations for verbal release of information may be in effect at the same time. The individuals authorized must be informed at initial discussions that, in order to preclude multiple individuals receiving information that differs based on the timing of their discussion with the FHA, it is desirable, if at all possible, to make arrangements so that only one person acquires information during periods of acute or crisis treatment.

Chapter 9, Sec. 1.0 Discharge Planning

REFERENCES: DEPARTMENT ORDER 917
DEPARTMENT ORDER 1001
DEPARTMENT ORDER 1002
NCCHC STANDARD P-E-13

PURPOSE: To provide guidance in supporting inmates who are approaching the end of their incarcerated period.

RESPONSIBILITY: It is the responsibility of the Contract Vendor Discharge Planner and the Vendor Facility Health Administrator to ensure that inmate-patients, who are suffering from serious health needs, are provided support planning and assistance as their release becomes imminent.

PROCEDURE:

1.0. Department Order 1001 provides guidance in the process of informing vendor health services of an impending release.

1.1. The Vendor health staff will review the inmate's health record and provide support services including, but not limited to:

- 1.1.1 Arranging for sufficient discharge medications as described in MSTM Chapter 4 Section 1.1.
- 1.1.2 Arranging for sufficient medication delivery supplies such as insulin needles/syringes.
- 1.1.3 Coordinating transfer of medical records to a releasee's accepting Provider (in order to continue care initiated during incarceration).
- 1.1.4 Assisting the inmate in applying for AHCCCS applications.
- 1.1.5 Informing the inmate of points of contact for acquiring State, County, or local services.
- 1.1.6 Informing inmates with specific diseases and undergoing lifelong treatment (e.g., dialysis, HAART, etc.) will receive assistance as necessary and desired by the releasee to locate Practitioners/Providers.

1.2. Actions and follow-up care for inmates released while an inpatient will be coordinated by the Contract Vendor Discharge Planner, Vendor Utilization Management, and the treating hospital.

2.0. Vendor Mental Health staff may also provide assistance in helping released inmates to gain access to Value Options or other "outside" mental health providers.

3.0. All AIDS Drug Assistance Programs (ADAP) applications and orders will be completed through the Vendor Release Planner.

3.1. The Health Planning Consultant/Release Planner will complete all the forwarded applications and acquire a provider's signature.

3.2. The application will then be forwarded to the ADAP office at Arizona Department of Health Services. The original prescriptions will then be forwarded to the Vendor pharmacy for entry into the medication tracking system.

Chapter 9, Sec. 2.0 Medical Research

REFERENCES: DEPARTMENT ORDER 203 (research projects)
DEPARTMENT ORDER 1103
NCCHC STANDARD P-I-07

PURPOSE: To provide guidance in requesting, authorizing, and performance of biomedical research involving inmate-patients.

RESPONSIBILITY: It is the responsibility of the Department Director and MSCMB Assistant Director to ensure that inmate privacy and health is fully protected in the conduct of any approved research.

PROCEDURE:

1.0. Department Order 203 provides guidance in the process for obtaining approval to conduct research.

2.0. Department Order 1103 provides guidance regarding the provision of care to individuals who are or may be infected with a communicable disease.

2.1. Confidential communicable disease information may be disclosed, subject to the approval of the Director and the Director of the Department of Health Services, for the limited purposes of special investigations of the natural history and epidemiology of AIDS or for collaborative research efforts with a public health purpose. Disclosures shall require written assurances of confidentiality of all participating agencies. Confidential communicable disease information may be disclosed to federal, state, or local public health agencies for the limited purposes of communicable disease surveillance and control.

3.0. Inmates placed into the custody of the Arizona Department of Corrections Rehabilitation & Reentry and disclose that they have been participating in a community-based research protocol prior to admission to ADCRR will be interviewed by a Vendor intake Physician/Practitioner, and be asked for contact information of the protocol administrator.

3.1. The intake Physician/Practitioner will contact the research study group to determine if an adverse reaction may result from the inmate's removal from the study. If an adverse reaction may result from the inmate's removal from the study, the intake Physician/Practitioner will immediately contact the Vendor Regional Medical Director or designee for approval and coordination with notification electronically to the ADCRR MSCMB Assistant Director, to allow the inmate to continue in the research study.

3.2. The Vendor FHA will contact the protocol administrator and receive written verification (faxed and mailed) that the removal of the inmate from the protocol will not harm the inmate.

3.3. All pertinent information, regarding any inmate who refuses to cooperate in identifying the protocol administrator or for whom the protocol administrator does not provide an affirmative response to removal of the inmate from the research protocol, is to be forwarded to the Vendor Regional Medical

Director with electronic notification to MSCMB Assistant Director or designee for consideration, action, and direction.

Chapter 9, Sec. 3.0 Access to Custody Information

REFERENCES: DEPARTMENT ORDER 201
DEPARTMENT ORDER 901
NCCHC STANDARD P-H-03

PURPOSE: To provide guidelines for promptly allowing authorized access to custody information in support of providing health care.

RESPONSIBILITY: All health services Contract Vendor personnel are responsible to provide a constitutional level of care to all incarcerated felons regardless of the crime or history.

PROCEDURE:

1.0. At times, complete and adequate care cannot be provided without background information on the patient (e.g., lifestyle, drug use history, injury history, family history). ADCRR possesses a significant amount of pre-sentencing information on all incarcerated individuals.

2.0. Department Order 901 provides the type of information that is available to Vendor health staff. It also describes the method of accessing and the restrictions in handling that information.

2.1. The health staff has access to information described in 901 as Public Information. This category includes and to be provided to Department staff as authorized and Health Care providers under contract to the Department:

- 2.1.1 Name and ADCRR number of any inmate committed to the Department.
- 2.1.2 Conviction data contained in the Judgment of Sentence or minute entry.
- 2.1.3 Verified conviction data from ACIS.
- 2.1.4 The date of admission.
- 2.1.5 The institution where the inmate is housed, unless the file indicates that location is not to be released.
- 2.1.6 The date of scheduled release and/or discharge.
- 2.1.7 Decisions of the Arizona Board of Executive Clemency (Board).
- 2.1.8 The name and office telephone number of the supervising Parole Officer.

Chapter 9, Sec. 4.0 Restraints and Medical Seclusion

REFERENCES: DEPARTMENT ORDER 705
DEPARTMENT ORDER 804
DEPARTMENT ORDER 807
DEPARTMENT ORDER 1103
NCCHC STANDARD P-I-01

PURPOSE: To provide clarification and guidance in the judicious use of clinically ordered restraints and clinically ordered seclusion.

RESPONSIBILITY: All Vendor health care Clinicians and Practitioners are professionally and morally responsible to ensure that clinically ordered restraints and seclusion are used when an inmate-patient exhibits behavior that poses a danger to himself or herself or others as a result of illness.

PROCEDURES:

1.0. Department Order 705 describes the procedure to use when restraining pregnant inmates. While this document is primarily designed for guiding transportation officers in the methods to be utilized, it is instructive for Vendor health staff.

2.0. Department Order 804 provides ADCRR guidance in procedures relative to inmate behavior control.

2.1. Placement of Inmates in Detention. This element describes that inmates may be placed in segregation/detention as necessary including for reason of identifying, minimizing, and intervening in the possibility of self- destructive behaviors.

2.2. Progressive Behavior Control. This element provides that physical force shall be used only when persuasion, direct orders, counseling and warnings are found to be insufficient to obtain cooperation from the inmate. All Staff are directed that no unorthodox, radical or extreme control techniques that might cause positional asphyxia or bodily injury to staff or inmates is to be used. Further, when an inmate continues unacceptable behavior, correctional staff shall isolate the inmate in seclusion. This may be for clinical reasons as outlined in Department Order 1103 if the inmate's behavior is related to mental illness, or may be self-abusive, or self-destructive.

2.3 Maximum Behavior Control. This element requires annual training for all employees and staff having inmate contact who are assigned to Alhambra Behavioral Health Treatment Facility, ASPC-Eyman-Special Management Units, ASPC-Perryville-Lumley, ASPC-Tucson-Rincon Unit, ASPC-Yuma, ASPC-Lewis, ASPC-Florence-CB 6, ASPC-Florence/Central Unit as well as any Central Detention Unit equipped with maximum behavior control beds/cells, or other facilities or locations authorized by the Director to utilize maximum behavioral control.

2.4 Maximum behavior control and maximum-control with restraints shall be the last recourse for controlling an inmate's self-destructive behavior. They may only be authorized when an inmate causes self-inflicted wounds and/or when an inmate continues to demonstrate violent self-destructive behavior and/or after all other less restrictive measures have failed. MBC may never be used as a form of punishment.

3.0. Department Orders 807 and 1103 provide guidance in restraint and/or seclusion of inmates who are exhibiting suicidal behaviors. Vendor Mental Health professionals will serve as the guiding profession in these cases.

Chapter 9, Sec. 5.0 Forensic Examinations and Information

REFERENCES: **A**rizona Revised Statutes 13-2505
DEPARTMENT ORDER 1101
NCCHC STANDARD P-I-03

PURPOSE: To provide guidance regarding collection of, or participation in collection of forensic information.

RESPONSIBILITY: All Contract Vendor Facility Health Administrators are responsible to ensure that Vendor staff assigned under their management does not participate in collection of forensic information for punitive purposes

PROCEDURE:

1.0. ADCRR Contract Vendor health staff shall not conduct forensic examinations except when:

1.0.1 Complying with State laws in collecting DNA samples for databases; or

1.0.2 Conducting body cavity searches or body fluid testing when done for medical purposes and under the orders of a physician; or

1.0.3 Conducting court ordered examinations with the consent of the inmate.

2.0. As described in MSTM 7.10.0, if a sexual assault forensic examination is appropriate (as determined in accordance with DI 241 *DO608 Criminal Investigation or D0125 Sexual Offense Reporting*), the suspect shall be taken by appropriate transportation means to a hospital emergency room for such an examination.

3.0. Incidental removal of foreign bodies from inmate-patients. This is provided as guidance to Vendor staff in collection of forensic or potential forensic evidence that has been acquired during the course of treatment. Forensic information is physical data or items collected from an inmate that may be used against him or her in disciplinary or legal proceedings.

3.1. The Arizona Department of Corrections Rehabilitation & Reentry generally prohibits Vendor health staff from participating in collection of forensic information.

3.2. There are specific exceptions to this policy that are driven when collection is authorized/requested by the inmate <u>or</u> required by State law <u>or</u> for medical purposes by Vendor Physician's/Practitioner's order. Specifically, in accordance with ARS 13-2505, the Department may request a Vendor licensed Practitioner to order that an x-ray be performed on any inmate if there is reason to believe the inmate is in possession of contraband as defined in Arizona Revised Statute 13-2501. If considered medically necessary for the inmate's safety, an X-ray may be completed

3.3. If in the course of medical treatment, a Vendor Practitioner/ Provider finds a need to collect or remove a foreign body (i.e., old bullet, shrapnel, pencil tip, etc.) and if the item to be removed may be considered evidence and if the collection may be postponed without causing additional harm to the patient, contact the CIU supervisor and authorize CIU's attendance at the removal. If the CIU supervisor determines the item to be of an evidentiary nature, they will witness the removal and advice in the preservation of the item.

3.4. If an item is removed as a result of an unplanned discovery, preserve the item and contact CIU for advice and direction.

3.5. Such action does not fall under the prohibition set by professional organizations, statute, or medical ethics standards because it is not an action that is collected specifically for the purposes of consideration for disciplinary or legal proceedings.

4.0. Although Vendor health personnel may be called upon to participate in investigative elements, they are prohibited from participating in any punitive activity that results from an inmate's nonparticipation in a collection process.

Chapter 9, Sec. 6.0 Executions

REFERENCES: DEPARTMENT ORDER 710
DEPARTMENT ORDER 1101
NCCHC STANDARD P-I-08

PURPOSE: To provide guidance to Medical Services Contract Monitoring Bureau and Contract Vendor Staff regarding the conduct of executions in the State of Arizona. Any real or perceived assistance in the execution of inmates would negatively impact the appropriate relationship between a Vendor Practitioner/Provider and his/her patient. Therefore, all such real or potential involvement is prohibited.

RESPONSIBILITY: It is the responsibility of the Contract Vendor to ensure that Vendor health staff are not assigned to perform services directly related to the execution of a condemned inmate.

PROCEDURE:

1.0. The MSCMB Assistant Director and the Contract Vendor shall ensure that health care continue throughout the lifespan of the incarcerated inmate.

1.1. Vendor health staff will not assist in directly causing the death of an inmate.

1.2. Vendor health staff will not supervise in activity that causes the death of an inmate.

1.3. Vendor health staff will not contribute to another individual's ability to cause the death of an inmate.

2.0. Vendor Mental Health services will be provided as necessary. This will not include competency determination. Competency determinations will be provided by contracted professionals and not by the Contract Vendor.

3.0. In no event shall an execution be performed in an area designated as a health unit.

Appendix A Statistics and Reporting Requirements

Statistics and Reporting Requirements:

To provide guidance relating to the completion and submission of all required reports and statistics.

It is the responsibility of the MS Contract Vendor to 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.

Appendix B **Dental Technical Manual**

APPENDIX B DELETED. SEE DENTAL TECHNICAL MANUAL

Appendix C, Sec. 1.0 Chronic Illnesses (Monitored Illnesses)

EXECUTIVE SUMMARY:

- ADCRR Contract Vendor monitors chronic illnesses. In accordance with A.R.S. 36-201.01 (G), and Department Order 1101-06. The Monitored Condition Database is a Centralized chronic disease electronic tickler system converted from paper in 2004. This Department Order requires that inmates be provided appropriate access to medical care at reasonable fees. The Department Order also requires that appropriate and uninterrupted health care be provided to inmates with chronic health illnesses. The Monitored Illness Database does just that by providing the following:
- Identification of inmates with the following Chronic Illnesses:
  - Blood Disorders (including those on anticoagulants (or long ter >6months)).
  - Cancer
  - Cardiac / Heart Disease
  - Chrones's Disease
  - Coccidiodomycosis (Valley Fever)
  - Diabetes
  - End Stage Liver Disease
  - Hepatitis C
  - HIV / AIDS
  - Hyperlipidemia
  - Hypertension
  - Hyperthyroidism
  - Neurological Disorders
  - Renal Diseases
  - Respirator Disorders
  - Rheumatological Diseases
  - Seizure disorders
  - Sickle Cell Anemia
- A mechanism for patient follow – up.
- Assist with re-ordering medications for inmates in a timely manner to treat their chronic illnesses minimizing interruption or unnecessary delay.
- In the past, tickler cards had generated follow up appointments for Inmates with Chronic Medical Illnesses. This process ensured that inmates received medical attention on a monthly basis. A report would be generated from a color code on the tickler card or a hand written list created for each month, allowing staff to identify Inmate follow-up appointments once a month or mid-month. This also required extensive research in ACIS to identify if the inmate still resided at the facility was a new commitment or had been transferred.
- With statewide implementation on an Electronic Health Record, the current electronic tickler system will be replaced or phased out. The eOMIS system, or other electronic health record system, will allow the Vendor health staff to enter the Chronic Illnesses in order that the inmates will have appropriate follow-up appointments. The "Private" prison complexes shall have a method of tracking the Chronic Illnesses i.e. Excel program, or other appropriate paper or electronic tracking system.

Appendix C, Sec. 2.0 Clinical Practice Guidelines for the Evaluation and Treatment for Viral Hepatitis C

Introduction: This guideline provides information regarding screening, education, routine laboratory monitoring, and clinical decision-making regarding patients who have chronic hepatitis C.

Background

- Hepatitis C: Hepatitis C virus (HCV) infection is a major public health problem in the United States, with a high incidence in the incarcerated population.
- The goal of treatment HCV-infected persons is to reduce all-cause mortality and liver-related health adverse consequences, including end-stage liver disease and hepatocellular carcinoma, by the achievement of virologic cure as evidenced by a sustained virologic response.
- HCV can cause both acute and chronic hepatitis. The acute process is self-limited, rarely causes hepatic failure, and usually leads to chronic infection.
- Chronic HCV infection frequently follows a progressive course over many years and can ultimately result in cirrhosis, hepatocellular carcinoma, and the need for liver transplantation.
- In the correctional environment, patients with a reactive HCV antibody (Ab) test were previously exposed to HCV by risky behaviors which resulted in exposure to blood, commonly through intravenous drug use or tattooing.
- 70% to 85% of patients who were exposed to HCV develop persistent HCV viremia, while 15-30% of patients will resolve the infection on their own.
- Patients with HCV-Ab and HCV-RNA (viral load) detectable in serum have chronic HCV.
- Approximately 25% or more of chronic HCV patients develop progressive hepatic fibrosis as a result of chronic hepatic inflammation and may progress clinically to cirrhosis or hepatocellular cancer.
- A small number of chronic HCV patients may also develop extrahepatic symptoms, including cryoglobulin-mediated vasculitis, causing skin lesions and renal failure, or a variety of other extrahepatic manifestations including adult onset diabetes mellitus, hyper- or hypo-thyroidism, other skin manifestations, or non-Hodgkin's lymphoma.

Identification

- An anti-HCV antibody test will be performed for the following inmates during the initial intake process through opt-out screening:
- Patients with chronic HCV who have progressive hepatic fibrosis or serious extrahepatic manifestations of HCV should be identified, appropriately staged and treated if necessary.

- National guidelines for viral eradication treatment are presently outlined at the website www.hcvguidelines.org, maintained by the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA).
- Because chronic HCV is a slowly progressive condition, criteria are useful in determining which patients are in need of treatment before others.
- Current guidelines recommend that all patients with chronic HCV should eventually be treated.
- Patients who test positive for HCV-Ab should have a reflex serum HCV-RNA quantification (viral load) test done.
    - A provider visit shall be scheduled to discuss the test results.
    - A repeat HCV-RNA is scheduled 6 months later to confirm chronic HCV.
- Patients with HCV-Ab and persistent viral load detection for >6 months confirms chronic HCV.
- These patients should be scheduled with a provider for future discussion of evaluation and staging.

Education and Prevention

- Persons with current HCV infection receive education and interventions aimed at reducing liver disease progression and preventing HCV transmission.
- Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption is advised for all persons with HCV infection.
- Evaluation for other conditions that may accelerate liver fibrosis, including hepatitis B and HIV infections, is recommended for all persons with active HCV infection.
- Evaluation for advanced fibrosis typically using imaging and/or noninvasive markers is recommended for all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy, and to determine the need for initiating additional measures for cirrhosis management (e.g. hepatocellular carcinoma screening).
- Vaccination against hepatitis A and hepatitis B is recommended for all susceptible persons with HCV infection.
- Influenza vaccine should be offered to all HCV-infected patients annually.
- Tetanus, diphtheria, and pertussis (Tdap) vaccine should be offered to all HCV-infected patients.
- Persons with cirrhosis are more susceptible to invasive pneumococcal infection and should receive pneumococcal vaccination (PPSV 23)
- All persons with HCV infection are provided education about how to avoid HCV transmission to others.
- Because persons with known or suspected bridging fibrosis and cirrhosis are at increased risk of developing complications of advanced liver disease, they require frequent follow-up. They should also avoid hepatotoxic drugs, such as excessive acetaminophen (>2 g/d) and certain herbal supplements.
- Nephrotoxic drugs, such as nonsteroidal anti-inflammatory drugs, should also be avoided. Ongoing imaging surveillance for liver cancer and gastroesophageal varices is also recommended for patients with cirrhosis.

Evaluation – Initial

- Patients with HCV-Ab and detectable HCV-RNA (viral load) for greater than 6 months have further evaluation and staging of chronic HCV.
- The patient is enrolled in the chronic care program and is scheduled for a provider visit within one month of the results or revealed medical history. The patient may decline further evaluation, and if so, a refusal is documented in the medical record.
    - Refusal to Submit to Treatment, Form 1101-4
- Initial laboratory evaluation of patients with chronic HCV includes CBC, CMP (to include AST, ALT, total bilirubin, albumin) and PT/INR.

- Screening for other conditions includes Hepatitis A antibody (HAV-Ab), Hepatitis B surface antigen (HBsAg), HIV antibody (HIV- Ab), and ferritin as screening for hepatic iron overload.
- If the patient is being considered for treatment of chronic HCV, additional laboratory testing includes HCV genotyping.
    - For treatment determination, a genotype should be completed within 12 months of treatment.
    - The HCV genotype should be the final test completed prior to treatment initiation.
- Patients who are positive for HCV genotype 1a and are being considered for treatment should be tested for the NS5A mutation, if it will affect the medication choice.
    - An NS5A should be ordered at the same time as the HCV genotype test.
    - The NS5A test will only be performed by the lab if the HCV genotype result is 1a.
- Patients who are candidates for Hepatitis C treatment must have enough time remaining in their sentence to complete the course of treatment. The provider must complete the Consent for Treatment and Consult Request.
    - Consent – Refusal for Treatment of Hepatitis C, Form 1101-50 (English/Spanish)
- All patients with positive HCV antibodies and a positive HCV RNA test, will be considered a candidate for treatment based on Priorities for Treatment criteria.

Assessment of the Liver

- The principal consequence of chronic HCV is inflammation of the liver which results in scarring or "fibrosis" and progression to cirrhosis. The amount of scarring is usually measured on the METAVIR scale:
    - F-0: inflammation, but no fibrosis
    - F-1: mild fibrosis
    - F-2: moderate fibrosis
    - F-3: severe fibrosis
    - F-4: cirrhosis
- The fibrosis scoring test should be done following confirmation of a diagnosis of chronic HCV (i.e. after 2 positive HCV-RNA viral loads performed >6 months apart).
- Liver biopsy is generally unnecessary. Noninvasive methods frequently used to estimate liver disease severity include:
    - Liver-directed physical exam (normal in most patients)
    - Routine blood tests (e.g., ALT, AST, albumin, bilirubin, international normalized ratio [INR], and CBC with platelet count). Simple calculations derived from routine blood tests - such as the serum AST-to-platelet ratio index (APRI).
        - A calculator is available at http://www.hepatitisc.uw.edu/page/clinical-calculators/apri
- Serum fibrosis marker panels. Evaluation of the amount of fibrosis is done with a proprietary predictive index (e.g. FibroSure), to initially assess the amount of fibrosis (liver scarring). A combination of age, sex, and several laboratory parameters are used to predict the fibrosis score (F0-F4).
- Liver imaging (e.g., ultrasound, or CT scan) can help identify cirrhosis or hepatocellular carcinoma.
- Evidence of portal hypertension on abdominal U/S (including use of the PLT/spleen diameter ratio), or other clinical/lab evidence of cirrhosis do not usually need further confirmation by elastography or liver biopsy (unless the serum fibrosis marker result do not correlate with abnormal findings of advanced or decompensated cirrhosis in ultrasound/CT findings then elastography would be used to confirm actual fibrosis staging).
- Transient elastography when other testing is not available or appropriate.

- The Child-Turcotte-Pugh (CTP) score is a useful tool to help determine the severity of cirrhosis. This score can help distinguish between compensated and decompensated cirrhosis. The CTP classification system utilizes two clinical parameters (encephalopathy and ascites) and three laboratory values (bilirubin, albumin, and prothrombin time) as shown in the table below:

	Points*		
Clinical and Lab Criteria	**1**	**2**	**3**
Encephalopathy	None	Grade 1 or 2	Grade 3-4
Ascites	None	Mild to Moderate	Severe
Bilirubin (mg/dL)	<2	2-3	>3
Albumin (g/dL)	>3.5	2.8-3.5	<2.8
Prothrombin time (10-12.1)			
Seconds or prolonged	< 12	12-14	>6 >14
Or			
INR	<1.7	1.7-2.3	>2.3
*Child-Turcotte-Pugh Class obtained by adding score for each parameter (total points)			
Class A = 5 to 6 points---Compensated Cirrhosis			
Class B = 7 to 9 points---Decompensated Cirrhosis			
Class C = ≥10 ---Decompensated Cirrhosis			

- In patients with advanced fibrosis and cirrhosis, HCV eradication reduces the rate of decompensation and will reduce the risk of Heptocellular Carcinoma (HCC).
    - In these patients, surveillance for HCC should continue.
- In patients with decompensated cirrhosis, HCV eradication reduces the need for liver transplantation.

Determining Treatment Eligibility

- Chronic medical conditions which could impact chronic HCV treatment should be under acceptable control.
- Behavioral risk reduction, counseling for substance use disorder and opiate substitution treatment can be an integral part of chronic HCV treatment.
    - The use of peer educators has been shown to have the greatest impact in this area.
    - Patients should have pro-sobriety attitudes assessed and documented in the medical record.
    - Patient-driven substance use disorder therapy with peer educators and sponsors have demonstrated improved outcomes and decreased relapse rates post-release. Patients are encouraged to participate in these programs.
- Eligibility based on Length of Stay post-treatment should:
    - Allow patients to know whether they have responded to therapy, as patients with established sustained virologic responses (SVRs) prior to discharge are known to have decreased rates of substance misuse relapse and re-infection, and so time enough for an SVR to be established (12 weeks post treatment for Direct-Acting Antivirals) is advised.
    - Time until release should also incorporate time enough for routine or unexpected system issues, such as inter-institutional transfers, to not compromise treatment.
    - Discharge counseling is to be provided for continued care and for SVR post 12-week treatment by a local community clinic if patient is released before his HCV treatment is completed.

Patient Prioritization

- Patients being evaluated for possible treatment for chronic HCV shall be placed on a medical hold until the workup, treatment, and 3 months post-treatment evaluation are completed.
- The medical hold will prevent movement to another facility and will allow for vital continuity of care to occur.

PRIORITY LEVEL 1 — Highest Priority for Evaluation and Treatment

- Fibrosis Stage 4 (F4), decompensated cirrhosis, including both symptomatic patients (e.g., with ascites, hepatic encephalopathy, esophageal varices, etc.) and asymptomatic patients with Child-Turcotte-Pugh scores greater than or equal to 7.
- Fibrosis Stage 4 (F4), compensated cirrhosis, with Child-Turcotte-Pugh scores of 5 to 6.
- Liver transplant candidates or recipients in consultation with and co-managed by a transplant hepatologist.
- Hepatocellular Carcinoma in consultation with a hepatologist for correct timing.
- Comorbid medical conditions associated with HCV, including cryoglobulinemia with renal disease or vasculitis, certain types of lymphomas, hematologic malignancies, or metabolic abnormalities (e.g., porphyria cutanea tarda).
- Continuity of care for those entering custody already on treatment.
- Patients taking immunosuppressant medications for a comorbid medical condition which may cause rapid progression of hepatic fibrosis.
- HIV co-infection
- HBV co-infection

PRIORITY LEVEL 2 —Intermediate Priority for Evaluation and treatment

- Fibrosis stage 3 (F3)
- Fibrosis stage 2 (F2) with comorbidities
- Comorbid liver diseases (e.g., autoimmune hepatitis, hemochromatosis, steatohepatitis)
- Chronic Kidney Disease with proteinuria
- Diabetes Mellitus
- Patients previously staged as F0, but who advanced in staging to F1 within 1-4 years are considered to have progressive hepatic fibrosis, and should be treated in this priority group.

PRIORITY LEVEL 3 - Active Monitoring for Direct Acting Antivirals (DAA) Treatment

- Fibrosis stage 2 (F2) without comorbidities
- Fibrosis stage 1 (F1)
- Fibrosis stage 0 (F0)

Treatment Refusal

- A refusal for treatment for Hepatitis C will be acknowledged by the patient's signature, and countersigned by the responsible provider.
    - Consent/Refusal for Treatment of Hepatitis C, Form 1101-50 (English/Spanish)

- A refusal to consent to treatment, with a concomitant refusal to sign the refusal, will be countersigned by the responsible provider and a witness.
- Patients being considered for treatment of HCV should have:
    - No contraindications to any component of treatment regimen
    - Should not be pregnant
    - Should have sufficient time remaining on their sentence in ADCRR in order to complete a course of treatment
    - Should demonstrate willingness and an ability to adhere to a rigorous treatment regimen and to abstain from high-risk activities while incarcerated.

Monitoring Candidates for Treatment

- Stable HCV patients should be enrolled in chronic care and seen every 6 months.
    - A CBC, CMP, and PT/INR should be performed every 6 months.
    - A baseline abdominal ultrasound should be performed.
    - The Fibrosure test may be repeated once per year.
    - Repeat HCV-RNA testing is not recommended in patients with chronic HCV, unless treatment will be started in the next 90 days.
- Patients with severe fibrosis (F3) or cirrhosis (F4) should have an abdominal ultrasound every 6 months to screen for hepatocellular carcinoma, regardless of HCV status.
    - Fibrosis testing should not be repeated in patients with a score of F3 or F4.
- Patients with decompensated cirrhosis may benefit from co-management by a gastroenterologist or hepatologist for care such as ongoing variceal surveillance, antibiotic prophylaxis if risk factors for bacterial peritonitis, optimized diuretic therapy for ascites and hepatic encephalopathy

Treatment Recommendations

- HCV treatment regimens are changing rapidly, as new agents are regularly becoming available. Evidence of the most effective ways to utilize the Direct Acting Antivirals (DAA) continues to evolve. Reference the AASLD and IDSA website, www.hcvguidelines.org, for the most current recommendations.
- All decisions on treatment will be made by the appropriate providers, using the clinical practice guidelines and appropriate administrative prioritization based on available resources. When using the present choices for therapy, cost-effectiveness is a valid selection criterion in choosing one agent over another, especially as more medications become available.
- Patients should be involved in decision-making, and prioritization of care should be explained and documented transparently in the medical record. The medical record needs to reflect individualized assessment and assignment to the appropriate treatment priority group and the plan for long-term management of those in the deferred treatment group and whether treatment was deferred medically or administratively.
- Directly observed therapy is strongly advised, with routine adherence checks documented by Contract Healthcare Provider (CHP) including nursing and medical provider staff.
- In patients who are coinfected with hepatitis B, comanagement with a hepatologist is highly recommended, due to the risk for HBV reactivation during or after treatment with HCV DAAs.
- Treatment of HCV patients with decompensated cirrhosis should be managed in consultation with a hepatologist.
- Expert consultation is required in patients eligible for liver transplantation. Generally, a Model for End-Stage Liver Disease (MELD) score should be computed (http://gihep.com/calculators/hepatology/fibrosis-4-score/) and if indicated the patient should be referred for liver transplant consideration.

Treatment Failure

- Treatment failure is defined as detectable HCV viral load 12 weeks following completion of therapy.
- If the HCV-RNA is in the <50 IU/ml or the "non-quantifiable" range then the test should be repeated in 4 weeks as this situation usually represents lab error and the repeat testing will be "not detected."
- In the case of true failure, the medical record should be reviewed for non-adherence, system failures in drug dispensing, possible drug-drug interactions, and the patient interviewed for illicit drug use and the ingestion of other acid-lowering medications or supplements.
- If no interfering risk factors are identified, the possibility of viral mutation causing drug resistance (or resistance associated substitutions [RAS]) should be considered.
- Further resistance testing and a secondary treatment regimen should be selected according to the principles and treatment recommendations contained in www.hcvguidelines.org.

Monitoring During Treatment

- Patient is to have outpatient clinic visit at 2-4 weeks after starting therapy in order to review adherence to the prescribed regimen and assess for side effects and the need for treatment modification.
- A CBC and CMP should be drawn at 4 weeks to rule out transaminase elevation due to autoimmune hepatitis or hepatitis B virus (HBV) reactivation. The CMP may also be used to reassure the patient that there is evidence of efficacy and encourage further adherence and program compliance. Progressive increases in the ALT may require more frequent monitoring or early discontinuation.
- An HCV RNA test can be considered at 4 weeks if there was prior treatment resistance or if there is coinfection with HIV or hepatitis B.
- For regimens containing ribavirin, a CBC and CMP is drawn 2 weeks after starting therapy, then at 4 weeks, then monthly or more frequently as clinically indicated. A ribavirin dosage adjustment may be required. Mild (1-3x upper limit of normal) elevation of the total bilirubin may be expected as a consequence of ribavirin-induced oxidative stress and red blood cell lysis.
    - Pregnancy testing is required prior to treatment with ribavirin-containing regimen, and thereafter as risk behavior for pregnancy occurs.

Monitoring After Treatment

- A post-treatment quantitative HCV-RNA assessment is drawn at 12 weeks after completion of treatment; and if HCV is undetectable, that defines a sustained viral response (SVR).
- For patients with SVR, the problem list should be updated to indicate that the patient's chronic HCV is 'resolved'.
    - The date of treatment and medication administered should be documented.
- A patient who sustains SVR (F0, F1, F2) may be removed from chronic care monitoring.
- Patients with severe fibrosis (F3) or cirrhosis (F4) should continue to be managed in the chronic care program.
    - Monitoring for hepatocellular carcinoma should continue to take place with an abdominal ultrasound every 6 months.
    - The patient's problem list should be updated to indicate severe fibrosis (F3) or cirrhosis (F4), as applicable.
    - Fibrosis testing should not be repeated in patients who have a score of F3 or F4.

Special Circumstances

- Consultation with a hepatologist should be considered in the following situations:
  - Decompensated cirrhosis
  - Candidates for liver transplantation
- Consultation with an infectious disease specialist or hepatologist may be considered on a case by case basis, with guidance from the medical director in the following situations:
  - HIV coinfection
  - HBV coinfection
- Continuation of outside therapy
  - If the patient is incarcerated while already undergoing Hepatitis C treatment:
    - Patient's records are requested from patient's liver specialist to include all treatment information up to current treatment (dose, length of treatment, adverse reaction, genotype, etc.)
    - Patient is continued on current treatment regimen while incarcerated
- Pregnancy
  - Treatment of HCV should be postponed until after delivery
- Reinfection with HCV after treatment
  - Patients who are reinfected with HCV and develop chronic HCV may be considered for repeat treatment, based upon established criteria that apply to all HCV patients.
- Cirrhosis: The following recommendations apply to all patients with cirrhosis, regardless of their chronic HCV status
  - Pneumococcal vaccine for all patients with cirrhosis who are 19 through 64 years of age
  - Influenza vaccine for all patients with cirrhosis annually
  - Hepatocellular carcinoma screening with an abdominal ultrasound every 6 months
  - Esophageal varices screening with an esophagogastroduodenoscopy (EGD)
  - Other interventions may include:
    - Beta blockers for the prevention of variceal bleeding in patients with esophageal varices
    - Antibiotic prophylaxis if risk factors for spontaneous bacterial peritonitis are present
    - Diuretic therapy for ascites
    - Lactulose or rifaximin therapy for encephalopathy
  - NSAIDs should be avoided in advanced liver disease/cirrhosis

Practice Pearls

- A positive urine drug screen does not disqualify patients from HCV treatment
  - Patients with suspected substance use disorder should be offered resources for treatment of their substance misuse.
- Do not repeat HCV Ab testing in positive patients
  - Once a patient tests positive, they will remain positive
- If a patient with a positive HCV Ab and an UNDETECTABLE HCV- RNA (viral load), the HCV-RNA should be repeated in 6 months to ensure that it remains undetectable.
  - There is no indication to repeat HCV-RNA testing in patients with 2 undetectable tests performed 6 months apart, unless there is a concern about reinfection.
- Patients with undetectable HCV-RNA tests may be dis-enrolled from the HCV chronic care program.
  - If the patient is at high risk for reinfection with HCV, then an HCV-RNA (viral load) may be repeated once per year.

Forms

- Hepatitis C Treatment Checklist, Form 1101-7
- Consent/Refusal for Treatment of Hepatitis C, Form 1101-50 (English/Spanish)

References

- Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection. Federal Bureau of Prisons. January 2018. https://www.bop.gov/resources/pdfs/012018_hcv_infection.pdf. Accessed May 1, 2021.
- HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. http://www.hcvguidelines.org. Accessed May 2, 2021.
- Overview of the management of chronic hepatitis C infection. www.UpToDate.com. Accessed April 22, 2021.

Appendix D, Sec. 1.0 Communicable Disease Definitions

PURPOSE:

Department Order 1103 provides a standard guideline for notification and documentation of reportable diseases, and for the appropriate management of inmates who require medical isolation to ensure that all inmates and staff are protected from communicable disease. This Department Order applies specifically to reporting, management and control of communicable diseases among inmates.

- In accordance with Department Order 1102, The Contract Vendor Facility Health Administrator (FHA) or designee shall submit a communicable disease report to the County Health Department (or Indian Health Service Unit) of a case or a suspect case of the diseases and conditions listed in Attachment A, Diseases To Be Reported, within the time frames noted on the attachment, by telephone or other equally expeditious means.
- The Vendor FHA or designee shall submit a weekly written report of positive laboratory findings for the communicable disease pathogens listed in Attachment B, Reportable Positive Findings, to the Arizona Department of Health Services.
- No inmate, area, unit or complex shall be placed in isolation status without the Vendor Regional Medical Director, or his representative's, approval. <u>All suspected or confirmed communicable disease are reported to the Contract Vendor Medical Director or designee immediately for guidance with notification to MSCMB Medical Program Administrator and Assistant Director.</u>
  - DISEASES TO BE REPORTED
  - LIST OF REPORTABLE DISEASES: Arizona Administrative Code Requires Providers to report the following Reportable Diseases

    1 Report within 24 hours of diagnosis if in food handler.

    2 Report outbreaks only.

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

AIDS	Hepatitis C	Rubella
Amebiasis*1*	Hepatitis D	Salmonellosis*1*
Anthrax	Hepatitis Non-A, Non-B, Non-C	Scabies*2*
Aseptic meningitis	Herpes genitals	Severe Respiratory Distress Syndrome
Encephalitis, viral	HIV infection & related disease	Shigellosis*1*
Botulism	Human T-cell Lymphotropic Virus (HTLV I/II)	Smallpox
Brucellosis	Invasive Relapsing fever	

Campylobacteriosis 1		Streptococcal Group A,
Chancroid (Haemophilus ducreyi)	Kawasaki Disease	Streptococcal Group B, invasive
Chlamydia	Lead poisoning 3	Syphilis Chlamydial infections (genital)
Coccidoidomycosis (Valley Fever)	Legionellosis	Taeniasis Cholera
Colorado tick fever	Leprosy	TB Infection in Children < 6 yrs
Congenital Rubella Syndrome	Leptospirosis	Tetanus Coccidioidomycosis
Conjunctivitis, acute 2	Listeriosis	Toxic Shock Syndrome
Cryptosporidiosis	Lyme disease	Trichinosisis
Dengue	Malaria	Tuberculosis
Diphtheria	Measles	Tularemia
Ehrlichiosis	Meningococcal Disease, Invasive	Typhoid Fever 1
Encephalitis: Vial or Parsitic	Mumps	Typhus Fever
Escherichia Coli O157:H71 infectious (Enterotoxogenic)	Pertussis	Vancomycin-resistant Staphlococcus aureus
Foodborne/Waterborne Outbreaks	Pesticide Poisoning 3	Vancomycin-resistant Enterococcus
Giardiasis 1	Plague	Vancomycin-resistant Staphylococcus epidermidis
Gonorrhea	Poliomyelitis	Varicella (chickenpox)
Haemophilus Influenzae	Psittacosis	Vibrio infection
Hantavirus Infection	Q Fever	
	Rabies	Yellow Fever
Hepatitis A, B, C, D	Reye syndrome	Yersiniosis
	Rocky Mountain spotted fever	

THE FOLLOWING DISEASES shall be reported to the County Health Department (or Indian Health Service Unit) within: Five days - (Twenty four hours if related to a food handler)

- Bordetella pertussis
- Brucella species
- Campylobacter species
- Chlamydia
- Coccidioides immitis: culture or serologies
- Cryptosporidium species
- Escherichia coli O157:H7
- Group A Streptococcus; isolated from normally sterile site, tissue or body fluid
- Group B Streptococcus: isolated from normally sterile site, tissue or body fluid
- Hantavirus
- Hemophilus influenza type b: isolated from normally sterile sites
- Hepatitis A Virus, symptomatic (anti HAV-IgM serologies)

- Hepatitis B Virus, symptomatic (anti-Hepatitis B core-IgM serologies and Hepatitis. B surface antigen serologies)
- Hepatitis C Virus (anti-Hepatitis C RIBA, PCR or other confirmatory test
- Hepatitis Delta Virus
- Human Immunodeficiency Virus (HIV)
- Human T-cell Lymphotropic Virus type I and II Legionella species: Culture or DFA
- Listeriosis sp.: culture isolated from normally sterile sites only
- Mycobacterium tuberculosis and its drug sensitivity patterns
- Neisseria gonorrhoeae
- Neisseria meningitidis isolated from normally sterile sites
- Plasmodium species
- Streptococcus pneumoniae and its drug sensitivity pattern; culture isolated from normally sterile sites only
- Treponema palladium (syphilis)
- Vancomycin resistant Entercoccus
- Vancomycin resistant Staphylococcus aureus
- Vancomycin resistant Staphylococcus epidermidis
- Vibrio species
- Yersinia species

An occasional requirement for a negative air flow room may be required to house an inmate in isolation while sputum testing is being accomplished to rule out an infectious disease such as tuberculosis. In these situations, the inmate will be transferred to one of the contracted community hospitals wherein these housing accommodations can be maintained.

Appendix E, Sec. 1.0 Emergency Response Orders

The Emergency Response Orders were developed to provide guidance in emergency or life threatening situations. Using these guidelines, licensed nursing staff may initiate emergency care based on nursing assessment in consultation with a Medical Practitioner.

The relevant medical history, pertinent physical findings, and vital signs shall be available for the Practitioner/ Provider and thoroughly documented in the medical record by the Nurse.

- These orders are for emergencies and life-threatening situations only. The Emergency Response Orders may be initiated by Contract Vendor Medical/ Nursing staff to manage emergencies and life threatening situations affecting staff and visitors. Vendor Medical/Nursing staff will complete an information report for staff or visitors and submit the report to the Vendor Facility Health Administrator. These procedures are to be utilized only if there is an immediate or imminent threat to the patient's life. Should an emergency or life-threatening situation occur, treatment should be implemented in the following order:
  - Activate ICS, if not already activated.
  - Have Complex Control access the local EMS system via 911, if necessary.
  - Institute emergency measures listed under the appropriate Emergency Response Orders.
- Note: Emergency Response Orders containing instructions to administer oxygen at the maximum flow rate of 15 liters per minute may not be possible in some of the ASPC health units due to equipment (tank regulator) limitations. In these situations, 8 liters or 10 liters per minute may be the highest flow rate that can be attained.
  - Notify Vendor health care Practitioner and obtain subsequent orders.
  - Document the incident as soon as possible in the Health Record. Documentation must be completed prior to the end of shift.
  - Any incident requiring use of the Emergency Response Orders and documentation in the Health Record must be signed by the responsible Vendor Practitioner on the following business day or as soon as possible.
  - If transport is required, complete Consultation Report form prior to transport.
- The Emergency Response Orders must be reviewed and signed at least annually by MS Contract Vendor Regional Medical Director, MS Contract Vendor Regional Director of Nursing, and MSCMB Medical Program Administrator.

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ACUTE ASTHMA / BRONCHOSPASM --- ORDER 1

Obtain pertinent history of current attack, measure vital signs including O_2 saturation, perform a nursing assessment/evaluation of the heart and lungs, and record in the Health Record.

For wheezing documented on examination, or poor tidal volume/air exchange is noted, initiate treatment as follows:

- Administer small volume nebulizer treatment (SVN) with 0.5 cc Albuterol mixed with 2.5 cc Normal Saline.
- May repeat immediately, if no improvement.
- Notify Vendor Practitioner and obtain subsequent orders, if indicated.

ANAPHYLAXIS --- ORDER 2

Anaphylactic reactions can be caused by insect bites, most notably bees and other stinging insects. They can also be caused by ingestion of foods, as well as medications, both prescriptive and illegal. Occasionally, such reactions can occur after inhalation of allergens or topical application of medication. Generally, parenteral and not oral administration of medication causes anaphylaxis.

Anaphylaxis is characterized by the onset of symptoms from the time of the triggering event is short, often between 5 and 60 minutes. Note: The more rapid the onset of symptoms, the more severe the reaction.

Common Signs/Symptoms:

- Tightness in the chest
- Rapid respiratory rate: tachypnea
- Cough
- Wheezing / Rales
- Generalized rash and hives/or itching
- Angioedema of the face or tongue
- Stridor due to laryngeal edema

Treatment

- Place patient in the supine position, or the position that best supports respiratory effort.
- Take and record vital signs, including Oxygen (O_2) saturation.
- Place patient in Trendelenburg by adjusting the position of the bed or by raising the lower extremities with several pillows if systolic blood pressure is less than 90 mm Hg.
- Begin O_2 at 15 liters per minute via non-rebreather mask, unless there is a known history of Chronic Obstructive Pulmonary Disease (COPD), in which case, O_2 should be administered by nasal cannula at no more than 2 liters per minute.
- Assess patient for evidence of stridor, facial swelling, and swelling of tongue, generalized rash, wheezes, or rales. If present, begin treatment with Epi-Pen per package insert instructions, or aqueous epinephrine (1:1000) 0.3 mg SUBCUT.
- After the first dose of epinephrine, administer Diphenhydramine 50 mg IM.

- Repeat vital signs and document**.**
- If above symptoms persist, repeat Epi-Pen per package insert instructions or aqueous epinephrine (1:1000) 0.3 mg SUBCUT every 20 minutes for a total of 3 doses.

Note: If a second dose is required, check vital signs and contact the Practitioner. Notify Complex Control to activate local EMS system.

- Start IV with Normal Saline. Run at an appropriate rate (not to exceed 200 cc/hr) to keep systolic blood pressure >110 mm Hg.
- Prepare patient for transport.

CARDIAC ARREST --- ORDER 3

- Activate ICS, if not already done.
- Assess ABCs
- Place patient on a firm horizontal surface.
- Have officers remove other inmates from the immediate area, if necessary.
- Assure Airway is patent.
- Begin Rescue Breathing.
- Perform external chest compressions to maintain Circulation.
- If AED is available, activate and shock if indicated, then continue CPR.
- Delegate rescue breathing/ventilation and external cardiac compressions to security staff.
- Begin IV with Normal Saline at a keep open rate.
- Notify Complex Control to activate local EMS via the 911 system.
- Continue CPR until the local EMS provider arrives on scene.
- Notify Practitioner and prepare for transport of patient.

CHEST PAIN --- ORDER 4

Take medical history, measure vital signs including O_2 saturation, perform a cardiac and respiratory assessment/evaluation, and record in the Health Record.

- Administer O_2 via non-rebreather mask at 15 liters per minute unless there is a known history of COPD; in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Administer Nitroglycerin 0.4 mg sublingually and Aspirin 81 mg orally (chewable). Measure vital signs and record.
- Obtain a 12 lead ECG.
- Notify Complex Control to activate EMS system via 911.
- May repeat nitroglycerin twice at five-minute intervals, if necessary.
  i. Monitor and record vital signs after each dose.
  ii. Document patient's response to medication in the Health Record.
- Start IV with Normal Saline at a keep open rate.
- Notify Practitioner and obtain subsequent orders.

HEATSTROKE --- ORDER 5

- Characterized by hot, dry skin, temperature generally greater than 104 Fahrenheit, and evidence of central nervous system (CNS) dysfunction, such as delirium, seizures, or coma.
- Instruct correctional officers to begin emergency treatment by moving patient to a shady area. Cover patient with wet towels or spray with cool water, if available, while being transported to the Health Unit. Have the patient drink cool water, if able.
- Upon arrival in Health Unit, take vital signs including temperature and O_2 saturation. Record in the Health Record.
- Remove all clothes, and cover with wet towels.
- If temperature is 104 degrees Fahrenheit or greater, or if delirium, seizures or unresponsiveness is present, notify Complex Control to activate local EMS via the 911 system.

- Administer O_2 via non-rebreather mask at 15 liters per minute, unless there is a known history of COPD; in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Begin IV with Normal Saline at a rate not to exceed 200cc/hr.
- Begin cooling using wet sheets with ice packed around patient.
  - Use fans to accomplish vigorous airflow over patient.
  - Use ice packs in axilla, neck and groin areas.
- Notify Practitioner and obtain subsequent orders, if indicated. Prepare for transport of patient.

HYPOGLYCEMIA --- ORDER 6

Treatment without unconsciousness:

- Take medical history; obtain vital signs, glucose meter reading, and O_2 saturation. Record in the Health Record.
- If blood glucose is below 60mg/dl, give up to three (3) glucose chew tablets 5g each (in individual blister pack) or glucose chew tablets 4g each (in packaged tubes). Instead of glucose chew tablets, may give one tube of glucose gel orally.
- Obtain repeat glucose meter reading in 30 minutes and record.
- Notify Vendor Practitioner and obtain subsequent orders.

Treatment with unconsciousness or altered state of consciousness:

- Obtain vital signs, glucose meter reading, and O_2 saturation. Record in Health Record.
- Start IV with D5W at keep open rate. If unable to obtain IV access, skip to #7.
- Give 50 cc D50 IV push. (RN only)
- LPN (Follow steps 7- 12 below)
- Obtain repeat glucose meter readings in 10 -15 minutes.
- If no response to D50, reassess patient using Emergency Response Order, Unconsciousness.
- Notify Vendor Practitioner and obtain subsequent orders.
- If unable to obtain IV access, administer Glucagon 1mg IM.
- Obtain glucose meter reading 15 minutes after administration of Glucagon.
- If glucose meter reading is 60mg/dl or less, or if patient is still symptomatic, may repeat Glucagon 1 mg IM.
- If no response to Glucagon and still unable to access IV, reassess patient using Emergency Response Order, Unconsciousness.
- Notify Vendor Practitioner and obtain subsequent orders.
- After stabilizing the patient, try to obtain a clear medical history. It is important to check for areas of possible injury if the patient lost consciousness.
- If there are potential neck injuries, immobilize the patient's neck with a cervical collar and notify the Practitioner.

OVERDOSE ---: ORDER 7

Overdose can occur with prescribed medication or illegal medication. It can be purposeful or accidental.

TREATMENT

- Unconscious Patient --Follow Emergency Response Orders, Unconsciousness.
- Conscious Patient
- Obtain medical history, including drug(s) taken. Measure vital signs, including O_2 saturation, and record in the Health Record.
- From any prison complex, Poison Control Center can be reached at 1-800-222-1222.
- If Poison Control Center indicates a need for oxygen, IV placement, or antidotes, follow instructions below:
- Start O_2 via nasal cannula at 4-6 liters per minute, unless there is a known history of COPD, in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Start IV with Normal Saline at keep open rate.

- Follow antidote instructions, up to and including the PO administration of activated charcoal. Use directions printed on the box for dosage and frequency.
- Notify Vendor Practitioner of incident and obtain subsequent orders, if indicated.
- Transport to Emergency Department at nearest hospital if advised by either the practitioner or the Poison Control Center.

SHOCK --- ORDER 8

Shock is a syndrome characterized by decreased tissue perfusion. While the syndrome itself is a diagnosis, there is always an underlying cause. Both the cause and the shock must be treated simultaneously or the outcome will be lethal.

Types of Shock:

- Hypovolemic shock
- Cardiogenic shock
- Septic shock
- Anaphylactic shock
- Other (pericardial tamponade, pulmonary embolus, venous obstruction, cervical cord transection)

Early in the syndrome, the following may occur:

- Slightly increased, normal, or slightly decreased blood pressure.
- Restlessness and anxiety
- Mild tachycardia
- Cool, clammy skin

As the syndrome progresses, the following may occur:

- Decreased systolic blood pressure (<90 mm Hg)
- Altered level of consciousness
- Tachycardia
- Tachypnea (usually a rapid, shallow respiratory pattern)
- Pale, cool, clammy skin

TREATMENT at the facility should be aimed at resuscitation, stabilization (if possible), and transport. Characterization of the type of shock is unimportant.

- Obtain pertinent medical history and vital signs including O_2 saturation and record in the Health Record.
- Place patient in the supine position.
- If systolic blood pressure is <90 mm Hg, place patient in Trendelenburg position by adjusting the position of the bed or by raising the lower extremities with several pillows. ICS, if not already done.
- Notify Complex Control to activate local EMS system via the 911.
- Administer O_2 via non-rebreather mask at 15 liters per minute. Unless there is a known history of COPD, in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Start IV with Normal Saline.
- Run at appropriate rate (not to exceed 200cc/hr) to keep systolic blood pressure at or above 110 mm Hg.
- Notify Vendor Practitioner and obtain subsequent orders.
- Transport to Emergency Department at nearest hospital.

SMOKE INHALATION --- ORDER 9

- Smoke and other toxic fumes, including those from chemicals are primarily respiratory mucosal irritants. Substantial exposure can lead to respiratory mucosal damage, and in severe cases, can destroy the respiratory epithelium.
- Varying degrees of respiratory symptoms and distress are seen with inhalation injuries. Cough is the most frequent symptom, along with mild respiratory distress. Moderate or severe respiratory distress, as evidenced by flaring of the nostrils, use of respiratory accessory muscles and sternal or costal retractions

are indicative of significant respiratory injury. Patient with anything other than mild distress following an inhalation injury should be transported to a definitive care center.

TREATMENT

- If moderate to severe respiratory distress is present, activate ICS.
- Notify Complex Control to activate the local EMS system via 911.
- Obtain a focused medical history including:
- Mechanism of inhalation, and
- Identification of substance inhaled, and
- Current diagnoses on record and current medication regimens, and
- Record this information on the Health Record.
- Obtain vital signs, including O_2 saturation, and record in the Health Record.
- Place patient in the supine position, with head elevated 45: 90 degrees.
- Administer O_2 via non-rebreather mask at 15 liters per minute, unless there is a known history of COPD; in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Start IV with Normal Saline at keep open rate.
- Notify Vendor Practitioner and obtain subsequent orders.
- Prepare patient for transport to Emergency Department at nearest hospital.

STATUS EPILEPTICUS --- ORDER 10

Status Epilepticus is a life-threatening condition. Generally, seizures that occur during Status Epilepticus are of the grand mal type, and occur one after the other. The patient may or may not regain some level of consciousness between seizures. Seizures may occur in rapid progression, or may have some short period of time (usually 10 minutes or less) between episodes. Cerebral hypoxia and anoxia are common, especially when the seizure activity is repetitive.

TREATMENT

- Activate ICS, if not already activated.
- Notify Complex Control to activate the local EMS system via 911.
- Place patient in the supine position, and be prepared to protect airway if necessary.
- Administer O_2 via non-rebreather mask at 15 liters per minute, unless there is a known history of COPD; in which case, administer O_2 via nasal cannula at no more than 2 liters per minute.
- Start IV with Normal Saline at keep open rate.
- For adults weighing 167-244 lbs: Administer Diastat (Diazepam) 20 mg RECTAL GEL, may repeat 4-12 hours later, or other appropriate rapid acting parenteral Bezodiazepine upon order from the Practitioner, with proper monitoring of the patient
- For adults weighing 112-166 lbs: Administer Diastat (Diazepam) 15 mg RECTAL GEL, may repeat 4-12 hours later, or other appropriate rapid acting parenteral Benzodiazepine upon order from the Practitioner, with proper monitoring of the patient.
- Notify Vendor Practitioner and obtain subsequent orders.
- Obtain pertinent medical information from the Health Record, check, and record vital signs in the Health Record.
- Prepare patient for transport to Emergency Department at nearest hospital.

UNCONSCIOUSNESS --- ORDER 11

Unconsciousness, or non-responsiveness, is a symptom rather than a disease entity.

Causes are many, and include trauma, cerebrovascular disease, cardiovascular disease, metabolic disorders, and medication overdoses from both prescribed and illegal drugs. Factitial unconsciousness may also be seen.

TREATMENT

- Activate ICS, if not already activated.
- Assume that trauma to the neck may have occurred, and stabilize the cervical spine.

- Place in the supine position. Be ready at all times to roll patient onto side if vomiting occurs. Have suction device available and ready for use.
- Obtain pertinent medical history, vital signs including blood pressure, glucose meter reading, and O_2 saturation. Record in the Health Record.
- Administer O_2 via non-rebreather mask at 15 liters per minute, unless there is a known history of COPD, in which case administer O_2 via nasal cannula at no more than 2 liters per minute.
- If systolic blood pressure is <90mm Hg, follow Emergency Response Orders, Shock (e.g., place patient in Trendelenburg position).
- If systolic blood pressure is >90 mm Hg, start IV with Normal Saline at a keep open rate.
- If glucose meter reading indicates hypoglycemia with a blood glucose value of less than 60 mg/dl, give 50 cc D50 IV push (RNs only) and follow Emergency Response Orders for Hypoglycemia.
- If hypoglycemia is not present, administer Narcan 2 mg IV push (RNs only).
- This may be repeated after five minutes, if no response.
- For LPNs, administer Narcan 2mg SUBCUT or IM.
- Insert Foley catheter to obtain urine for drug screen.
- Notify Vendor Practitioner and obtain subsequent orders.
- EMS to transport patient to Emergency Department at nearest hospital.

Appendix E, Sec. 2.0 Nursing Encounter Tools (NETs) Symptom and Intervention Guide

AUTHORIZED TO BE USED BY MS CONTRACT VENDOR		
SORTED ALPHABETICALLY BY SYMPTOM		
PRIMARY SYMPTOMS	NETS TITLE	INTERVENTION
Abrasion, laceration, scrapes or bruising	Abrasions & Lacerations (NA6200)	Clean abrasions with Normal Saline apply bacitracin and dry sterile dressing QD-Notify Provider immediately for lacerations requiring sutures.
Abscess / boil /Cellulitis	Abscess /boil /Cellulitis (NA6207)	No OTC, Notify Provider
Acne	Skin /Nails (NA6213)	No OTC, Notify Provider
Allergic reaction without respiratory symptoms	Skin /Nails	Hydrocortisone cream 1% apply to affected area BID PRIN x 7 days and/or
Facial swelling	Allergic Reaction (NA6231)	See urgent intervention
Allergic reaction with non-urgent respiratory symptoms		Chlorophenirامine 4mg every 6 hrs. PRN x7d
Ankle sprain	Musculoskeletal (NA6226)	Rest, Ice, Compression, Elevation and Ibuprofen 200mg 2 tablets PO BID or APAP 325mg 1-2 tablets PO BID PRIN x 7 days
Asthma attack, wheezing	Asthma (NA6249)	No OTC, Notify Provider
Athlete's foot	Foot Fungus	Athlete’s Foot Cream; apply to affected area BID PRN x 28 days
Bites: Animal or Human	Bites: Animal or Human (NA6205)	Ibuprofen 200mg 2 tablets PO BID or APAP 325mg 1-2 tablets PO BID PRN x 7 days
Bites: Insect bites or stings	Bites or Stings : Insect (NA6204)	Hydrocortisone cream 1% apply to affected area BID PRIN x 7 days

Burn 1st degree	Burns (NA6208)	Ibuprofen 200mg 2 tablets PO BID or APAP 325mg 1-2 tablets PO BID PRN x 7 days
Burn 2nd or 3rd degree	Burns (NA6208)	No OTC, Notify Provider
Constipation	Abdominal Pain-Male (NA6265) or Female (NA6239)	Magnesium Hydroxide 30cc BID PRN x3 days or Psyllium 2 tsps 1-3x per day x5 days, increase fluids if no MB > 3 days notify Provider
Ears, nose and throat, common cold, cough	Upper Respiratory (NA6268)	Give Acetaminophen 325mg 2 tablets PO BID PRN and / Chlorpheniramine 4mg every 6hrs PRN x7 days
Ears: foreign object	Ears (NA6202)	No OTC, Notify Provider
Earwax Buildup	Ears (NA6202)	No OTC, Notify Provider
Eye complaints, foreign Body to the Eye	Eye Problem (NA6233)	No OTC, Notify Provider
Eye complaints, dryness	Eye Problem (NA6233)	No OTC, Notify Provider
Facial Trauma	Facial Trauma (NA6280)	Symptom specific
Flu like symptoms (without achiness use URI or allergic)	Influenza Like Illness (NA6230)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tables PO BID PRN x 7 days
Fracture: suspected, old or stated	Fracture (NA6258)	No OTC, Notify Provider
GI bleeding symptoms with or without history, vomiting blood, rectal bleeding	GI Bleeding (NA6224)	No OTC, Notify Provider
Head Lice	Lice/Scabies (NA6212)	No OTC, Notify Provider
Headache acute or chronic	Headache (NA6236)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tables PO BID PRN x 7 days, Provider referral required
Heat Issues	Heat Related Illness (NA6262)	No OTC, Notify Provider
Hemorrhoids	Lower GI (NA6218)	Hemorrhoidal Ointment Qid RN x5 days
High blood pressure-stated current	High Blood Pressure (NA6266)	No OTC, Notify Provider
Hyperglycemia-stated current or symptomatic of or blood sugar	Hyperglycemia: (Symptomatic) (NA6275)	No OTC, Notify Provider
Hypoglycemia-stated current or symptomatic of, or blood sugar <60	Hypoglycemia (NA6280)	No OTC, Notify Provider
Indigestion/Heartburn	Abdominal Pain-Male (NA6265) or Female (NA6239)	Liquid antacids 30ccpo PRN x 5 days
Ingrown toenail (Non-Infected)	General Sick Call (NA6245)	No OTC, Notify Provider

Injury-Head	Head injury (NA6252)	No OTC, Notify Provider
Itching / Skin / Rash	Lice/Scabies (NA6212) Skin/Nails (NA6213)	Hydrocortisone cream 1% apply to affected area BID PRN x 7 days
Itching: groin, burning, rash	Jock Itch (NA6210)	No OTC, Notify Provider
Itchy feet, Athlete's Foot	Foot Fungus (NA6201)	Athletes foot cream 1% apply to affected area Bid PRB x28 days
Loose stools	Lower GI (NA6218)	No OTC, Notify Provider
Menstrual cramps	Abdominal pain female (NA6239)	Ibuprofen 200mg 2 tables PO BID <u>or</u> APAP 325mg 1-2 tablet PO BID PRN x 7 days
Mental Health: Inmate requesting	Mental Health Sick Call (NA6279)	No OTC, Notify Provider
Minor Discomforts not addressed by NET title	General Sick Call (NA6245)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tablet PO BID PRN x 7 days
Nasal allergy	Upper Respiratory (NA6223)	Chlorpheniramine 4mg q 6hr PRN x7 days
Nose bleed	Nose Bleed (NA6245)	No OTC, Notify Provider
Overdose: reported, observed or discovered	(Suspected) Overdose (NA6270)	No OTC, Notify Provider
Pain Abdominal	Abdominal pain Male (NA6265) or Female (NA6239)	See listing by primary symptom
Pain Back	Back Pain (NA6255)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tablet PO BID PRN x 7 days, Analgesic balm PRN
Pain Chest (suspicious for cardiac, PE or infection)	Chest Pain (NA6251)	No OTC, Notify Provider

Pain Chest not suspicious for cardiac, PE or infection	Chest Pain (NA6251)	Symptom specific, i.e. indigestion, musculoskeletal, Provider referral required
Pain - joint or soreness, Not for suspected or c/o fracture (use Fracture)	Musculoskeletal (NA6226)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tablet PO BID PRN x 7 days
Pain -tooth, injury, oral lesion	Dental Complaint (NA6232)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tablet PO BID PRN x 7 days
Painful urination	Abdominal Pain: Male (NA6265) or Female (NA6239)	No OTC, Notify Provider
Pregnant any complaint when < 20 wks pregnant or thinks she may be pregnant	Pregnancy Under 20 Weeks (NA6243)	No OTC, Notify Provider
Puncture wound	Abrasion & Lacerations (NA6200)	No OTC, Notify Provider
Seizure: reported or observed	Seizure (NA6246)	No OTC, Notify Provider
Sleep disturbance	Sleep Disturbance (NA6246)	No OTC, Notify Provider
Sore Muscles	Musculoskeletal (NA6226)	Ibuprofen 200mg 2 tables PO BID **or** APAP 325mg 1-2 tables PO BID PRN x 7 days **and/or** Analgesic Balm apply topically to affected area BID PRN x 7 days.
Spider Bite, boil, sore	Abscess / Boil /Cellulitis (NA6207)	No OTC, Notify Provider
Stuffy Nose	Upper Respiratory (NA6268)	Chlorphenimine 4mg every 6 hrs PRN x 7days.
Use of force on inmate; complaint related to	use of Force (NA6255)	Ibuprofen 200mg 2 tables PO BID or APAP 325mg 1-2 tables PO BID PRN x 7 days
Vaginal discharge	Vaginal Discharge (NA6259)	No OTC, Notify Provider
Violent incident between inmates	Victim of Violence (NA6259)	Symptom specific
Site Medical Director (SMD) Signature		Date Signed
SMD Printed Name		
Site DON (Director of Nursing) Signature		Date Signed
DON Printed Name		

Appendix E, Sec. 3.0 Nursing Assessment Protocols (Private Prisons)

Introduction to Nursing Assessment Protocols

The Nursing Assessment Protocols are clinical guidelines for licensed Nursing staff when a Practitioner is not readily available or on site. Using these guidelines, licensed Nursing staff shall initiate protocols based on their nursing assessment and/or observation.

Documentation in the SOAPE note by the Nurse must include the relevant medical history, pertinent physical findings, and vital signs. In addition, the specific reason for the OTC administration should be clearly linked to a health condition, which is identified in the protocol. The specific protocol and health condition must be documented in the SOAPE.

The Nursing Assessment Protocols shall be reviewed and signed at least annually by the Medical Services Contract Monitoring Bureau (MSCMB) Program Evaluation Administrator, MSCMB Medical Program Administrator, Vendor Medical Director, Vendor Director of Nursing (DON) and MSCMB Nurse Monitor.

Nurse Treatment Protocol #	Title
1	OTC Medications for Symptomatic Complaints
2	Allergic Reactions
3	Conditions Related to Heat
4	Open wounds
5	Hypertension
6	Pepper Spray, Mace and Tear Gas Exposure
7	Burns
8	Seizures
9	Inhalation Injuries
10	Snake Bites
12	Toothache/Dental Abscess
13	Sore Throat
14	Acute Anxiety
15	Common Cold
16	Constipation
17	Diarrhea, Acute onset

18	Earache
19	Eye Examinations / Eye Wear
20	Headache
21	Hearing Loss
22	Impacted Cerumen
23	HIV Test Request (Patient HNR)
24	Minors Sprains and Contusions
25	Nausea and Vomiting
26	Medication Orders on Transfer of Patient
27	Contact w/Practitioners on Urgent Notification
28	Medical Ice
32	Indications for C-Spine and Spine Board Precautions
34	Athlete's Foot (Tinea Pedis) or Jock Itch (Tinea Cruris)
35	Lice (Pediculosis) and Scabies
36	Vaccinations
36A	Tetanus and Diptheria (Td) Vaccine
37	Tuberculosis
38	Waivers and Special Need Orders
39	Kitchen Clearance
40	Disruption of Health Care Services
41	Monitored Conditions
42	Eye Injuries / Red Eye

PROTOCOL 1 --- OTC MEDICATIONS FOR SYMPTOMATIC COMPLAINTS

Certain OTCs are authorized to be given to inmates under this protocol. These medications may be used to address a symptomatic complaint if there are no other symptoms to indicate that a serious medical problem exists. OTCs may not be repeated without a Practitioner evaluation.

Symptoms for which nursing staff may provide OTC medications:

A. Symptomatic Complaint: Fever Must have temp >100 F orally on nursing assessment	OTC TO BE USED: ASA 325 mg (2) orally q 6h as needed (#24) Acetaminophen 325 mg (2) orally q 6h as needed (#24)
Contraindications: ASA	Known bleeding disorder, Coumadin therapy, Gastro Esophageal Reflux Disease (GERD), Gastritis, Peptic Ulcer Disease (PUD), Known drug allergy
Contraindications: Acetaminophen	Known End Stage Liver Disease (ESLD), Known drug allergy
B. Symptomatic Complaint: Pain For symptomatic minor aches and pains, when the etiology of the pain is known, e.g., minor sprains and contusions.	OTC to be used: ASA 325 mg (2) orally q 6h as needed (#24) Acetaminophen 325 mg (2) orally q 6h as needed #24); Ibuprofen 200 mg (2) orally q 6h as needed (#24)
Contraindications: ASA	Known bleeding disorder, Coumadin therapy, GERD, Gastritis, PUD, Known drug allergy

Contraindications: Acetaminophen	Known ESLD, Known drug allergy
Contraindications: Ibuprofen	Known bleeding disorder, Coumadin therapy, GERD, Gastritis, PUD, ESLD or Rectal Disease, Known Drug allergy
C. Symptomatic Complaint: Minor Heart Burn	OTC to be used: Liquid antacid #1 (4 oz) take 2 tablespoons every 4 hours as needed for 3 days
Contraindications:	Recent history of vomiting blood, Known drug allergy
D. Symptomatic Complaint: Diarrhea, simple	OTC to be used: Loperamide 4 mg orally at onset, then 2 mg orally after each loose stool, not to exceed 16 mg per day
E. Symptomatic Complaint: Inflammation of Hemorrhoids	OTC to be used: Apply Hydrocortisone 1.0 % cream #1 (15 g) to affected area in A.M. and P.M. and after each bowel movement. Refer to medical practitioner if significant bleeding occurs.
F. Symptomatic Complaint: Skin Rash (minor) Insect bites	OTC to be used: Hydrocortisone 1.0% cream #1 (15 g) Clean the affected area and sparingly apply cream. Refer to medical practitioner if any signs of secondary bacterial infection are present.
G. Symptomatic Complaint: Allergies, runny nose, itching	OTC to be used: Chlorpheniramine 4 mg, 1 tab orally three times daily as needed for five (5) days

OTC Protocols may be implemented based on nursing assessment and/or observation. Protocols must be documented in the medical record. The practitioner assigned to the health unit will sign the OTC order the next business day or as soon as possible.

Inmates requesting an appointment for the same (or similar) complaint within 96 hours (4 days) are to be referred to the medical practitioner. IMPORTANT!

PROTOCOL 2 --- ALLERGIC REACTIONS

Adverse Drug Reaction Occurring Immediately After Initiation of Drug:

- Consider diagnosis of anaphylaxis.
- Place patient in supine position, or position which best supports respiratory effort.
- Monitor vital signs and record.
- Obtain orders from Practitioner.
- Notify pharmacy of adverse reaction (i.e., complete Adverse Drug Reaction report).
- Document adverse reaction in the SOAPE note.

Adverse Drug Reaction Delayed Onset:

- Discontinue suspected drug immediately.
- Forward medical chart to Practitioner in A.M., or the next business day. Observe patient until symptoms abate, or condition is stable.
- Notify pharmacy of adverse reaction (i.e., complete Adverse Drug Reaction Report).
- Document adverse reaction in the Continuous Progress Record.

Insect Sting: Local swelling in the area of the sting:

- Apply cold compress to affected area.

Generalized hives/urticaria:

- Consider diagnosis of anaphylaxis.
- Place patient in supine position.
- Monitor vital signs and record.

- Obtain Practitioner's orders.

PROTOCOL 3 --- CONDITIONS RELATED TO HEAT

Heat Cramps: Heat cramps are painful, involuntary muscle spasms that usually occur during heavy exercise or exertion in hot environments. The spasms may be more intense and prolonged than typical nighttime leg cramps. Muscles most often affected are those in the abdominal wall, back, arms and calves although any muscle group may be involved after exercise or exertion. Inadequate fluid intake often contributes to heat cramps. Findings include temperature and vital signs within normal range, moist skin and no CNS symptoms.

- Obtain thorough history from patient.
- Record vital signs (TPR, including blood pressure).
- Have patient drink cool water (500 cc to 1000 cc water).
- Record hydration status.
- Follow up with Practitioner ASAP.
- No duty status until released by Practitioner.
- NO salt tablets.
- Instruct patient that residual muscle soreness can typically last 24 48 hours.

Heat exhaustion (Heat Prostration, Heat Collapse): Instructions for Correctional Officers in the Field

Heat exhaustion is the most common heat disorder. It should be suspected when patient develops nausea, vomiting, dizziness, or headache, and may include confusion or disorientation. Vital signs can vary from a normal to elevated pulse, normal or low BP, a normal or elevated temperature, but if elevated, is usually less than 104° F.

- Move the patient out of the sun and into a shady or air-conditioned location. Begin cooling measures, such as spraying the patient with a garden hose or sponging him or her with cool water and fanning.
- Loosen or remove the patient's clothing as needed.
- Have patient brought to health unit ASAP.
- Place patient in supine position and elevate legs and feet slightly.
- Obtain vital signs, including blood pressure. Note temperature and record vital signs in the Health Record.
- Have patient drink water, 500 to 1000 cc, if conscious, and airway maintained.
- Cool the patient by spraying or sponging him or her with cool water and fanning.
- Notify the Practitioner, if on site.
- If the Practitioner is not immediately available and patient is not able to take oral fluids due to altered level of consciousness, obtain phone orders from Practitioner.
- Monitor the patient carefully. (Heat exhaustion can quickly become heatstroke.)
- If fever is greater than 102 degrees F, or if fainting, confusion, or seizures occur, activate EMS via the 911 system.
- Call receiving medical facility with complete history.

PROTOCOL 4 --- OPEN WOUNDS (e.g., Abrasions, Lacerations, Punctures, Avulsions, Amputations)

Protective gloves and other personal protective equipment should be utilized prior to any *hands on* evaluation of a laceration.

Physical Examination:

- Obtain the following information:
  - Time of injury
  - Mechanism of injury
- Obtain vital signs, blood pressure and weight. Record in the Health Record.
- Skin -Description of wound, full or partial, location, length, extent of bleeding and involvement of underlying tissue.
- Wound-Describe location, length, extent of bleeding, the edges of lacerations if applicable, and involvement of deeper structures, e.g., nerves, vessels tendons, bones, joints, organs.
- With extremity involvement: assess vessel, nerve or joint involvement, assess distal pulses, and assess motor and sensory status.

- Check history of tetanus immunization.
- Refer to Immunization Log filed under the Medical Work-Up Sheet.
- Refer to Nursing Assessment Protocols, Vaccinations.

Small or uncomplicated lacerations, abrasions or puncture wounds (including taser removal):

- Gently cleanse the affected area with warm water and antibacterial soap. (If applicable, remove Taser using 4x4s dampened with warm water and antibacterial soap, then gently cleanse the puncture site.)
- Apply triple antibacterial ointment and band-aid.
- If applicable, apply skin tape or tissue adhesive (steri-strips). Schedule on nurse line within 48 hours for follow up.
- Document accurate history and description of wound in the Health Record.
- Draw a picture on Wound Documentation Flow Sheet (#11-1-41).
- Record vital signs in treatment section on Wound Documentation Flow Sheet (#1101-41).
- Recommend elevation and rest as necessary for 48 hours.
- Notify Practitioner if there are any questions regarding treatment.
- Provide inmate with Common Sense Care Form: Abrasions and Lacerations (minor cuts).
- Inmate must sign Inmate Information Sheet Checklist acknowledging receipt of education.
- Follow up with HNR as needed.

Large or complicated wounds such as lacerations with controlled bleeding:

- Document accurate history and description of wound/laceration in Health Record. (Draw a picture on Wound Documentation Flow Sheet #1101-41.)
- Record vital signs in Treatment section on Wound Documentation Flow Sheet (#1101-41).
- Notify Practitioner after cleansing of wound to receive treatment orders. These often require suturing or other special care.

Wounds, such as lacerations with active bleeding:

- Apply firm, direct pressure on wound for 10 minutes with moist, saline gauze.
- If bleeding is not controlled with 10 minutes of direct pressure, dress with heavily moistened saline gauze pressure bandage.
- Should dressing become saturated with blood, do not remove. Apply additional dressings as needed.
- Notify the Practitioner.

Single or multiple wounds, such as lacerations with uncontrolled bleeding despite direct pressure:

- Dress wound(s) with heavy gauze pressure bandages.
- Obtain practitioner's orders as soon as possible. Be prepared to activate EMS via 911, if needed.

Continuous Wound Care:

- Follow wound care orders as prescribed by Practitioner. Order should be transcribed on the Wound Documentation Flow Sheet, Form #1101-41, in the treatment section in upper right hand corner.
- Each encounter will be documented on Flow Sheet, not in the Health Record.
- Vital signs, including TPR, blood pressure and weight will be obtained at each encounter and recorded in the Treatment Section.
- As working documents, flow sheets will be maintained as treatment logs.
- Completed flow sheets will be filed in the Med Sheets/Miscellaneous section of the Inmate Medical Record.
- As indicated, kitchen clearance will be denied until open wounds are healed.

PROTOCOL 5 --- HYPERTENSION

- Obtain medical history, including current medications, and note presence or absence of headache, visual difficulties, or neurological symptoms and document in the Health Record.
- Document blood pressure in the sitting and supine position, as well as the pulse, respiratory rate, and temperature.
- Blood pressures >160 mm Hg systolic or >95 mm Hg diastolic should be repeated after 5 minutes of rest in the supine position.

Patients known to have hypertension:

- If BP is >160 mm Hg systolic or >95 mm Hg diastolic on two separate occasions, notify the practitioner.
- If BP is >145 mm Hg systolic or >90 mm Hg diastolic and patient has a headache, visual difficulties, or neurological symptoms, notify the Practitioner ASAP.

Patient not known to have hypertension:

- If BP is >145 mm Hg systolic or >90 mm Hg diastolic and patient has a headache, visual difficulties, or neurological symptoms, notify Practitioner ASAP.
- Hypertension is a chronic condition under ADCRR guidelines. Patients who are hypertensive must be followed by the Practitioner in accordance with ADCRR policy.

PROTOCOL 6 --- PEPPER SPRAY, MACE, TEAR GAS EXPOSURE

- Remove contaminated clothing and irrigate affected areas with copious amounts of cool water. (Make sure contaminated clothing is removed prior to coming to the health unit.)
- If eyes are affected, irrigate eyes with water for 15 minute with water or buffering agent, such as milk, if available
    - Note: Milk is an extremely effective buffer for mucous membranes and secretory areas, such as eyes, mouth, testes.

THEN:

- Observe for signs of cardiac distress. Should there be any indications of cardiac distress, notify the Practitioner immediately. Be prepared to institute the appropriate Emergency Response Order, if indicated.
- Observe for signs of respiratory distress, dyspnea, or complaints of chest tightness:
- If signs of respiratory distress are evident, provide O_2 4-6 L/min by nasal cannula, or 6-10 L/min via simple face mask.
- If there is a known history of COPD, administer O_2 at 2 L/min by nasal cannula.
- Notify Practitioner immediately for subsequent orders. Be prepared to institute the appropriate Emergency Response Order, if indicated.

PROTOCOL 7 --- BURNS

Obtain medical history, including mechanism of burn injury, current medications, tetanus prophylaxis history, and record in the Health Record. A nursing assessment including vital signs, assessment of cardio respiratory system, and estimation of Total Body Surface Area (TBSA) of burn using the "Rule of Nines" below must be performed. Estimation of the degree is essential. Smoke inhalation, rescue from a structure fire, or exposure to an explosive event increases the risk of significant respiratory mucosal burn. Any such history, when associated with a facial burn, is nearly always diagnostic of respiratory mucosal injury. These patients should be transported immediately to the nearest Emergency Department.

DEGREE CLASSIFICATION OF BURNS AND SPECIFIC PROTOCOLS

First Degree Burns:

- Skin is erythematous only.
- No blistering is present.
- Prototype first-degree burn is sunburn.
- Clean with mild soap/water, if needed.
- Follow up on nurse line for reassessment in 24 hours.
- Return to duty after 48 hours with counseling on sunlight exposure.

Second Degree Burns:

- Skin is erythematous.
- Intact or broken blisters will be present.
- Clean with mild soap/water, if dirty. Leave blisters intact.
- Notify Practitioner who may order if indicated, silver sulfadiazine (Silvadene) to be applied to the burned area with a dry dressing.

Third Degree Burns:

- Skin may be dark red, gray or white.
- Inmates with third degree burns will be transported to a hospital ED.

Fourth Degree Burns:

- Skin may or may not be visible.
- Burn will extend into subcutaneous tissue or underlying muscle.
- All fourth degree burns must be treated in a burn center.

RULE OF NINES

- Each upper extremity equals 9% of Total Body Surface Area (TBSA).
- Each lower extremity equals 18% TBSA.
- Anterior and posterior trunk each equals 18% TBSA.
- Head and neck equals 9% TBSA.
- Genitalia and perineum equals 1% TBSA.

SPECIAL ISSUES

- Notify Practitioner under the following circumstances:
- Burned area with more than 15% TBSA.
- Burn involves face, genitalia or perineum.
- Patient is over 55 years of age and burn is >9% TBSA or involves the face, genitalia or perineum.
- If respiratory distress is present (respiratory rate <10 or >30), begin O_2 via non- rebreather mask at 15 L/min.
- If there is a known history of COPD, begin O_2 via nasal cannula at 2 L/min.
- If wheezes or rales are present, obtain Practitioner's orders.

ELECTRICAL BURNS/ELECTROCUTION:

Injuries from electrocution, or near electrocution, are caused by exposure to DC (direct current), such as lightning and high voltage power lines, or AC (alternating current) found in homes, offices, and factories. DC shock usually results in respiratory arrest from apnea, with circulatory collapse due to asystole. AC shock can result in immediate circulatory arrest due to ventricular fibrillation. In both instances, the treatment is the same: Airway restoration and maintenance, breathing for the victim utilizing artificial respiration and Circulatory support utilizing external cardiac compression. Patient exposed to large voltage DC currents from lightning or high- tension power lines, or from AC current of 440 volts should be evaluated in an Emergency Department setting. For any electrocution victim who is not responsive: MAKE SURE ELECTRICAL SOURCE IS REMOVED FROM VICTIM OR IS DISABLED PRIOR TO ENTERING AREA SURROUNDING PATIENT. IF SO:

- Evaluate for respirations and pulse. If neither is found, begin treatment for cardiac arrest.
- If patient is responsive, obtain a brief, focused medical history including mechanism of shock, associated complaints, and current medications. Obtain vital signs.
- Perform a physical assessment looking for entrance/exit wounds, burns, or other injuries that may have occurred because of the near-electrocution. Record in the Continuous Progress Record.
- Perform ECG.
- Notify the Practitioner as soon as possible for subsequent orders.

CHEMICAL BURNS:

- Begin immediate rinsing of affected area with copious amount of tap water.
- Obtain brief, focused medical history, including how the exposure occurred, the identity of the chemical or the product, current medication, and tetanus prophylaxis history. Estimate size of burn, using the "Rule of Nines" if appropriate.
- Refer to MSDS sheet.
- From all prison complexes, contact the Poison Control Center at 1-800-222- 1222.
- Notify Practitioner as soon as possible for subsequent orders.

As indicated, kitchen clearance will be denied until the burn is healed.

PROTOCOL 8 --- SEIZURES

- Seizures can be the cause of injury; however, seizures are rarely life threatening as a single event.
- Protect patient from self-injury, and be prepared to roll patient on side to protect airway in the event of vomiting.
- DO NOT attempt to manipulate the mouth during the seizure.
- After seizure is complete, obtain vital signs and record in the Health Record.
- Obtain a focused medical history including seizure medication taken, illicit medication history, and current diagnoses. Record in the Health Record.

Status Epilepticus is a true medical emergency, and occurs when a patient has repetitive seizures without regaining full consciousness, or if consciousness is regained, the duration of consciousness is very short. Refer to ERO for Status Epilepticus. These patients must be transported without delay to the nearest Emergency Department facility.

PROTOCOL 9 --- INHALATION INJURIES

All inhalation injuries are potentially life threatening. Chemical inhalations, especially with acids, alkalis, chlorine, herbicides or pesticides must be treated immediately in an Emergency Department setting. Mild smoke inhalations, in which the symptoms are limited to cough and no preexisting lung disease is present, may be treated on site.

TREATMENT:

- Treat all inhalation exposures by following Emergency Response Orders, Smoke Inhalation.
- Notify the Practitioner to obtain subsequent orders.

PROTOCOL 10 --- SNAKE BITES

- Instructions for correctional officers in the field for patient with snake bite:
- Do not try to capture the snake.
- Immobilize the bitten area and keep it lower than the heart.
- Do not try to cut the wound or attempt to remove the venom.
- Keep patient calm and as quiet as possible.
- Transport to nearest Emergency Department immediately.
- Notify health unit of incident.
- Patient brought to Health Unit:
- Obtain history on Bite Assessment Form, 1101-03, file in C.M.A./SOAP Section.
- Keep patient calm and place in supine position.
- Monitor vital signs including blood pressure.
- Wash bite with antibacterial soap and water.
- Immobilize the bitten area and keep it lower than the heart.
- Activate EMS via 911.
- If there is evidence of hypotension or shock, and if Practitioner is not immediately available on site, follow Emergency Response Orders for Shock.
- Notify Practitioner by phone to obtain subsequent orders.
- Prepare patient for transport to the nearest Emergency Department as soon as possible.
- Notify hospital of patient history prior to arrival.

PROTOCOL 11 --- SPIDER, SCORPION, & INSECT BITES/STINGS

Spider Bites

All spiders inject venom when they bite. Only two spiders, the Black Widow and the Brown Recluse, cause significant envenomation syndromes. Bites occurring from spiders other than the Black Widow and Brown Recluse may be treated symptomatically.

Treatment of Non-Black Widow / Non-Brown Recluse Spider Bites

- Record medical history, including history relevant to the bite, on the Bite Assessment Form, 1101-33.
- Obtain and record vital signs on the Bite Assessment Form, 1101-33.
- Cleanse the wound and apply cold compresses.

Black Widow Spider Bites

- The Black Widow Spider is endemic to Arizona. The female of the species is black, with a globular body approximately 1 cm. long, and has an orange-red hourglass marking on the ventral surface. The adult male of the species is approximately half the size of the adult female.
- Initially, there is a sharp pain at the site of the bite, which quickly resolves. Local muscle cramping will develop within 15 minutes to 2 hours. Envenomation typically results in generalized muscle pain, painful muscle contractions, and ascending motor paralysis. The abdomen may become rigidly board-like, and symptoms such as delirium, seizures, shock, and respiratory distress may be seen. Only rarely does Black Widow envenomation cause death. Antivenin is available; however, it is given only in the hospital setting.

Treatment

- Record medical history, including history relevant to the bite, on the Bite Assessment Form, 1101-33.
- Obtain and record vital signs on the Bite Assessment Form, 1101-33.
- Cleanse wound and apply cold compresses.
- Notify Practitioner for further orders.
- Activate EMS via 911, if indicated.
- Prepare patient for transport, if indicated.

Brown Recluse Spider Bites

The Brown Recluse Spider is also endemic to Arizona. It is brown in color, and has a dark brown violin shaped marking on the dorsal thorax. It is approximately 1 cm. in length. The Brown Recluse venom is cytotoxic and hemotoxic, causing progressive local necrosis and coagulation syndromes, including disseminated intravascular coagulation. Development of coagulopathies, which occurs rarely, may be life threatening. The bite is usually only mildly painful, but invariably progresses to being intensely painful. A blister will form at the site of the bite, which progresses to an eschar within a week. Over the next 2-6 weeks, the eschar loosens to reveal a necrotic ulcer. Location and depth of the ulcer dictate whether or not surgical treatment is necessary.

Treatment

- Record medical history, including history relevant to the bite, on the Bite Assessment Form, 1101-33.
- Obtain and record vital signs on the Bite Assessment Form, 1101-33.
- Cleanse the wound and apply cold compresses.
- Arrange for Practitioner follow-up.

Scorpion Stings

Scorpions are generally found only in the Southwest. Scorpions are endemic to Arizona. Most scorpion species are harmless, or relatively so, with stings causing only mild local reactions. One scorpion in particular, however, has a sting, which can cause systemic as well as local reactions. This scorpion is *Centruroides exilicauda*, which is yellowish in color, 1-3 inches long, and has a prominent tubercle at the base of the stinger. There is usually intense pain immediately at the site of the sting, but usually there is little swelling present. Even light touch to the area of the sting some hours later produces excruciating pain. Systemic reactions include restlessness, uncontrolled jerking, incontinence, excessive salivation and sweating, wheezing and elevated blood pressure. Recovery usually occurs within 12 hours.

Treatment

- Record medical history, including history relevant to the sting, on the Bite Assessment Form, 1101-33.
- Obtain and record vital signs on the Bite Assessment Form, 1101-33.
- Cleanse the wound and apply cold compresses.
- Do not elevate affected extremity or body part.
- Observe in health unit for at least 1 hour for symptom progression. If none, return to housing unit.

Bee and Wasp Stings

Bee and wasp stings generally cause a local reaction at the site of the sting, unless there is an allergy to bee or wasp venom. Although it is common practice to use antihistamines in the treatment of local reactions, there is no benefit.

Treatment

- Record pertinent medical history, including history relevant to the sting on the Bite Assessment Form, 1101-33.
- Obtain and record vital signs on the Bite Assessment Form, 1101-33.
- Remove stinger by scraping with a tongue blade, cleanse site, and apply cold compresses.
- Watch for signs and symptoms of allergic reaction.

PROTOCOL 12 --- TOOTHACHE / DENTAL ABSCESS

- Record medical history including affected area in the progress notes.
- Obtain and record vital signs in Health Record.
- If patient is febrile (100 degrees Fahrenheit orally or greater) or is having difficulty swallowing, contact the dentist for orders.
- If not febrile, submit patient's record for review by medical Practitioner or dentist within 3 working days.
- See Nursing Assessment Protocols for OTCs for symptomatic relief.
  a. May administer Acetaminophen 325 mg, 2 tabs orally q 4-6 h as needed for pain #24, or
  b. Ibuprofen 200 mg 1-2 tabs orally q 4-6 h as needed for pain #24.

If an abscess is clearly visible, contact the urgent notification dental or medical Practitioner for orders:

- Instruct patient to rinse mouth with warm water every 4 hours.
- Discontinue if pain persists.
- Continue medication as ordered until evaluated by Dentist, or Practitioner, if dentist is not available.

DRY SOCKET:

If patient is febrile (100 degrees Fahrenheit orally or greater) or is having difficulty swallowing, contact the dentist for orders. Otherwise, follow the steps below:

- Gently irrigate the socket with saline.
- Do not curette the socket. Leave the non-lysed blood clot intact.
- Carefully suction all excess saline.
- Gently insert a small strip of iodoform gauze soaked with Dry Socket Paste into the socket.
- Remove and replace the dressing every day or every other day for the following 3 to 5 days until symptoms subside. If symptoms continue or if patient develops a fever, please contact Dentist immediately.
- May administer OTC medications, such as acetaminophen 325 mg, 2 tab orally q 4-6 h for pain # 24, or ibuprofen 200 mg 1-2 tabs q 4-6h orally, as needed for pain # 24.
- Follow up with the Dentist.

PROTOCOL 13 --- SORE THROAT

- Most often sore throat occurs because of infection, and viruses are the most common cause of throat infections. The next most common cause is bacterial.
- Viral infections cannot be effectively treated with antibiotics. Antibiotics are effective only in bacterial infections.
- Viral infections cannot be easily distinguished from bacterial infections. There is virtually no physical finding pathognomonic of bacterial infection.
- A sore throat may have other causes, such as irritation from smoking or noxious fumes. Sore throat can also be the first symptom of laryngeal or pharyngeal cancer.

PROCEDURE

- Complete ENT nursing assessment, obtain vital signs and document in the medical records.

- Instruct patient to gargle with saltwater solution consisting of 1/2 tbsp. salt dissolved in 8 oz very warm water.
- A Special Need Order will need to be completed by the nurse to allow the patient to obtain salt packets from the kitchen. (Refer to Waivers/Special Need Orders, Protocol #41.)
- May use acetaminophen 325 mg (2) orally four times daily as needed #24 or Ibuprofen 200 mg (2) orally three times daily as needed for discomfort #24.
- Contraindications:
- Ibuprofen are: Known bleeding disorder, Coumadin therapy, GERD, gastritis, PUD, known drug allergy.
- Acetaminophen are: Known End Stage Liver Disease (ESLD), known drug allergy.
- Instruct the patient to submit HNR if symptoms persist.

PROTOCOL 14 --- ACUTE ANXIETY

- Acute anxiety can be caused by organic disease, such as cardiovascular, respiratory and metabolic disease. Organic causes must be ruled out prior to ascribing the anxiety to a mental disorder.
- Obtain a medical history and document in the Health Record.
- Measure vital signs and document in the Health Record.
- Perform a nursing assessment and record in the Health Record.
- Notify Mental Health Practitioner for orders, if indicated.
- Hyperventilation not caused by organic disease may be treated with a re-breather bag.

PROTOCOL 15 --- COMMON COLD

- The common cold is caused by a number of different viruses. There is no known cure, only symptomatic relief. Document history, obtain vital signs, perform an ENT and respiratory nursing assessment and document into the health record.
- May issue:
  - Chlorpheniramine 4 mg, (1) tablet t.i.d., orally, as needed, #24.
  - Acetaminophen 325mg (2) orally q 4h, #24 dispensed, for discomfort. Advise patient to increase fluid intake. Saltwater gargles may be advised if sore throat is present. Have patient dissolve 1/2 tbsp. salt in 8 oz. of warm water to gargle. (Refer to Waivers/Special Need Orders, Protocol #41.) Re-evaluate on a PRN basis.
- Instruct patient to submit HNR if fever, chills or productive cough develop, or if symptoms continue for more than 1 week.

PROTOCOL 16 --- CONSTIPATION

Constipation is a symptom and not a disease process. The most common cause of constipation is inadequate fluid intake, or it may be a side effect of medication, or lack of adequate fiber intake. It can occasionally be the symptom of serious disease.

- Obtain history, vital signs, a nursing assessment and record in the Health Record.
- Review current medications that may cause constipation i.e. analgesics, antacids, anti-cholinergic, anti-depressants, anti-parkinsonians, barium sulfate, diuretics, iron sulfate, laxative abuse, opiates and psychotherapeutics.
- Constipation with abdominal pain or fever should be evaluated by Practitioner. If no organic cause is apparent, instruct patient to:
  - Eat more fiber and vegetables.
  - Drink six 8 ounce glasses of water per day.
  - May give M.O.M. 2 tbsp (30 cc) orally at night up to 3 times --- if needed and not contraindicated.
- Inmates complaining of constipation with abdominal pain, rebound tenderness, absent, or diminished bowel sounds or fever should be scheduled ASAP with a Practitioner, or if after hours, a practitioner should be notified.
- Enemas may not be given without an order from a Practitioner.

PROTOCOL 17 --- DIARRHEA, ACUTE ONSET

Diarrhea is a symptom of other disease, rather than a disease entity. Most of the time, diarrhea is self-limiting, and responds to simple measures. In the presence of other disease, or as a result of other disease, diarrhea can become life threatening.

HISTORY AND EXAMINATION

- Obtain a medical history and document positive and negative findings in the medical record. Include the following:
  - Date of onset of the diarrhea.
  - Number of loose stools per day.
  - Presence or absence of fever, chills, or associated nausea and vomiting.
  - Presence or absence of any blood, mucous, or pus in the stools.
  - Recent change in medications.
- Change in diet or history of eating old/unrefrigerated food.
- Current history of diabetes.
- Current history of hypertension.
- Current history of neoplastic disease.
- Current history of HIV infection.
- Obtain vital signs and document in the medical record:
  - Blood pressure and pulse first in the supine position, followed by blood pressure and pulse in the sitting position.
  - Temperature.
  - Respiratory rate.
  - Weight.
- Perform an abdominal exam:
  - Presence of a rigid abdomen.
  - Presence or absence of abdominal tenderness and location.
  - Presence or absence of guarding.
  - Presence or absence of bowel sounds

TREATMENT

- Notify Practitioner ASAP if:
  - There is a positive finding in the medical history, and
  - Orthostatic findings are present when BP and pulse are taken
  - (>10 mm Hg drop in either the systolic or diastolic BP in the sitting BP as compared to the supine BP), or an increase in the pulse rate by 10 beats/minute in the sitting position as compared to the supine position
  - Temperature orally > 101 F, or
  - Respiratory rate >30/ min, or
  - Abdominal examination demonstrates absence of bowel sounds or rigidity.
- If none of the above is present, treatment may be accomplished with the following:
  - Increase fluid intake.
  - Non duty status until diarrhea is resolved.
  - No food handling assignments.
  - Loperamide 4 mg orally at onset, then 2 mg orally after each loose stool, as needed, not to exceed 16 mg/day.

PROTOCOL 18 --- EARACHE

Earache is typically the result of infection. It can also be due to impacted cerumen, self-induced trauma, or may be the result of trauma inflicted by another inmate.

- Complete history, vital signs, physical exam, including ENT exam and document in the Health Record.
- Inability to see the tympanic membrane, redness of the tympanic membrane or ear canal, purulent or bloody discharge, or perforation of the tympanic membrane should be referred to the practitioner as soon as possible.

- See Nursing Assessment Protocols, OTC meds for symptomatic relief.

PROTOCOL 19 --- EYE EXAMINATIONS / EYE WEAR

- Upon receipt of a Health Needs Request form for eye clinic services, a Health Services staff member shall perform an initial screening using the Snellen chart (for both near and far-sighted vision).

Vision should be recorded as follows: (OD=Right; OS=Left)

FAR Uncorrected Corrected

R eye	20/	OD	20/	OD
L eye	20/	OS	20/	OS
Both	20/	OU	20/	OU

NEAR Uncorrected Corrected

R eye	20/	OD	20/	OD
L eye	20/	OS	20/	OS
Both	20/	OU	20/	OU

- Corrected visual acuity >20/40 in either eye separately or in both eyes shall be referred to the optometrist.
- Visual acuity <20/40 may be referred for routine follow-up according to the following schedule.

  < 40 years of age: Every three (3) years

  > 40 years of age: Annually
- Contact lenses are not provided unless medically necessary.
- If contact lenses are prescribed by an ADCRR Optometrist or Ophthalmologist, ADCRR shall provide contact lens solution.
- If contact lenses are not an ADCRR prescription, ADCRR shall not provide contact lens solution.

PROTOCOL 20 --- HEADACHE

Headache is a symptom of other disease, rather than a disease entity. Most of the time, headache is self-limiting, and responds to simple measures. In the presence of other disease, or as a result of other disease, headaches may signal a life-threatening condition.

PROCEDURES

- Obtain a medical history and document positive and negative findings in the medical record. Include the following:
  - Date of onset of the headache.
  - Have the patient describe the character of the headache, i.e., sharp, dull, throbbing, knife-like, unilateral, and bilateral.
  - Recent history of head, neck or facial trauma.
  - Recent history of toothache, upper/lower respiratory infection, earache/ear infection, sinus drainage/infection, sore throat, vomiting, fever or chills.
  - History of hypertension.
  - History of neurological symptoms such as slurring of speech, difficulty understanding speech, difficulty with vision, numbness or weakness of the face, arm or leg on one side of the body, confusion, dizziness, or a headache that began suddenly.
  - Presence of fever, chills, or associated nausea and vomiting.
  - History of lower back pain, recent back surgery, or procedures, such as spinal tap or myelography.
- Obtain vital signs, blood pressure and weight. Document in the health record.
- Have patient rate headache pain on a 1-10 scale. Document in the health record.
- Record in the health record the following:
  - Pupil size in millimeters.
  - Any evident facial weakness; evidenced by asymmetry or inability to smile.
  - Whether or not flexion of neck causes the headache to worsen.

- Grip strength bilaterally.
- Whether or not headache pain is affected by passive lifting of lower extremity off exam table.
- If there are no positive findings in the medical history or examination, and headache is 7 or less on the pain scale, the nurse may administer: 1 Acetaminophen 325 mg. (2) orally every 4 hours for 24 hours (#24 tabs).

- For headache with positive history or examination findings, 8 or greater on the pain scale, or sudden onset headache with or without positive medical history or exam findings, the medical Practitioner must be notified ASAP.

PROTOCOL 21 --- HEARING LOSS

- An HNR regarding a patient complaint of hearing loss shall be referred to nursing to perform a screening audiogram. This test shall record each ear according to air conduction of sound. Document findings in health record.
- Screening audiograms with significant abnormal results (>25 dB loss) in either or both ears shall be referred to a Practitioner to evaluate the need for a referral to the Audiologist.
- If hearing aid(s) are dispensed after the Audiologist's recommendation, re-evaluations on a biennial basis shall occur.

HEARING AIDS:

- When a patient arrives in the Department of Corrections with their own hearing aid, the Nurse shall document during reception assessment:
  - How long the patient has had the hearing aid.
  - How long it has been since the patient's last hearing evaluation
  - Refer for scheduling of evaluation, if needed.
- Per HNR request by the patient, the Vendor Medical Supply Coordinator will supply and dispense batteries to the nursing staff. Used batteries are to be exchanged when receiving new ones.

PROTOCOL 22 --- IMPACTED CERUMEN

- If impacted cerumen is present, and any of the following conditions are noted, refer to Practitioner immediately.
  - Fever.
  - Ear Pain.
  - Swollen lymph nodes.
  - If there is known injury or rupture of the tympanic membrane.
  - If there is a history of draining ears.
  - If there is a history of perforation or other complications from previous ear irrigation.
  - If the ear canal is red or swollen.
  - If there is anything in the ear other than cerumen.
- If impacted cerumen is present, and none of the conditions noted above are present, begin treatment as follows:
  - Debrox (or generic equivalent) 3 gtts bid in the affected ear(s) x 3 days.
  - After the third day, if ear wax still present, irrigate the affected ear canal gently with warm water.
  - If unsuccessful at removal, refer to the Practitioner.
  - During the irrigation process, observe the patient for signs of pain or dizziness. If either occurs, stop the procedure immediately and arrange for follow-up with the practitioner.

PROTOCOL 23 --- HIV TEST REQUEST (Patient HNR)

- Nursing staff will review the HNR request and the health record.
- The Nurse will schedule the patient on the nurse's line to obtain the consent and then refer to the laboratory technician to collect the HIV specimen.
- Upon return of the HIV test results, the patient will be scheduled on nurse's line if the results are negative or on the Practitioner line for post-test counseling if results are positive. The respective health care discipline providing the post-test counseling will complete and sign the POST-TEST COUNSELING CHECKLIST.

- The Nurse will record the date the HIV test was performed on the Medical Work-Up Sheet.
- Based on a self-initiated request, the patient will be charged for the nursing visit. Subsequent HIV testing may be ordered by the Practitioner at no charge.

PROTOCOL 24 --- MINOR SPRAINS AND CONTUSIONS

- Obtain history, including mechanism of injury, vital signs, perform a nursing assessment, and document in the Health Record.
- If appropriate, immobilize the affected area. May apply ice to the affected area for 72 hours to decrease swelling and pain.
- For mild to moderate pain and inflammation, may issue Ibuprofen 200mg (2) orally four times daily #24 or Acetaminophen 325 mg (2) orally q 4h #24, as needed. See OTC Medication for Symptomatic Complaints.
- May issue crutches for three (3) days if patient is unable to bear weight on affected extremity.
- No duty until cleared.
- Schedule on nurse's line in three (3) days to reassess affected area and to determine if the continued use of splints, ace bandages or crutches is needed.
- If affected area has improved, clear for return to duty.
- If affected area has not improved, continue with no duty status and refer patient to the Practitioner ASAP. Practitioner will need to clear for duty.

PROTOCOL 25 --- NAUSEA AND VOMITING

Nausea and/or vomiting are symptoms of other disease, rather than a disease entity. Most of the time, nausea and/or vomiting is self-limiting, and responds to simple measures. In the presence of other disease, or as a result of other disease, nausea and vomiting can become life-threatening.

Procedures

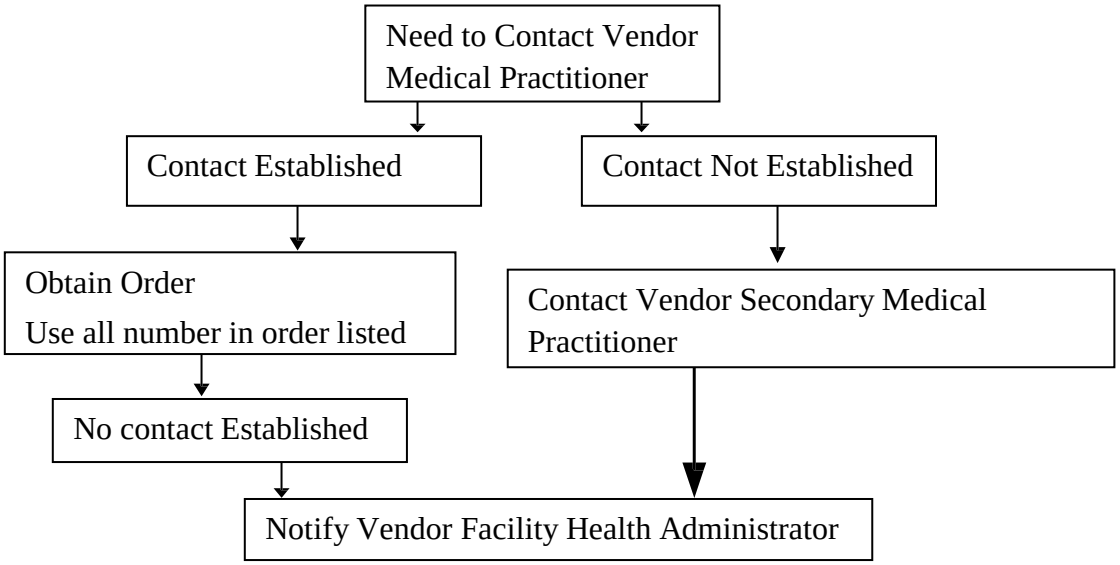
- Obtain a medical history and document positive and negative findings in the medical record. Include the following:
  - Date of onset of the nausea/vomiting.
  - Number of episodes of emesis per day.
  - Presence of fever, chills, or diarrhea.
  - Presence of any blood, mucous, or pus in the emesis.
  - Recent change in medications.
  - Change in diet or history of eating old/unrefrigerated food.
  - Current history of diabetes.
  - Current history of hypertension
  - Current history of neoplastic disease.
  - Current history of HIV infection.
  - Current history of peptic ulcer disease, GERD or gastritis.
- Obtain vital signs, blood pressure and weight.
  - Document in the medical record.
  - Obtain blood pressure and pulse first in the supine position, followed by blood pressure and pulse in the sitting position.
- Perform an abdominal exam:
  - Presence or absence of abdominal tenderness and location.
  - Presence or absence of guarding.
  - Presence or absence of a rigid abdomen.
  - Presence or absence of bowel sounds.
- Notify practitioner ASAP if:
  - There is a positive finding in the medical history, and
  - Orthostatic findings are present when BP and pulse are taken (>10 mm Hg drop in either the systolic or diastolic BP in the sitting BP as compared to the supine BP or an increase in the pulse rate by 10 beats/minute in the sitting position as compared to the supine position), or
  - Temperature orally > 101 F, or

    - Respiratory rate >30/ min, or
    - Abdominal examination demonstrates absence of bowel sounds or rigidity.
- If none of the above is present, treatment may be accomplished with the following:
    - Bed rest for 48 hours.
    - Nothing by mouth for 24 hours, except small sips of water or ice chips.
    - Schedule follow-up with nurse in 24 hours.
    - Nausea or vomiting that does not resolve within 48 hours will be scheduled ASAP with Practitioner.
    - Non-duty status until nausea/vomiting is resolved.
    - No food handling assignments.

PROTOCOL 26 --- MEDICATION ORDERS ON TRANSFER OF PATIENT

- Obtain from the HEALTH RECORD the current medications the patient was taking at the sending facility.
- Forward medical record to Practitioner for continuation of therapy.
- In the case of inter-facility transfer, Pharmacy and Nursing services at the receiving institution may continue current medications until the expiration date of the original prescription.
- Upon return from an acute care facility, medications lawfully dispensed by the acute care facility, or referring medical Practitioner, may be continued for up to 72 hours, provided that the medication accompanies the patient.

PROTOCOL 27 --- CONTACT W/ PRACTITIONERS ON URGENT NOTIFICATION LIST



PROTOCOL 28 --- MEDICAL ICE

Indications:

- Acute injuries, such as sprains, strains, dislocations, fractures, or conditions where soft tissue injury is resulting in swelling.
- Some localized allergic or inflammatory reactions, such as bee or wasp stings.
- Any specialist recommendations for medical ice must be reviewed by the medical Practitioner for approval.
    - Not indicated for: Authorization for ice pack is not indicated for chronic problems, such as chronic swelling or pain. When indicated, a licensed Nurse or Practitioner must document the authorization on a Special Need Order for medical ice three (3) times daily. Medical ice may be authorized by the nurse for a maximum of 72 hours.

PROTOCOL 32 --- INDICATIONS FOR C-SPINE AND SPINE BOARD PRECAUTIONS

To ensure that Nursing staff evaluate and manage the patient who has had a potential injury to the spine the following protocol and understanding of the injury must be considered.

MECHANISM OF INJURY

- Evaluation of the mechanism of injury is critical. If the mechanism of injury is unknown or any of those listed in #2 below, special precautions are necessary prior to transport. Otherwise, the patient may be transported to the health unit by any appropriate means.
- Presence of spine injury and an unstable spine should be assumed in the following situations:
  - Any mechanism that causes violent impact on head, neck, torso, or pelvis.
  - Sudden acceleration, deceleration or lateral bending.
  - Falls from significant height, landing on feet or head.
  - Falls resulting in one part of body to stop suddenly while other parts continue to fall.
  - Any situation where possible spine damage has occurred as with:
    - Head injury and change in level of consciousness
    - Significant blunt injury from torso to above clavicle

  Impacted or other decelerated fractures of legs or hips
    - Significant localized injuries to the spinal column
    - Fall from a significant height
  - Ability to walk does NOT rule out spinal injury.
  - Lack of neurological deficit does NOT rule out fracture or unstable spine.

ASSESSMENT:

- Vital Signs with assessment of:
  - Airway
  - Breathing
  - Circulation
  - Assessment of Neurological status and suspected injury site.
- Rapid survey of scene, situation, and history of event to determine likelihood of spinal injury exists
- Note: If a spinal injury MIGHT exist: it DOES exist until proven otherwise.
- Spine must be manually protected
  - The head, unless contraindicated, should be placed in a neutral position in-line position.
  - The head must be maintained with manual immobilization until replaced with spine immobilization.
- Devices for spinal immobilization:
  - Half spine board
  - Long spine board
  - Vest-type device
- Evaluate for other injuries due to traumatic event.
- Physical sign and symptoms of spine trauma
- Pain or pain on movement
- Point tenderness
- Deformity
- Crepitus
- Guarding area of spine
- Neurological signs and symptoms
- Bilateral paralysis
- Partial paralysis
- Paresis
- Numbness, tingling, prickling
- Males: priapism
- Signs and symptoms of neurogenic shock
- Indicators of spine trauma requiring treatment
- Mechanism of injury: regardless of absence of any other signs and symptoms.
- Other injuries that indicate violent forces acted upon the spine.

MANAGEMENT

- Patients generally present in one of four postures:
  - Sitting

    - Semi-prone
    - Supine
    - Standing
- If obvious major injury, inmate should be maintained at scene and ambulance called.
    - Any patient with suspected spine instability should be immobilized in supine position on a rigid spine board in neutral in-line position.
    - The head, neck torso and pelvis must each be in neutral in-line position to prevent any further injury or damage to the spinal cord.
- The supine position is the most stable to ensure protection during handling, carrying and transport of patient.
- The supine position also allows for access to airway, chest and abdomen.
- The spine must be protected and immobilized immediately and continuously from time of discovery until mechanically secured to spine board.
- Management of a patient with suspected spine injury must include:
    - Manual in-line immobilization
    - Evaluation of ABCDE and assessment of need for resuscitation, evaluation of motor, sensory, and circulatory functions in all four extremities.
    - Examination of neck and application of proper cervical collar.
    - Cervical collars used alone do not immobilize.
    - The spine board is the "gold standard" for cervical spine immobilization.
    - Immobilization of torso, then legs to spine board so torso cannot move in any direction.
    - Pad behind head.
    - Once secured on spine board, immobilize arms at chest.
    - Recheck using ABCDE method and reassess motor, sensory and circulation in all four extremities.

TRANSPORT

- Transport the fully immobilized inmate to the health unit.
    - Officers may be used to assist under medical direction.
    - Recheck using ABCDE method and reassess motor, sensory, and circulation in all four extremities.
    - Call Practitioner on-call for further instructions.

PROTOCOL 34 --- ATHLETE'S FOOT (TINEA PEDIS) or JOCK ITCH (TINEA CRURIS)

SIGNS AND SYMPTOMS

- Commonly referred to as "ringworm."
- Scabbing and/or cracking of skin primarily between the toes and on the soles of feet
- Flat, red skin rash that forms a ring around normal skin
- Inflammation
- Burning
- Itching
- Vesicular lesions in severe cases
- TINEA CRURIS occurs predominately in males.

TREATMENT

- Complete nursing assessment, obtain vital signs and document in the health record.
- Advise elimination of the moisture to affected area, wear dry socks and under garments.
- Instruct patient to wear and wash shower shoes and thoroughly dry affected area, especially between toes, prior to application of cream.
- May use Tolnaftate 1% anti-fungal cream b.i.d. for 14 days. Apply Tolnaftate sparingly.
- Instruct inmate to submit a HNR, if condition worsens before the end of treatment.
- Schedule on nurse line for reassessment at the end of therapy.
- If scabbing and cracking or secondary bacterial infection is evident upon reassessment, refer to medical Practitioner.

PROTOCOL 35 --- LICE (PEDICULOSIS) AND SCABIES

Three types of lice and one type of mite affect human beings:

- Pediculosis capitis: head louse
- Pediculosis corporis: body louse
- Phthirius pubis – pubic louse/crab louse can attach only curly hair – pubes, axillae, and eyebrows.
- Sarcoptes scabies – scabies mite. A skin condition caused by a burrowing organism.
- Each type of louse generally remains in the area designated by its name, but may occasionally be noted in other areas of the body. Lice are transmitted by direct contact with people or their personal belongings harboring the lice. Scabies is generally associated with poor living conditions.

Signs and Symptoms:

- The primary symptom is severe itching and scratching of the affected area. Infestation may result in serve itching and excoriation of the scalp and body.
- Body lice may produce minute red lesions with black or rust – colored dots clinging to the base of the hairs.
- Lice may infest hairs of chest, pubic axillary hair, beard and eyelashes.
- Grey-blue macules (1-3 cm in diameter) may be seen on the trunk, thigMS and axillae a result of the action of the louse saliva.
- Scabies should be considered in every case of persistent itching.

Prevention and Treatment (Lice):

- Provide *Inmate Information* material, Human Lice (HEP 1016). Instruct the patient as follows:
  - Shower with soap and water.
- After shower, instruct patient to apply Lice Treatment Shampoo thoroughly covering the affected area. Leave on for about 10 minutes and then wash the affected area with warm water and soap. Rinse and dry with a clean towel.
  - Wash hands immediately after use.
  - Repeat Lice Treatment Shampoo once 7-10 days later to kill any newly hatched lice.
  - Do not apply to eyebrows, eyelids, or eyelashes: may cause eye irritation.
  - Apply ophthalmic petrolatum to eyelashes: smothers the lice and allows easier removal of nits and lice.
  - Remove nits manually from eyelashes and eyebrows with cotton-tipped applicator.
- Provide inmate with a fine tooth comb, if allowed, to remove scalp lice from scalp hair.
- Recommend that the inmate discard combs, hairbrushes and caution against shaving. Do not wear other inmates' hats.
- Wash linens in water temperature above 52 °C. (120°F.) for 10 minutes or store in a closed bag for 10 days.

SCABIES:

- Instruct inmates to apply Permethrin 5% cream from head to the soles of their feet, including under your nails and in skin folds, such as between the toes, as directed. Apply this medication as soon as possible after it is prescribed.
- Massage the cream into skin. Do not use more medication than prescribed. Wash off the cream after 8-14 hours by showering or taking a bath.
- Permethrin 5% cream has a residual effect and should kill lice and eggs in one application.
- Follow-up on nurse line in 7: 10 days to observe and document the response to treatment:
- Note the change in the degree of discomfort caused by itching.
- Observe infected areas for changes in the characteristics of the lesions.
- Observe for systemic manifestations of infections. Refer to Practitioner for treatment.
- To avoid giving scabies to another person or getting it again, instruct inmates on the following: Clothing and bed linens that have been in contact with their skin less than 2 days before treatment should be machine-washed with hot water/machine dried or removed from body contact for 72 hours.
- Notify Facility Health Administrator to facilitate the proper washing and drying of linens and clothing.

PROTOCOL 36 --- VACCINATIONS

NOTE: Administer vaccines only when epinephrine 1:1000 is available in Health Unit to treat adverse reactions. MEASLES RUBELLA CRITERIA: For all inmates born after 1957 and without a confirmed history of prior vaccination (except during pregnancy).

PROCEDURE:

- Provide inmate with Vaccine Information Statements (VISS)
- Have inmate read and sign the Medical Consent Form (form 11-0-3P)
- Administer MR 0.5 ml sub q.
- Document on Immunization Record (Form 1101-17P) or in an appropriate electronic record.
- For "Return to Custody" inmates, review the health record prior to administering MR.

INFLUENZA/PNEUMONIA VACCINATIONS CRITERIA: Criteria for high risk groups will be identified by CO prior to flu season and include the following:

- Patients 65 years of age and older
- Patient with identified chronic conditions (cardiac, respiratory, diabetes, cancer, HIV+).
- Offer vaccine, advising inmate/patient of contraindications and possible side effects.
- Special considerations: Pneumonia vaccine is to be given only once. It provides lifetime immunity. Allergic reactions have occurred among those given second doses.
- Influenza vaccine: contraindicated for:
  - Those who have an allergy to eggs that causes a dangerous reaction, if eaten.
  - Those who have had a serious reaction to previous influenza vaccinations should consult with the Practitioner prior to receiving the vaccine.

PROCEDURE:

- The inmate will sign the Medical Treatment Consent Form (Form # 11-03P)
- Administer vaccination (as directed by manufacturer).
- Document administration on Immunization Record (Form 1101-17P).

TWINRIX [HEPATITIS A INACTIVATED & HEPATITIS B (RECOMBINANT)]

Administration of each injection of TWINRIX will be recorded on the yellow Immunization Record (Form 1101-17P) or appropriate notation made in an electronic record, and the Medication Administration Record (MAR).

PROTOCOL 36A --- TETANUS AND DIPHTHERIA (Td) VACCINE

Assessment:

- Inmates with injuries, such as puncture wounds, burns, or lacerations shall be assessed for the need of a tetanus booster.
- Assessment must include:
  - Length of time since exposure
  - Length of time since last known Td booster or immunization.
  - Nature and location of wound.

Procedure:

Administration

- The Nurse will administer a Td booster based on the following guidelines:
  - Active immunization is maintained by a Td booster every 10 years.
  - Inmates *who sustain wounds that are contaminated with dirt, feces or saliva, puncture wounds, avulsions or burns* do not require a Td booster provided there is evidence of primary Td vaccination with a booster within the past five (5) years.
  - Inmates *who sustain minor, uncontaminated wounds* do not require a Td booster provided there is evidence of primary Td vaccination with a Td booster within the past ten (10) years.
  - If there is no evidence of primary Td vaccination with a Td booster and the inmate sustains *a wound of any type*, a Td booster will be given immediately. In addition, inmates with *wounds that are contaminated with dirt, feces or saliva, puncture wounds, avulsions or burns* shall receive tetanus immune globulin along with the booster.
  - Since the incubation period of tetanus can be very long, it is never too late to receive prophylaxis.

- A licensed Nurse will administer Tetanus-diphtheria (Td) vaccine.

Documentation

- The inmate must read and sign Medical Treatment Consent Form, (Form # 11-3-OP).
- Nurse must document the immunization on the Immunization Record (Form#1101-17P) or appropriate notation made in an electronic record.

PROTOCOL 37 --- TUBERCULOSIS

GUIDELINES

- All inmates shall have a tuberculosis evaluation within 48 hours of arrival at the Reception Center and annually thereafter, regardless of BCG vaccinations unless:
  - Documentation of PPD administration and results within the past 12 months.
  - Confirmed past positive PPD
  - Confirmed history of tuberculosis
- If the inmate is a known TB skin test reactor, a TB skin test will not be administered.
- Any inmate not compliant with the TB evaluation procedures shall have testing/screening facilitated as defined by D.O.1102.5.1.4.
- All inmates shall be given a Mantoux Tuberculin (TB) (Purified Protein Derivative PPD) skin test, and read in millimeters (mm).

PROCEDURE:

- Administer intra-dermally 0.1 ml of 5 TU Purified Protein Derivative (PPD), on inner aspect of the left forearm.
- Document administration date on Medical Work-Up sheet (Form 1101-68P) or in an appropriate electronic record.
- Read within 48-72 hours after the administration of the test. Results will be documented in millimeters on the Medical Work-up Sheet. (Form 1101-68P)
- For a known positive TB skin test reactor, the Nurse will screen the inmate using TB Symptomatology Checklist (Form 1106-61P) upon intake and annually thereafter.

ASSESSMENT OF INDURATION:

- The presence or absence of induration determined by inspection and palpation determines a positive reaction.
- The diameter of induration should be measured transversely in millimeters.
- The induration should be recorded on the Medical Work-Up Sheet (Form 1101-68P).
- Three cut-off levels are recommended for defining a positive tuberculin reaction:
  - >=5mm (greater than or equal to 5 millimeters)
  - >=10mm (greater than or equal to 10 millimeters)
  - >=15mm (greater than or equal to 15 millimeters)

RESPONSE TO INDURATION

- Reaction of >=5mm of induration:
  - Considered positive for those who are at highest risk for developing TB disease, which includes the following.
    - Persons whose chest radiographs are suggestive of previous TB disease, i.e. fibrotic changes of chest x-ray consistent with prior TB.
    - Close contacts of a person who has infectious (active) TB.
    - Persons known to have HIV infection.
    - Persons with organ transplants and other immunosuppressed patient (receiving the equivalent of >= 15/mg/d of prednisone for 1 month or more). If the initial PPD reaction if 5: 9 mm induration, with no known history of exposure to TB, a repeat PPD shall be performed between 7-12 days following the first PPD to the right forearm.
- Reaction of >=10 mm of induration:
  - Considered positive for those persons with an increased risk for TB, such as:
    - Recent immigrants from high prevalence countries (within the last 5 years).

        - Injection drug users.
        - Residents and employees of high-risk setting, i.e. prisons, jails, nursing homes, other long-term care facilities for the elderly, residential facilities for AIDS patient, and homeless shelters.
        - Persons with silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (i.e., leukemias and lymphomas), other specific malignancies such as carcinoma of the head and neck and lung, weight loss >= 10% ideal body wt, gastrectomy and jejuno-ileal bypass. Mycobacteriology laboratory personnel.
        - Children younger than 4 years of age or infants, children and adolescents exposed to adults at high-risk.
    - Reaction of >=15mm of induration:
        - Considered positive in those with no risk factors for TB.
            - If the inmate's annual PPD screening test is positive:
            - The CRN shall complete the TB Symptomatology Checklist (Form 1106-61P) or document in an appropriate electronic record. If the inmate is symptomatic, notify appropriate Vendor Practitioner and Facility Health Administrator immediately, institute airborne precautions and discontinue kitchen clearance.
            - If the inmate is asymptomatic, the CRN will requisition a chest x-ray (posterior-anterior view) to be completed within 72 hours of a positive PPD.
            - The CRN shall notify the appropriate Vendor Practitioner and schedule a Practitioner appointment for evaluation and/or treatment upon receipt of x-ray results.
- INH therapy will be:
    - Unit Dosed
    - Twice weekly for 9 months
    - The Nurse will record INH Therapy or INH Form
    - (A copy of the INH Form will be provided to inmate upon ADCRR release.
    - Inmate may return to kitchen duty after one month of compliant INH therapy. If the inmate is non-compliant, refer to CRN. Have the inmate sign a Refusal of Treatment Form. A SOAPE entry will be made, and the health record will be referred to the medical Practitioner.
    - A baseline liver function test should be requested. If INH therapy is initiated, the CRN will requisition a Chemistry lab panel prior to and after 30 days of therapy. Lab results will be forwarded to the Practitioner.
    - Notification: The CRN will notify the Facility Health Administrator and Central Office of a confirmed or R/O case in an inmate. A coordinated plan of surveillance will be discussed.

PROTOCOL 38 --- WAIVERS AND SPECIAL NEED ORDERS

- Request for renewal must be initiated by a HNR.
- Waivers and Special Need Orders may be renewed by an RN for 72 hours only. This includes but is not limited to:
    - Arch Supports
    - Broken Glasses
    - Extra Mattresses
    - Ice
    - Limited Duty
    - Lower Bunk
    - Medical Shoes
    - Salt Packets from Kitchen- To be given to inmate for saltwater gargle in Nursing Assessment Protocols (Sore Throat and Common Cold). Nurse to specify the number of packets with each meal and include end date on the SNO.
    - Nurses may initiate this SNO without an order from the Practitioner as instructions are covered in the Nursing Assessment Protocols.
- The nursing assessment will be completed in the SOAPE format.

- The nurse will complete Duty/Special Need Order (Form 1101-60P) or Restricted Diet Order (form 912-3P) or annotate in an appropriate electronic record.
- Waivers, Diets and Special Need Orders will be logged on Medical Work-Up Sheet or an appropriate electronic record.

PROTOCOL 39 --- KITCHEN CLEARANCE

- Nursing staff will clear inmates with health conditions for assignment to the kitchen as a Food Service Worker. Clearance will only be required once during each incarceration, unless an inmate presents with a health condition that disqualifies him/her from kitchen duty.
- Inmate will receive a medical clearance for a Food Service Worker upon intake at the receiving facility.
- Medical clearance will be exclusionary. All are considered eligible for assignment as a Food Service Worker unless a health condition exists which precludes kitchen duty.
- Health conditions that are exclusionary include:
  - Acute gastrointestinal illnesses.
  - Chronic diarrhea or a disease associated with chronic diarrhea.
  - Hepatitis A (HAV).
  - HIV +.
  - (+) PPD -must have completed 30 days of INH therapy. If after 30 days of therapy, an inmate becomes non-complaint, the inmate should be excluded from kitchen duty until IHN therapy compliance has resumed.
  - Open, unhealed or infected wounds.
- Kitchen clearance as a Food Service Worker will be documented onto the Inmate Kitchen Clearance Form and Medical Work-up Sheet (Form 1101-68P).

PROTOCOL 40 --- DISRUPTION OF HEALTH CARE SERVICES

- The delivery of routine health care services on a specific yard and/or entire complex may be disrupted due to extenuating circumstances. It is not within the scope of a licensed nurse to terminate the delivery of health services. If routine services are disrupted, the Nurse will:
- Attempt to administer/deliver medications or provide health services to inmates with acute and chronic conditions by being escorted to the inmate housing area or have the inmate brought up to the health unit.
- If circumstances prevent health services from being delivered as prescribed, and alternate modes of delivery cannot be accomplished, the Nurse will:
  - Contact the Facility Health Administrator. Describe the circumstances preventing delivery of care and any alternate attempts to continue the delivery of services. Describe the impact based on the number of inmates with acute and chronic conditions who will be affected by the disruption in the care.
  - Obtain a verbal order from the lead Practitioner to alter or adjust any delivery of care. If after hours, contact the medical Practitioner. If unable to contact either, notify the Medical Director or designee.
  - The circumstances and the Practitioner order should be written on an Information Report.
- Once the delivery of services resumes, the date and time should be entered into the comments section of the Information Report.

Medication Refusals

- Inmates must report for medication pass; nursing cannot accept a NO SHOW as a refusal. If the inmate is a NO SHOW, nursing will:
  - Notify the shift commander
  - Complete a Medication Error Report Form
  - Complete an Information Report when an inmate refuses medications.
  - The medication Nurse will identify the medication on the Refusal Form.
  - The inmate will identify on the Refusal Form why the medication is refused and sign the form.
  - Nursing will ensure the signed Refusal Form is entered into the medical record, within two business days.

PROTOCOL 41 --- MONITORED CONDITIONS

- Nursing will, upon receipt of the Monitored Condition List, arrange for the following data/lab tests to be obtained and reported in the health record prior to the inmate seeing the Practitioner:

  OTHER CHRONIC CONDITIONS MONITORING LAB TESTING WILL BE BASED ON THE PRACTITIONER'S ORDERS.
- Vendor Nursing will request the Monitored Condition laboratory tests.

CONDITION	MEDICAL INFORMATION
CARDIAC	Chem 14+6 (no CBC)
COPD/Asthma	Peak Flow, Oximetry (If O2 is prescribed, obtain O2 saturation on and off O2. Wait a minimum of 15 minutes between obtaining parameters)
Diabetes	Hemoglobin A1C, ACP, CBC, Lipid panel, and Microalbumin-to-creatinine ratio Quarterly
HIV	CD4 Monitoring Panel ACP (w/CBC), viral load
HYPERTENSION	Chem 14 + 6 (no CBC)
SEIZURES	Drug level for prescribed anticonvulsant

- Inmates have been evaluated for active disease states during intake processing at ASPC Phoenix (Alhambra).
- Occasionally, the Vendor intake Physician, Nurse Practitioner, or PA will order certain testing, such as an ECG, labs, or X-rays.
- Nursing staff at receiving facilities are hereby authorized by this Nursing Assessment Protocol to complete tests properly ordered and signed off by ASPC Phoenix medical Practitioners.

PROTOCOL 42 --- EYE INJURIES / RED EYE

The single most important "vital sign" in the eye injuries/red eye evaluation is visual acuity. For eye injuries/red eye evaluations, the following process will be followed:

HISTORY

Obtain an accurate history regarding the eye injury or red eye.

Injury:

1. History of blunt force or penetrating injury
2. Presence or absence of any difficulty with vision
3. Job history (welding, metal grinding)
4. Prior surgical/medical history of eye disease (corneal graft, keratoconus, intraocular lens, glaucoma)

Red Eye:

1. Presence or absence of pain, drainage
2. Presence or absence of any difficulty with vision
3. Job history (welding, metal grinding)
4. Prior surgical/medical history of eye disease (corneal graft, keratoconus, intraocular lens, glaucoma)

PHYSICAL ASSESSMENT

1. Obtain visual acuity in the right, left and both eyes. Assessment is to be completed with and without corrective lenses, if worn. Current visual acuity must be compared to prior visual acuity measurement.
2. Assess light reflex of pupil. Place patient in darkened room for this assessment. Pupils should react briskly to light.

3. Contact Practitioner for immediate evaluation if there is a penetrating injury (or the possibility of a penetrating injury), significant change in visual acuity, red eye with significant pain, sluggish or absent light reflex.
4. For purposes of this Nursing Assessment Protocol, immediate evaluation means evaluation within 4 hours, either by an ADCRR Vendor Practitioner or outside consultant.

Schedule appointment for next business day for eye injury/red eye if there is no possibility of penetration, no significant visual acuity change, no significant pain, and normal light reflex. Use eyewash solution to gently cleanse affected eye.

Appendix E, Sec. 4.0 Treatment Guidelines

PURPOSE: Clinical Treatment Guidelines are provided as additional guides to ADCRR Health Services Contract Vendor medical Professional staff in the disposition of selected, specific health conditions. The Guidelines facilitate the initiation and continuation of treatment of identified conditions and ensure appropriate medical management. As these are "Guidelines", it is understood that deviation from published treatment guidelines may become necessary. Changes in medical therapy is a dynamic process as new information becomes available. The MS Contract Vendor Regional Medical Director or designee along with the Vendor complex Medical Directors are responsible for the annual review of these Treatment Guidelines. Each Guideline is written in consideration of current national health industry standards of care, Centers for Disease Control, National Institutes of Health, and other industry guides.

RESPONSIBILITIES: The Vendor Regional Medical Director or designee is responsible for development of all Treatment Guidelines. The Vendor Regional Director or designee holds responsibility to consider and publish pertinent Treatment Guidelines and algorithms. The Vendor may adopt and use previous ADCRR Treatment Guidelines.

PROCEDURES:

- The Vendor may develop other Treatment Guidelines based upon unique or specific needs to be addressed at a particular institution. Any Treatment Guideline developed or modified by the Vendor is to be submitted to the MSCMB Medical Program Administrator for review and discussion prior to its establishment at the institution. Medical Treatment Guidelines/Algorithms that are approved for use at a specific institution, but not statewide, are to be clearly noted as such in the MSTM Appendix E Table of Contents and on the Guideline itself.
- The Vendor FHA and complex Medical Director are responsible for orienting appropriate Vendor health care employees to the existence and use of Treatment Guidelines.
- Treatment Guidelines will be kept in a MSTM in the facility's health units.
- In the absence of a Medical Treatment Guideline for any single case, the Practitioner is expected to manage the patient's illness using sound clinical decision-making skills coupled with personally acquired science-based clinical information. Communication with peers and the Vendor Regional Medical Director is strongly encouraged when dealing with difficult or complex cases.

THIS APPENDIX CONTAINS THE FOLLOWING GUIDELINES WITH SUPPORTING TABLES AND ALGORITHMS:		
GUIDELINE	REVISION DATE	DEVELOPMENT CONSIDERATION
Contemporary Management of	1/1/2014	American College of Cardiology

Angina		
Angina (Chronic Stable)	1/1/2014	American College of Cardiology and American Heart Association 2012
Angina (Unstable)	1/1/2014	
Hypertension	1/1/2014	U.S. Department of Health and Human Services; National Institutes of Health, National Heart, Lung and Blood Institute; National High Blood Pressure Education Committee, JAMA 2014
Asthma (Chronic)	1/1/2014	National Asthma Education and Prevention Program (National Institutes of Health)
COPD (Chronic Obstructive Pulmonary Disease)	1/1/2014	Texas Tech University Managed Health Care Network Pharmacy & Therapeutics Committee University of Texas Medical Branch Correctional Managed Care, NIH
Diabetes (Type 1)	1/1/2014	American Diabetes Association Clinical Practice Guidelines (ADA)
Diabetes (Type 2)	1/1/2014	ADA
Hepatitis C	1/1/2014	National Digestive Disease Information Clearinghouse (NDDIC NIH) American Association for the Study of Liver Disease (AASLD) 2014
HIV (Naïve)	1/1/2014	Dept. of Health and Human Services 2014
Seizure	1/1/2014	Compilation of Community standards: Treatment of Chronic Epilepsy/Status Epilepticus JAMA and University of Texas Medical Branch Correctional Managed Care: Academic Institution; Epilepsy Foundation
Clinical Opiate Withdrawal Scale	1/1/2014	Journal of Psychoactive Drugs 2003
Clinical Institute Withdrawal Assessment-Alcohol	1/1/2014	NIH 2003; British Journal of Addiction 1989
Benzodiazepine Withdrawal Scale	1/1/2014	J. Psychoactive Drugs 2003; NIH
GUIDELINE	REVISION DATE	DEVELOPMENT CONSIDERATION
Substance Abuse:	1/1/2014	
Alcohol Withdrawal	1/1/2014	NIH; British Journal Addiction 1989
Barbiturate Withdrawal	1/1/2014	NIH 1998
Substance Withdrawal	1/1/2014	World Health Organization

Evaluation and treatment of Cataracts	1/1/2014	N/A
Neurological Disorders, (Parkinson's Disease Myasthernia Gravis)	12/11/2014	Rocky Mountain MS Research, Neuropsychiatric Disease Treatment 2011, NIH, Consultant 360 Medical Journal 2013
Coccidioidomycosis	12/1/2014	Valley Fever Center for Excellence, Mayo Clinic, University of Arizona
End Stage Liver Disease	12/1/2014	AASLD Practice Guidelines 2014
Hyperlipidemia	12/1/2014	American Heart Association-2013
Guidelines for Management of Chronic Kidney Disease	12/1/2014	National Kidney Foundation, Case Western University School of Medicine, Kidney International 2011
Management of Coagulation Disorders	12/1/2014	Pathology Outlines.com, revised 2013
Guidelines for the Management of Warfarin Therapy	12/1/2014	Agency for Healthcare Research and Quality, 2011; Institute of Medicine
Management guidelines for Hereditary Hemochromatosis	12/1/2014	Consultant 360 Medical Journal, 2002
Treatment Guidelines for Inflammatory Bowel Disease	12/1/2014	Consultant 360 Medical Journal, vol. 51, 2011
Management Guidelines for Cystic Fibrosis	1/1/2015	Cystic Fibrosis Foundation; Dept Med. Johns Hopkins University; University of Washington
Treatment Guidelines for Rheumatoid Arthritis	12/1/2014	Annals of Rheumatic Diseases, 2010; British Medical Journal; Consultant 360 Medical Journal Vol. 42, 2002
Management Guidelines for SLE	12/1/2014	Medscape 2016
Management Guidelines for Hyper Thyroidism	12/1/2014	Thyroid Journal Vol 21, 2012
Management Guidelines for Sickle Cell Disease	1/1/2015	U.S. Dept HMS, NIH, Expert Report 2014

Appendix E, Sec. 4.1 Cardiovascular Risk Factors

Cardiovascular Risk Factors:

- Hypertension
- Cigarette Smoking
- Obesity (BMI > 30 Kg/m2)
- Physical Inactivity
- Dyslipidemia
- Diabetes mellitus
- Microalbuminuria or establish GFR < 60 ml/mm
- Age (Men >55, Women >65)
- Family history of premature cardiovascular disease
- (Men <55, Women <65)

Appendix E, Sec. 4.2 Contemporary Management of Angina

- Risk Assessment
  - Stratifying patients according to risk is important early in the course of the disease to identify patients who require invasive (percutaneous or surgical) treatment.
  - Surgery improves morbidity and mortality in a well-defined group of patients with left ventricular dysfunction and left main coronary artery disease or triple-vessel disease. Patients with proximal left anterior descending artery disease and moderate or severe ischemia benefit from surgery as well. All other patients, definitive treatment includes aspirin, ACE/ARB, beta-adrenergic blockers and lipid-lowering agents. Percutaneous revascularization palliative measure never had been shown to improve mortality more than medical therapy.
  - Chronic stable angina, a manifestation of coronary artery disease, can represent increased morbidity and mortality from the disease.
  - Despite the many advances in the management of coronary artery disease that has occurred since the 1970's the consistent conclusions of these studies remain undisputed today. Major survival benefit of surgical revascularization compared the medical therapy is in "sicker" patients defined by the extent of coronary artery disease the presence of left ventricular dysfunction and the severity of angina or ischemia.
  - Advances in percutaneous revascularization, such as stents and multi-vessel percutaneous transluminal coronary angioplasty, and improvements in adjuvant anti-platelet and anticoagulant therapy, coupled with aggressive reduction of cardiovascular risk factors, now allow an alternative to coronary artery bypass surgery.
  - Table 1

    New York Heart Association Functional Classification of Angina

    Class I –Angina only with unusually strenuous activity

    Class II -Angina with slightly more prolonged or slightly more vigorous activity than usual

    Class III –Angina with usual daily activity

    Class IV –Angina at rest
  - Many criteria that identify patients at high and low risk of myocardial infarction and death so that high-risk patients can be appropriately referred for early surgical treatment and low-risk patients can be safely and appropriately treated medically.
  - Risk stratification depends primarily on three variables: amount of jeopardized myocardium the amount of irreversibly necrotic myocardium (reflected by left ventricular function) and number of diseased vessels. With the exception of the last piece of information, this information can be obtained from the history, the physical examination and cardiovascular testing.
- Clinical Assessment of Risk

- Data from the registry at Duke University Medical Center, Durham, N.C. indicate that the "tempo" of angina, defined by the frequency, stability and severity of angina over time, is an important factor in predicting subsequent cardiac events.
- Patients who develop progressive angina symptoms generally fare better with surgical treatment than with medical treatment. This, a progressive from one stage to the next or any increase in the frequency of angina should alert the physician to the need for more aggressive evaluation.
- Table 2
  - Indicators of Left Ventricular Dysfunction
  - Clinical History
  - Orthopnea
  - Dyspnea on exertion
  - Lower extremity edema
  - Paroxysmal nocturnal dyspnea
  - Pulmonary edema
  - Fatigue
- Left ventricular function stands out as one of the most important predictors of survival; the need to probe carefully for signs or symptoms of congestive heart failure cannot be overemphasized.
- Age is also a predictive indicator.
- Elderly patients have a poorer prognosis with medical treatment. Although advanced age increases the morbidity and mortality associated with coronary revascularization procedures, the survival rate of elderly patients treated medically is also reduced. As such, they comprise of subgroup to whom the relative survival benefits of coronary revascularization over medical therapy as particularly increased.
- The findings from the history and physical examination can be misleading: Systolic function can be severely impaired despite a lack of symptoms, and ischemia can be asymptomatic, making clinical assessment of the amount of scarred and jeopardized myocardium difficult. A radionuclide myocardial perfusion stress test (and an echocardiogram when it is indicated) is more sensitive, specific and objective than the history and physical examination and can aid in the risk-stratification process.
- INDICATORS OF LEFT VENTRICULAR DYSFUNCTION
  - Physical examination
  - S3 gallop
  - Rales
  - Paradoxically split S2 (without left bundle branch block)
  - Diffuse apical impulse
  - Elevated jugular venous pressure
  - Peripheral edema
  - Electrocardiogram
  - Left ventricular hypertrophy
  - Left bundle branch block
  - Chest radiograph
  - Enlarged cardiac silhouette
- TABLE 3

  Risk Assessment of Patients with Angina

Low Risk	**High Risk**
Stable angina	Unstable angina
No congestive heart failure	Congestive heart failure
Normal findings on resting ECG	Q waves or ischemic ST-T on resting ECG
Normal left ventricular function	Markedly depressed systolic function

(ECG = electrocardiogram)

- Contraindications to exercise stress testing should be clarified during the history and physical examination (Table 4), and the choice of exercise stress testing versus pharmacologic testing should be considered in patients in whom any type of stress test is deemed too risky.
- Noninvasive Testing:
- Pathologic Q waves indicative of an old myocardial infarction, resting ST-T wave changes and evidence of an interventricular conduction delay are associated with a poor prognosis in patients with underlying coronary artery disease.
- Echocardiogram or Ventriculogram to Assess Left Ventricular Function.
- Impaired ejection fraction identifies the patient at increased risk for myocardial infarction and death regardless of whether coronary revascularization is performed or drug therapy is initiated.
- Well established that the relative survival benefit of coronary revascularization over medical therapy is greatest in patients with a combination of left ventricular dysfunction and three-vessel or left main coronary artery disease.
- Ejection fraction correlates directly with survival in a continuous fashion; patients with the lowest ejection fraction benefit that most from surgical revascularization.
- Clinical history, physical examination, ECG and chest radiograph are extremely helpful in disclosing the presence of left ventricular dysfunction, objective assessment by echocardiogram or left ventriculogram clarifies the extend of disease.
- Determines the potential benefit of surgical revascularization.
- Echocardiogram is not required for everyone; however patients without signs or symptoms suggestive of congestive heart failure and those who are deemed at low risk and are not being considered for revascularization are unlikely to benefit from the information in an echocardiogram.
- Warranted in patients with a history consistent with congestive heart failure and in patients with moderate to severe angina in whom a revascularization procedure is being considered. Objective evaluation of left ventricular function is also warranted when the prognosis needs to be further clarified. Identification of ischemia in the region o the wall motion abnormality is of particular importance.

- TABLE 4
  - General Contraindications for Exercise Stress Testing:
  - Consider pharmacologic stress test under the following circumstances:
    - Acute thrombophlebitis or deep venous thrombosis
    - Neuromuscular, musculoskeletal or arthritic condition that precludes treadmill exercise
    - Patient’s inability or lack of desire to perform the test
    - Easy fatigability
  - Consider cardiac catheterization under the following circumstances:
    - Recent (within 6 days) acute myocardial infarction
    - Angina at rest
    - Severe symptomatic left ventricular dysfunction
    - Potentially life-threatening arrhythmias
    - Acute pericarditis, myocarditis or endocarditis
    - Sever aortic stenosis
    - Acute pulmonary infarct or embolus
    - Acute or serious general illness
  - Testing in diagnosing coronary artery disease are only 65 to 80 percent, still contributes significantly to the identification of patients with coronary artery disease who would benefit from cardiac catheterization. (Table 5).
  - Patients with large areas of under-perfused but viable myocardium are most likely to benefit from revascularization.
  - Exercise duration is one of the strongest independent prognostic indicators and correlates directly with outcome. Patients in the Duke University registry who were able to enter stage IV of the exercise protocol had excellent long-term survival.
  - In patients with ischemia, the longer the exercise duration, the better the prognosis.

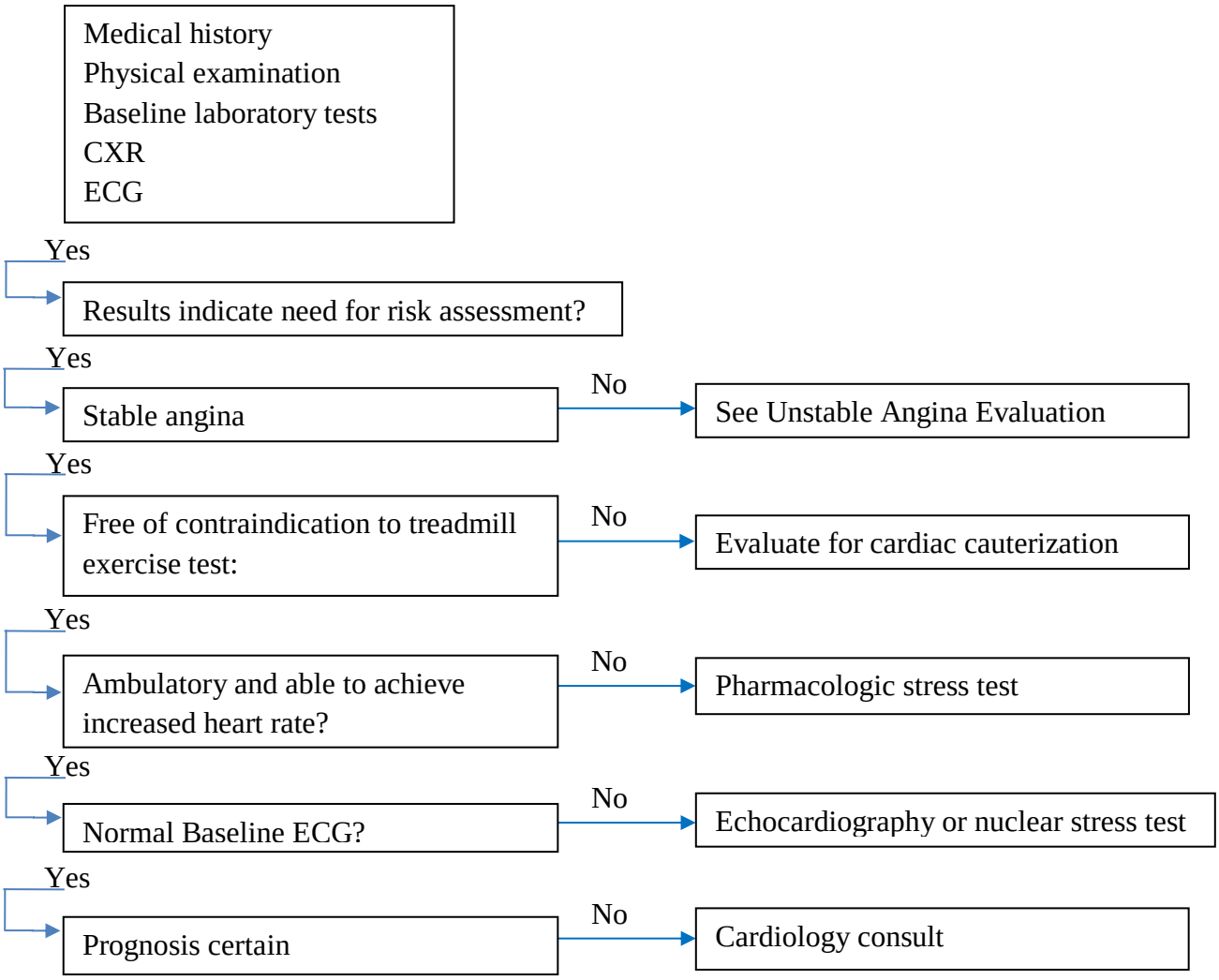
- Patients with ischemic ST-segment depression who enter stages III, IV or V of a Bruce protocol have a significantly better survival rate than patients with the same degree of ST depression who are unable to complete stage I. Patients categorized as low risk on the basis of treadmill testing have an excellent survival rate, even in the presence of multi-vessel disease.
- Finally, patients with triple-vessel disease who were stratified into the high-risk category on the basis of treadmill results alone demonstrated a significant survival benefit from surgery compared with medical therapy (81 percent versus 58 percent).
- Those in the low-risk group experienced an excellent survival rate regardless of the treatment modality.
- Data acquired from the patient's history, physical examination, ECG, echocardiogram and stress test enable adequate evaluation of the degree of left ventricular dysfunction and the extent of angina and ischemia.
- In patients undergoing cardiac catheterization, once the number and severity of diseased vessels are known, the optimal treatment can be determined.
- ACC/AHA guidelines note that surgery is an acceptable option in all patients with three-vessel disease. Patients whose symptoms are more severe (NYHA angina class III or IV), especially with objective evidence of significant ischemia or left ventricular dysfunction, surgery should be considered regardless of the number of diseased vessels, with the understanding that its purpose may not be prolongation of survival but rather palliation of symptoms.
- Patients who have single-vessel disease (with the exception of disease of the left main coronary artery or severe narrowing of the proximal left anterior descending artery), functional class I or II angina, mild ischemia or mild left ventricular dysfunction show no benefit from surgery.
- Aspirin, beta-blockers, ACE inhibitors and lipid-lowering agents, have been shown to prevent myocardial infarction and to improve survival and should be considered the definitive treatment for all patients with coronary artery disease.
- Pneumococcal vaccine is recommended as per package insert for patients with cardiac disease, including angina, CAD, CHF, cardiomyopathy or cardiac vascular disease.

- TABLE 5
  - Variables of the Treadmill Exercise Test that Indicate High Risk:
    1. Exercise duration <5 METs
    2. ST-segment depression
    3. Magnitude (>=2 mm)
    4. Time of onset (stage I or II)
    5. Duration (>5 minutes)
    6. Number of leads (>=5)
    7. Blood pressure
    8. Low (<130 mm Hg) peak systolic blood pressure
    9. Decrease of systolic blood pressure to below the resting standing blood pressure
    10. Inability to attain target heart rate
    11. Presence of exercise-induced angina
    12. Ventricular ectopy (couplets of tachycardia) at low workload

METs = metabolic equivalent, energy expended while in a resting rate

Target heart rate is 85% of maximum predicted heart rate for age (maximum predicted heart rate = 220 – patient's age).

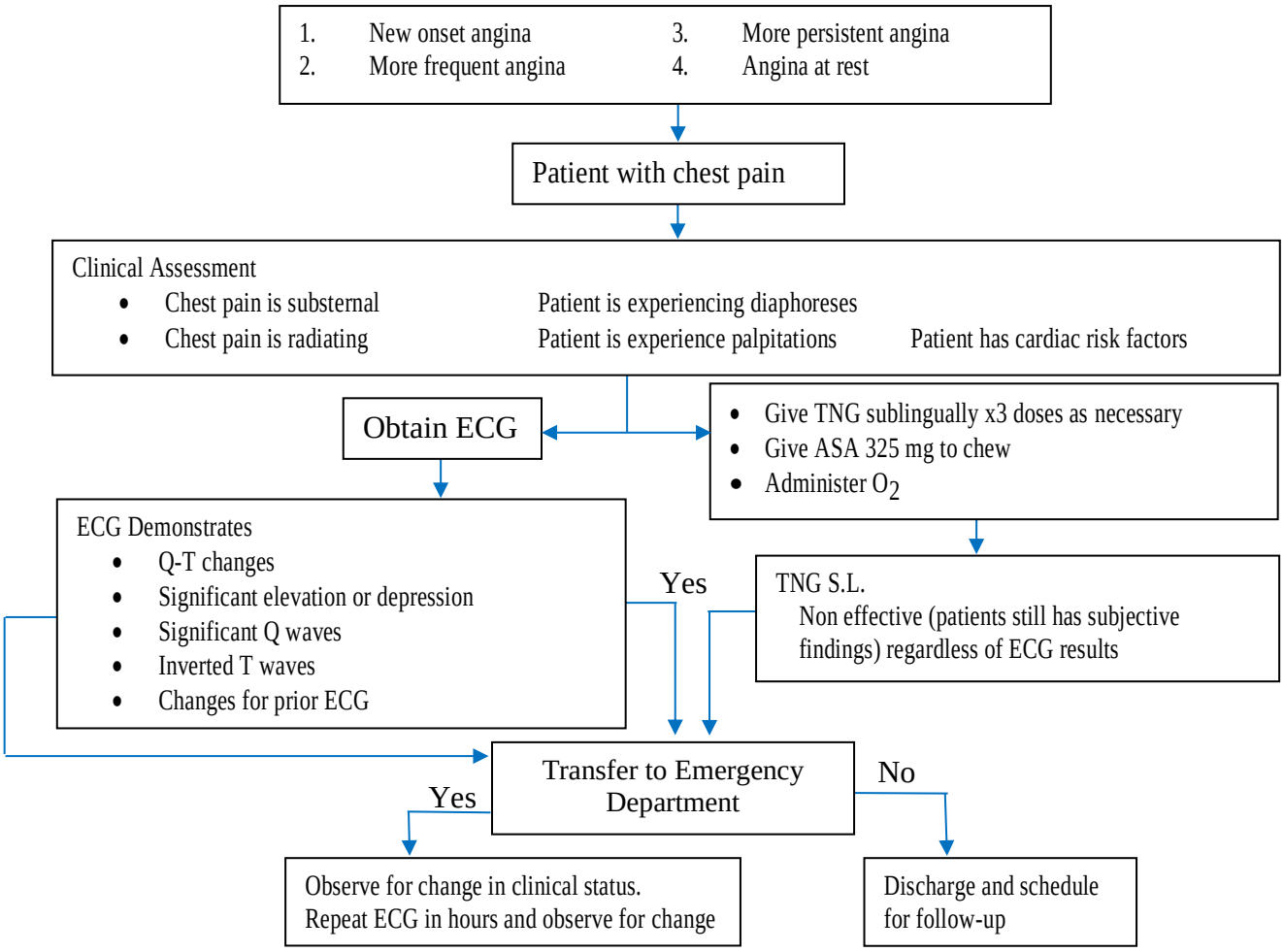
Appendix E, Sec. 4.3 Guidelines for the Evaluation and Management of Chronic Stable Angina



Appendix E, Sec. 4.4 Guidelines for the Evaluation and Management of Unstable Angina

Guidelines for the Evaluation and Management of Unstable Angina

Clinical Syndrome diagnosed by a history of one of the following:



6/13/2014

Appendix E, Sec. 5.0 Guidelines for the evaluation and treatment of chronic Asthma

National Asthma Education and Prevention Program:

Classification of Asthma Severity

Table (a)

Classification	Symptoms	Night symptoms	Lung function
Step 1: mild intermittent asthma	Symptoms occurring twice a week of less. No symptoms and normal PEF between exacerbations. Brief exacerbations (lasting a few hours to days) with variable intensity.	Symptoms occurring no more than twice a month.	FEV_1,/FVC is 80% or more of predicted PEF variability of less than 20%
Step 2: mild persistent asthma	Symptoms occurring more than twice a week. Exacerbations may affect activity.	Symptoms occurring more than twice a month.	FEV_1/FVC is 80% or more of predicted PEF variability of 20 to 30%
Step 3: moderate persistent asthma	Daily symptoms Daily use of inhaler short-acting beta agonist. Exacerbations affect activity. Exacerbations occur more than twice a week and may last for days.	Symptoms occurring more than once a week.	FEV_1/FVC is greater than 60%, but less than 80% of predicted PEF variability is greater than 30%
Step 4: severe persistent asthma	Continual symptoms. Limited physical activity. Frequent exacerbations.	Frequent symptoms.	FEV_1/FVC is 60% or less of predicted PEF variability of greater than 30%

PEF= peak expiratory flow, FEV_1= forced expiratory volume in on second; FVC= forced vital capacity; FEV_1/FVC%=FEV_1 as percentage of FVC.

The initial classification is based on the presence of certain clinical features before treatment. The presence of one of the features of severity is sufficient to place a patient in that category. A patient should be assigned to the

most severe grade in which any feature occurs. The characteristics noted in this classification are general and may overlap because asthma is highly variable.

Pneumococcal vaccine is recommended and shall be given if no contraindications, as per package insert.

NOTE: THREE PEAK FLOW MEASUREMENTS SHALL BE PERFORMED AND DOCUMENTED AT EACH CC ASTHMA/COPD VISIT.

Table (b) Reasons for Failure to Achieve Asthma Control

1. Problems with patient adherence to treatment plan
2. Problems with patient technique in using medications
3. Coexisting conditions (e.g., sinusitis, allergen or irritant exposure, gastroesophageal reflux)
4. Psychosocial or family barriers
5. Need for temporary increase in anti-inflammatory medication (e.g., short course of a corticosteroid)

Table (c) Outcome Measures

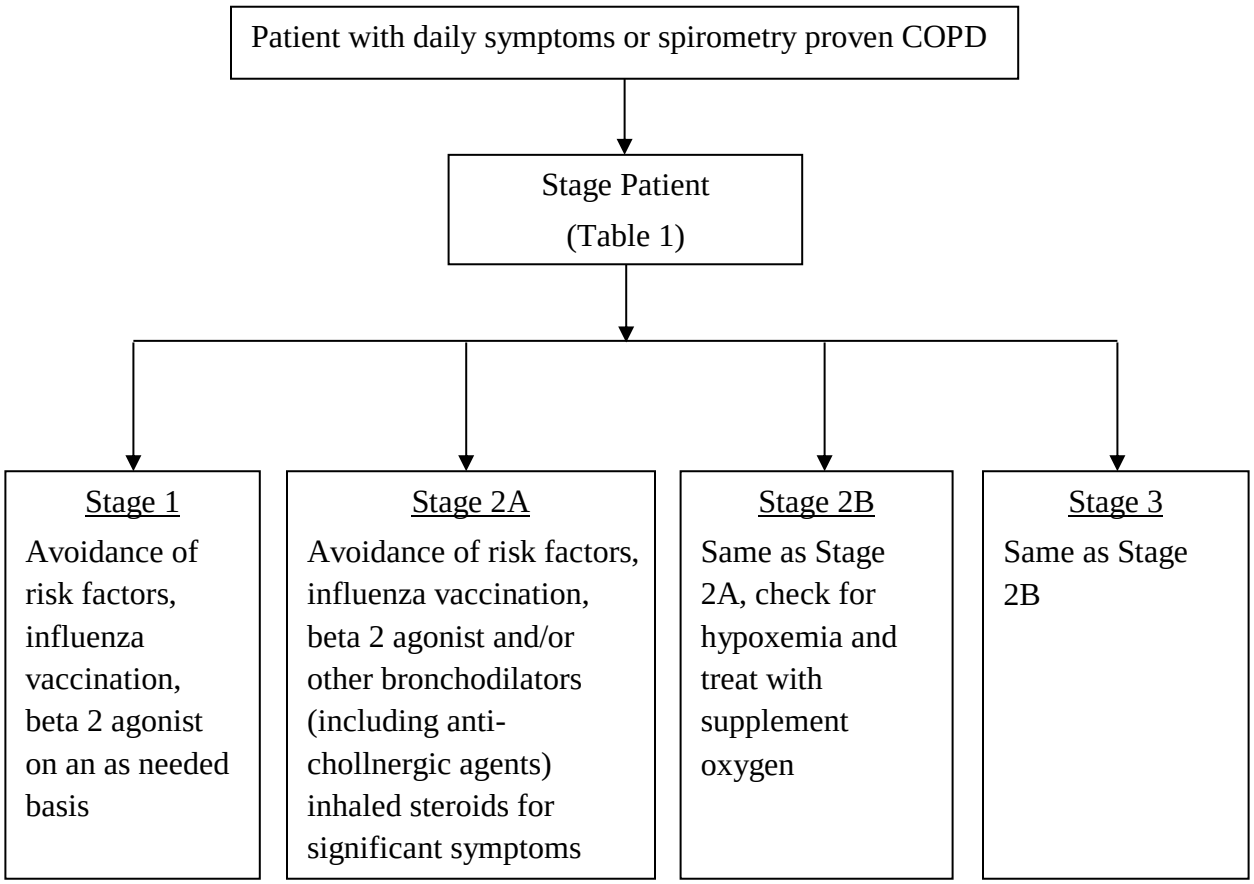
Good Control	Fair Control	Poor Control	Improved Status	Unchanged Status	Worsened Status
≤1 B-agonist MDI refill per month No visits to on site ER No nighttime wakening w/asthma symptoms.	≤1 B-agonist MDI refill per month. ≤1 on-site ER visit for asthma in past month ≤1 weekly nighttime wakening w/asthma symptoms.	>1 B-agonist MD1 refill per month. >1 on site ER visit for asthma in past month >3 weekly nighttime wakening w/asthma symptoms.	Less use of B-agonist MDIs and less frequent symptoms presentation.	Since the last visit both the use of B-agonists and frequency of symptoms are unchanged.	Greater use of B-agonists, more acute symptoms, or an Increase in emergency room visits.

Table (d) Predicted Peak Expiratory Flow		
Height (inches)	Height (Cm)	PEF
60	152	362
61	155	375
62	157	387
63	160	400
64	163	412
65	165	426
66	168	438
67	170	451
68	173	464
69	175	476
70	179	489
71	180	502
72	183	514
73	185	527
74	188	540

To determine peak flow for heights not listed, use the following formula:

[(Hgt-in) x 2.54) – 80] x 5 or [Hgt (cm) – 80] x 5

Appendix E, Sec. 6.0 Guidelines: Evaluation and Treatment of Chronic Obstructive Pulmonary Disease (COPD



NOTE: Pneumococcal vaccine is indicated or patients with COPD and should be administered per package insert

Updated: 03/14/06

Appendix E, Sec. 6.1 Differentiating between COPD and Asthma

Characteristic COPD symptoms include dyspnea, chronic cough, and sputum production. These symptoms also may be present in patients with asthma, albeit with great variability. Several clinical features are not absolute. Fixed airflow obstruction is a definite feature of COPD, but airway remodeling occurs often in asthma and may lead to fixed component of airflow obstruction in some asthma patients. In particular, patients with longstanding asthma may demonstrate irreversible airway obstruction and some patients with asthma may have a pseudo-emphysematous pattern. While atopy is very common in asthma, some COPD patients also have atopy. Although smoking is the most common cause of COPD, 10% to 15% of patients with COPD have never smoked. While inflammation in asthma is dominated by eosinophils, patients with severe asthma may have predominantly neutrophils in their sputum, a characteristic more typical of COPD.

Pneumococcal and Influenza vaccines shall be administered to patients with COPD per package insert.

Table 1 - Clinical features distinguishing asthma from COPD

Clinical features	**COPD**	**Asthma**
Smoker or ex-smoker	Nearly all *	Possibly
Symptoms under age 35 years	Rare	Often
Progression of symptoms	Chronic, slowly progressive	Episodic and highly variable
Chronic productive cough	Common	Uncommon
Breathless	Persistent and progressive	Variable
Nighttime awakening with shortness of breath	Uncommon	Common
Atopic symptoms and seasonal allergies	Uncommon	Common
Significant diurnal/day-to-day variability	Uncommon	Common
Airway inflammation	Neutrophilic	Eosinophilic
Favorable response to ICS	Inconsistent	Consistent
Response to bronchodilators	Less	More

*10%-15% of patients with COPD have never smoked

COPD-chronic obstructive pulmonary disease; ICS inhaled corticosteroid 5/22/14

Table (a) Classification of Chronic Obstructive Pulmonary Disease

Stage 0	**Stage 1**	**Stage 2A**	**Stage 2B**	**Stage 3**
Chronic cough or sputum production	With or without chronic cough or sputum production	Same + or dyspnea	Same	Presence of respiratory failure or clinical signs of right heart failure
FEV, normal FEV, FVC normal	>80% pred <70% pred	50-80% pred <70% pred	30-50% pred <70% pred	<30% pred <70% pred

Pneumococcal vaccine/Annual influenza vaccines are recommended as per package insert.

1/1/2014

Appendix E, Sec. 7.0 MSCMB Diabetes Management Policy

Introduction

Diabetes mellitus is a complex, chronic illness requiring continuous medical care with multi-factorial risk reduction strategies beyond glycemic control. On-going patient self-management education and support are crucial in preventing acute complications and reducing the risks of long-term complications. Significant evidence supports a range of interventions to improve the diabetes outcome. The Medical Practitioner is encouraged to review updated national guidelines in the treatment of Diabetes Mellitus.

- Intake Processing:
  - Inmates identified as diabetic will have a capillary blood glucose measurement. Inmates identified as diabetic will have a complete medical history and undergo an intake physical examination by a licensed health care Practitioner within policy timeframes.
  - Inmates identified as diabetic will continue insulin and/or medications, and will have an appropriate diet ordered.
  - Inmates identified as diabetic, who exhibit signs or symptoms of hypoglycemia or hyperglycemia will have an immediate capillary blood glucose measurement.
  - Intake Labs
    - Patients identified as having diabetes during the intake evaluation will have the following labs ordered by the Vendor intake physician:
      - CBC
      - Chem Panel
      - Lipid Panel
      - Thyroid Panel
      - HgbA1C
      - UA
      - Urine micro albumin with micro albumin-to-creatinine level
- Diabetic Screening
  - Risk Factors for Type 2 Diabetes:
    - Age > 45.
    - BMI > 25 kg /m2.
    - First degree / family history of diabetes.
    - Race – African American, Hispanic American, Native American, Asian American, Pacific Islander.
    - Habitual physical inactivity.
    - Previous identified Prediabetes, impaired fasting glucose (IFG), or impaired glucose tolerance (IGT).

- Hemoglobin A1c (Hgb A1c) between 5.7-6.4%.
- History of gestational diabetes or delivery on a baby greater than 9 pounds.
- Hypertension (> 140/90 mm Hg).
- HDL cholesterol <35 mg/dl and/or triglyceride level > 250 mg/dl.
- Polycystic ovary syndrome.
- History of vascular disease.

- General Requirements for the Evaluation of High Risk Individuals
  - Patients aged 45 and older with a BMI of > 25 kg/m2 shall be screened for diabetes with a fasting blood glucose and/ or HGBA 1c every 3 years or as clinically indicated.
  - Patients aged 45 and older with one other risk factor (other than BMI > 25) shall be screened for diabetes with a fasting blood glucose and/or HGB A1c. If, based on clinical judgment, such screening is clinically warranted, and if so, such screening should be carried out every 3 years.
  - Patients aged 45 and older with 2 other risk factors (other than a BMI >25mg/kg) shall be screened for diabetes with a fasting blood glucose or HgbA1C every 3 years or as clinically indicated.
  - Patients aged 44 and younger, with any risk factor (s), may be considered for diabetic screening based on clinical judgment.
  - Patient screened for diabetes with a fasting blood glucose between 100 and 125 (Prediabetes) shall be screened for diabetes every 3 years or as clinically indicated.
  - Patients screened for diabetes with a fasting blood glucose >125 mg/dl or HgbA1C of ≥5.7 will have a repeat fasting blood glucose within 30 days.
  - Patients with a repeat fasting blood glucose >125mg/dl or HgbA1C >6.5will be enrolled in the diabetic chronic care clinic.
- Diabetes Chronic Care Clinic
  - Diabetics will be seen in Diabetes Chronic Care Clinic at least every 3 months: at shorter intervals if not controlled.
  - A diabetic management plan will be developed and discussed with the patient at the first chronic care visit which will be within 30 days of intake. This management plan will address goals for HgbA1C, pre-prandial blood glucose level, blood pressure, LDL, HDL, and triglycerides. In addition, the management plan will reflect the results of the comprehensive foot exam and the ordering of a base line dilated fundoscopic exam.
  - Each chronic care visit will address the current management plan, and if the management plan is changed, it will be documented in the record and discussed with the patient. Additionally, the following will be addressed during the Diabetes Chronic Care Clinic:
    - Foot Examination:
      - A comprehensive foot exam will occur annually focusing on skin integrity, structural abnormalities, adequacy of perfusion and neurological function findings, either negative or positive, will be documented in the record.
    - Eye Examination:
      - An annual dilated fundoscopic examination shall be performed by a licensed eye care professional.
      - Renal:
      - A spot urine for determination of micro albumin – to –creatinine ratio shall be performed.
      - Patients with micro albuminuria should be treated with ACE inhibitors or angiotensin receptor blockers as appropriate. Blood pressure should be treated to achieve less than 130/80.
    - Cardiac:
      - Blood pressure shall be measured at each chronic care visit. Blood pressure goals are less than 130/80.
      - Aspirin therapy should be used as appropriate in patients over the age of 40 with diabetes with cardiovascular risk factors.
    - Lipids:
      - Attempts should be made to treat LDL levels to <100, HDL levels to > 40 in men and > 50 in women, triglycerides treated to < 150.

- Monitoring Labs
  - Glycemic Monitoring.
  - Blood Glucose Monitoring.
  - All patients with diabetes on insulin shall have pre-prandial blood glucose measurement twice daily, before the morning meal and evening meal.
  - Blood glucose values shall be recorded on a flow sheet or in an appropriate electronic format.
  - Monitoring labs shall be reviewed at the next scheduled chronic care appointment, and as clinically necessary.
- Patients identified as having diabetes and not on insulin, shall have a pre prandial blood glucose measurement twice weekly or as clinically indicated.
  - HgbA1C Monitoring:
  - Glycosylated hemoglobin (HgbA1C) shall be obtained quarterly on all diabetic patients, whether receiving insulin or not.
  - This lab value shall be obtained prior to the chronic care visit, and available for Practitioner review.
  - Other Monitoring
  - Quarterly:
  - In addition to the HgbA1C, a Chem. Panel shall be obtained quarterly and will be available for Practitioner review during the next scheduled chronic care visit.
  - Annual:
  - In addition to the quarterly HgbA1C and ACP, a CBC, lipid panel, and micro albumin-to-creatinine ratio shall be obtained on an annual basis and available for Vendor Practitioner review during the scheduled chronic care visit.
- Diabetes Urgent and Emergency Issues
  - Hyperglycemia:
  - Patients at risk for DKA shall be identified; risk factors include those patients who have had a prior history of DKA.
  - Hyperglycemia may be due to concurrent illness, missed or inadequate medication, corticosteroid use, or significant dietary indiscretion.
  - More frequent blood glucose monitoring may be necessary for patients exhibiting significant hyperglycemia, and will be ordered by the treating Practitioner, as clinically necessary.
  - Temporary adjustments to the treatment program may be required for significant hyperglycemia.
  - The development of ketones may signal impending DKA, and hyperglycemia with ketones should be aggressively managed.
- Hypoglycemia:
  - Patients exhibiting signs or symptoms of hypoglycemia shall have blood glucose levels checked immediately.
  - Blood glucose levels < 60 mg/dl need aggressive intervention, either with glucose tablets, or glucagon injection.
  - Patients experiencing hypoglycemia requiring glucose tablets or glucagon shall have their treatment plan reviewed and re-evaluated by their Practitioner.
  - More frequent blood glucose monitoring will be necessary for patients exhibiting significant hypoglycemia, and shall be ordered by the treating Practitioner, as clinically necessary.
  - Temporary adjustments to the treatment program will be required for significant hypoglycemia.

Other:

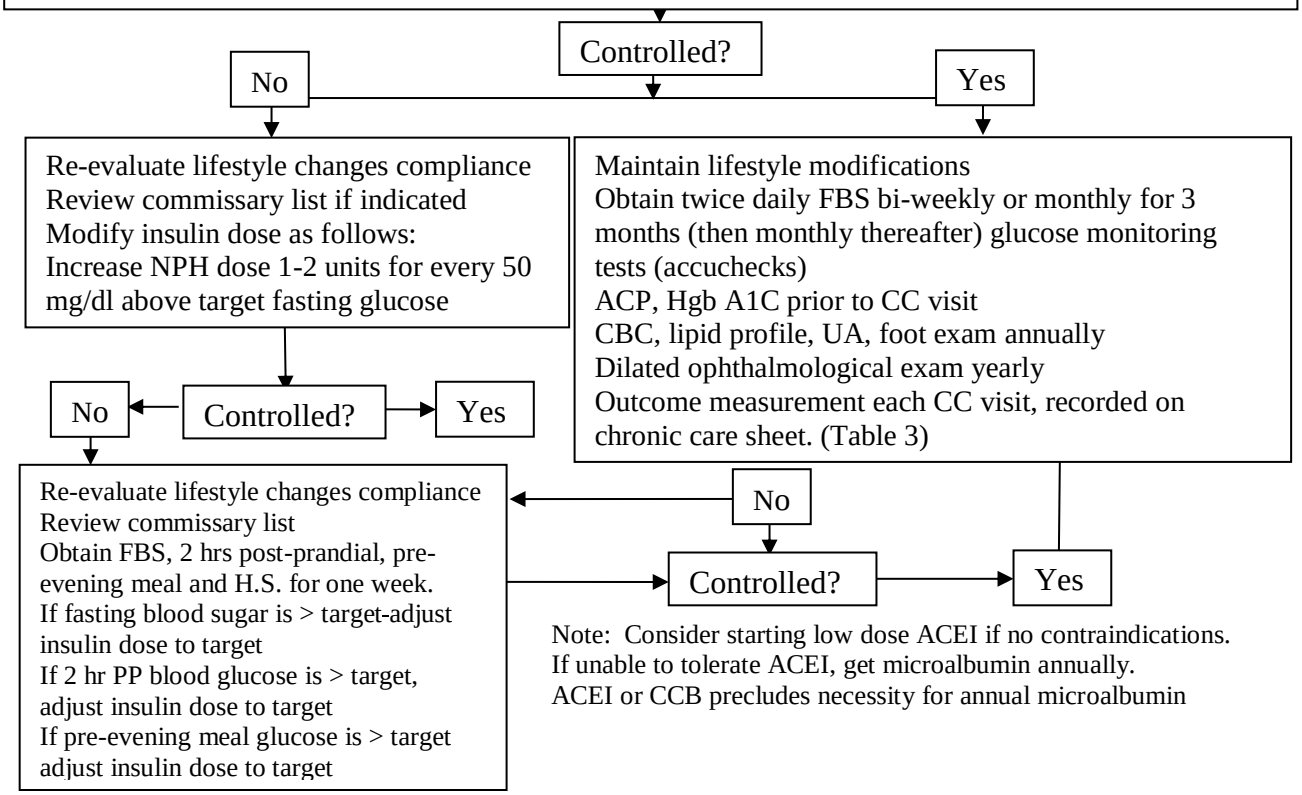
- For each diabetic patient, whether receiving insulin or not, the responsible Vendor Practitioner shall specify in the record values for blood glucose levels which require notification by Nursing staff to either the responsible Practitioner or another Practitioner.

- Patients identified as having diabetes shall have an appropriate diet prescribed by the responsible Practitioner.
- PATIENTS IDENTIFIED AS DIABETICS SHALL RECEIVE ANNUAL INFLUENZA VACCINE, AND SHALL BE GIVEN IMMUNIZATION AGAINST THE PNEUMOCOCUS, AS PER PACKAGE INSERT INSTRUCTIONS.
- Variable dosing of short acting insulin (sliding scale) on a routine basis is discouraged, and should be used primarily:
- In patients who are extraordinarily difficult to control in spite of dietary compliance
- In patients who, because of a concurrent illness, have lost control
- In patients who are being evaluated for the appropriate long acting insulin dose
- In patients who are good candidates for tight glycemic control
- Off site transport poses risks to a patient with diabetes. Therefore, when an outside consult request is written for a patient with diabetes, the word "DIABETIC" should be written in the lower left corner of the Consult Request Form, thereby, requiring arrangements for a shelf stable meal to be ordered by the Vendor Clinical Coordinator.

Appendix E, Sec. 7.1 Guidelines for the Evalualtion and Mnaagement of Type 1 Diabetes

Recommend/Initiate lifestyle changes (Table 1).
Education given and documented21
Schedule Chronic Care clinic
Obtain baseline labs (Table 2)
Evaluate for target organ damage (TOD) and co-morbidities
Routine FBS <200, Hgb A1c <7 = Control
Pneumococcal vaccine is indicated for type 1 diabetes and should be administered per package insert.

Type I Diabetic patients on Insulin Therapy.
Start Insulin: NPH or (Long acting insulin-10-15u/d) Initial total daily dose 0.5-0.6 units/Kg/daily
Dosing Schedule; Suggested dosing is 50-60% of total daily dose in AM., 40-50% of total daily dose in PM
AM dose to be given prior to breakfast, giving 2/3 of AM dose as NPH, 1/3 of AM dose regular, PM dose to be given prior to evening meal, giving ½ or 2/3 of PM dose as NPH, and 1/3 to ½ of PM dose as regular
Monitor with FBS and 2 hr post prandial bold sugar X one week. Re-evaluate in one week.



Note: Consider starting low dose ACEI if no contraindications.
If unable to tolerate ACEI, get microalbumin annually.
ACEI or CCB precludes necessity for annual microalbumin

Appendix E, Sec. 7.2 Pharmacological Therapy Guidelines for Hyperglycemia in Type 2 Diabetes

1. The choice of therapeutic agents should be based on their differing metabolic actions and adverse effects profile. Insulin is required in all patients with T1DM and should be considered for patients with T2DM when noninsulin antihyperglycemic therapy fails to achieve target glycemic control.
2. Metformin, if not contraindicated and if tolerated, is the preferred initial pharmacological agent for type 2 diabetes.
3. In newly diagnosed type 2 diabetic patients with markedly symptomatic and/or elevated blood glucose levels or A1C, consider insulin therapy, with or without additional agent from the outset.
4. If non-insulin monotherapy at maximum tolerated doses does not achieve or maintain the A1C target at three months, add a second oral agent, such as, glucagon-like peptide 1(GLP-1) receptor agonist, incretin enhancers (dipeptidyl-peptidase 4 inhibitors (DPP-4), or sodium glucose co-transporter-2 inhibitor (SGLT-2) or insulin.
5. Due to the progressive nature of type 2 diabetes, insulin therapy is eventually indicated for many patients with type 2 diabetes.

INSULIN PUMP THERAPY

Insulin Pump therapy is useful in motivated and DM-educated patients with T1DM and in certain insulinopenic patients with T2DM who are unable to achieve optimal glycemic control with metered-dose insulin. Thorough education and periodic evaluation of insulin pump users, as well as insulin pump expertise of the prescribing Practitioner, is necessary to ensure patient safety. Due to safety concerns in the use of insulin pump in a prison setting, each request shall be evaluated by the Contract Vendor on a case by case basis and if not indicated, alternative method of insulin administration, which may include other oral therapy, may be ordered by the health care Practitioner in achieving appropriate glycemic control.

Appendix E, Sec. 7.3 Diabetes Tables Lifestyle Modifications

Table 1

1. ADCRR Approved (Heart Healthy) Diet 2. Exercise aerobically 3. Weight loss to ideal Body Weight + 10%

Table 2

Baseline Labs	Ongoing Labs	Annual Labs
CBC Chem Panel Lipid Panel Hgb A1C Thyroid Panel UA Urine Microalbumin	Chem Panel and Hgb A1C prior to chronic care visit	CBC Lipid Panel UA Microalbumin (unless on ACE1 or CCB)

Table 3 Outcome Measures

Good Control	Fair Control	Poor Control
Hgb A1C is within normal laboratory value range	Hgb A1C is <2 percentage points above the laboratory normal range	Hgb A1C >2 percentage point above the laboratory normal range

Status

Improved	Unchanged	Worsened
Reduction in the Hgb A1C or the average of finger-stick levels, or for Type 2 Diabetics when there has been intentional weight loss of 25% due to diet and exercise	When the Hgb A1C and the average of finger-stick levels are the same as previously recorded and the weight is relatively unchanged.	When the Hgb A1C or the average of finger-stick levels are increased, or for Type 2 Diabetics there has been a weight gain of 25%

Target Organ Damage

Heart	Brain	Chronic Kidney Disease	Peripheral Arterial Disease	Retinapathy
Left ventricular hypertrophy Angina or Prior MI Prior Coronary Revascularization	Stroke or TIA			

Pneumococcal and seasonal influenza vaccines are recommended and shall be administered as per package insert.

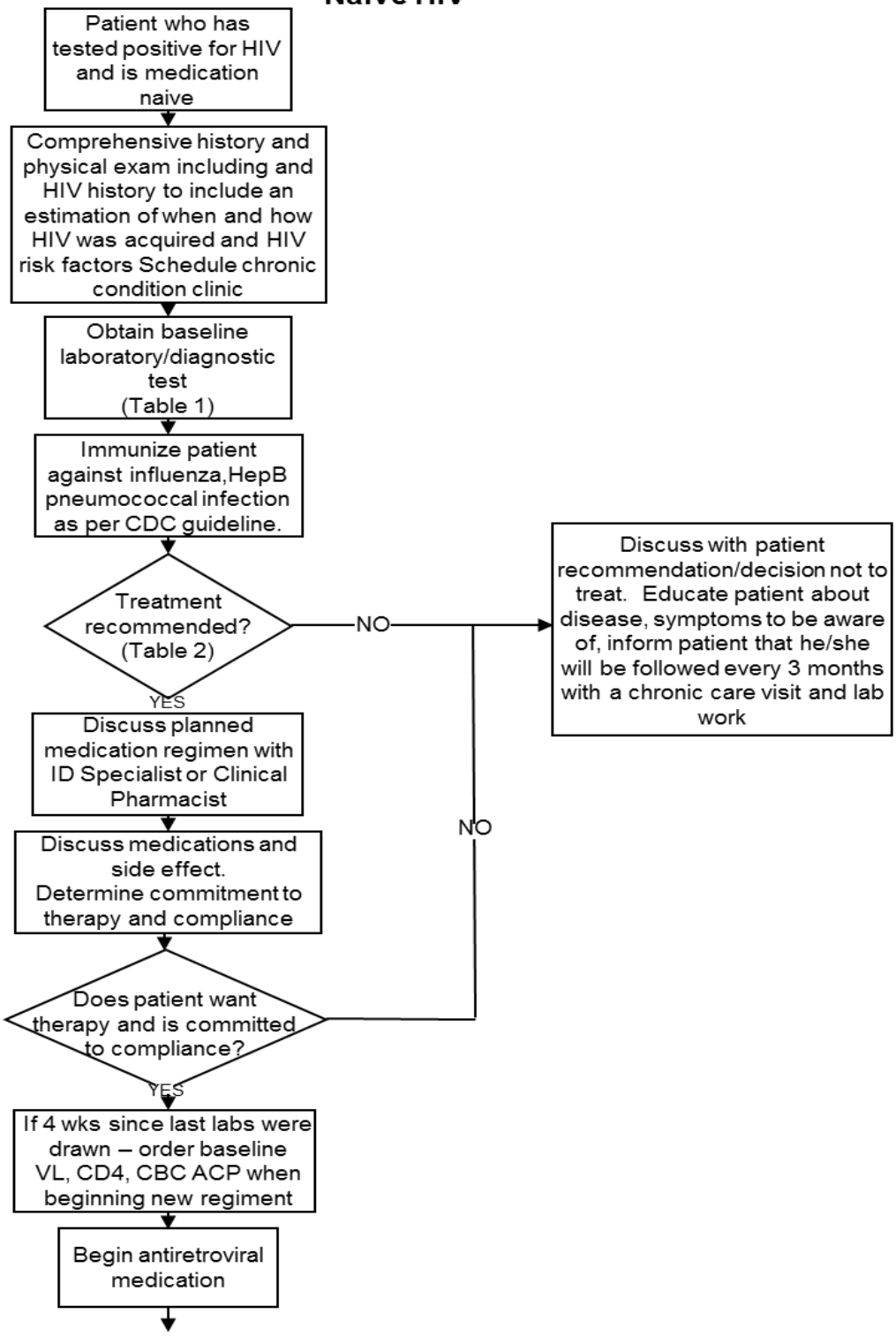
Appendix E, Sec. 7.4 Diagnosis of Gestational Diabetes Mellitus (GDM)

- Risk assessment of GDM should be undertaken at the first prenatal visit. Women with clinical characteristics consistent with high risk of GDM (marked obesity, personal history of GDM, glycosuria, or a strong family history of diabetes) should undergo glucose testing as soon as feasible. If they are found not to have GDM at that initial screening, they should be retested between 24 and 28 weeks of gestation. Women of average risk should have testing at 24 and 28 weeks of gestation.
- Certain factors place women at lower risk for the development of glucose intolerance during pregnancy, and it is likely not cost effective to screen such patients. Pregnant women who fulfill these criteria need not to be screened for GDM:
  - <25 years of age
  - Normal body weight
  - No family history (i.e. first-degree relative) of diabetes
  - No history of abnormal glucose metabolism
  - No history of poor obstetric outcome
  - Not a member of an ethnic/racial group with a high prevalence of diabetes (e.g. Hispanic America, Native America, Asian American African American, Pacific Islander)
- A fasting plasma glucose level of >125 mg/dl or a random plasma glucose >200 mg/dl meets the threshold for the diagnosis of GDM. In the absence of unequivocal hyperglycemia, the diagnosis must be confirmed on a subsequent day. Confirmation of the diagnosis precludes the need for any glucose challenge.
- In the absence of this degree of hyperglycemia, the diagnosis of GDM in women with average or high risk characteristics should be made following these guidelines:
  - A 50 gm oral glucose tolerance test with a 1 hour blood sugar value <140 mg/dl is normal.
  - A 100 gm glucose load test (3 hour OGTT) may also be used with the following normal values (normal values may vary slightly among different laboratories.)

Fasting	<95 mg/dl
1 hour	<180 mg/dl
2 hours	<155 mg/dl
3 hours	<140 mg/dl

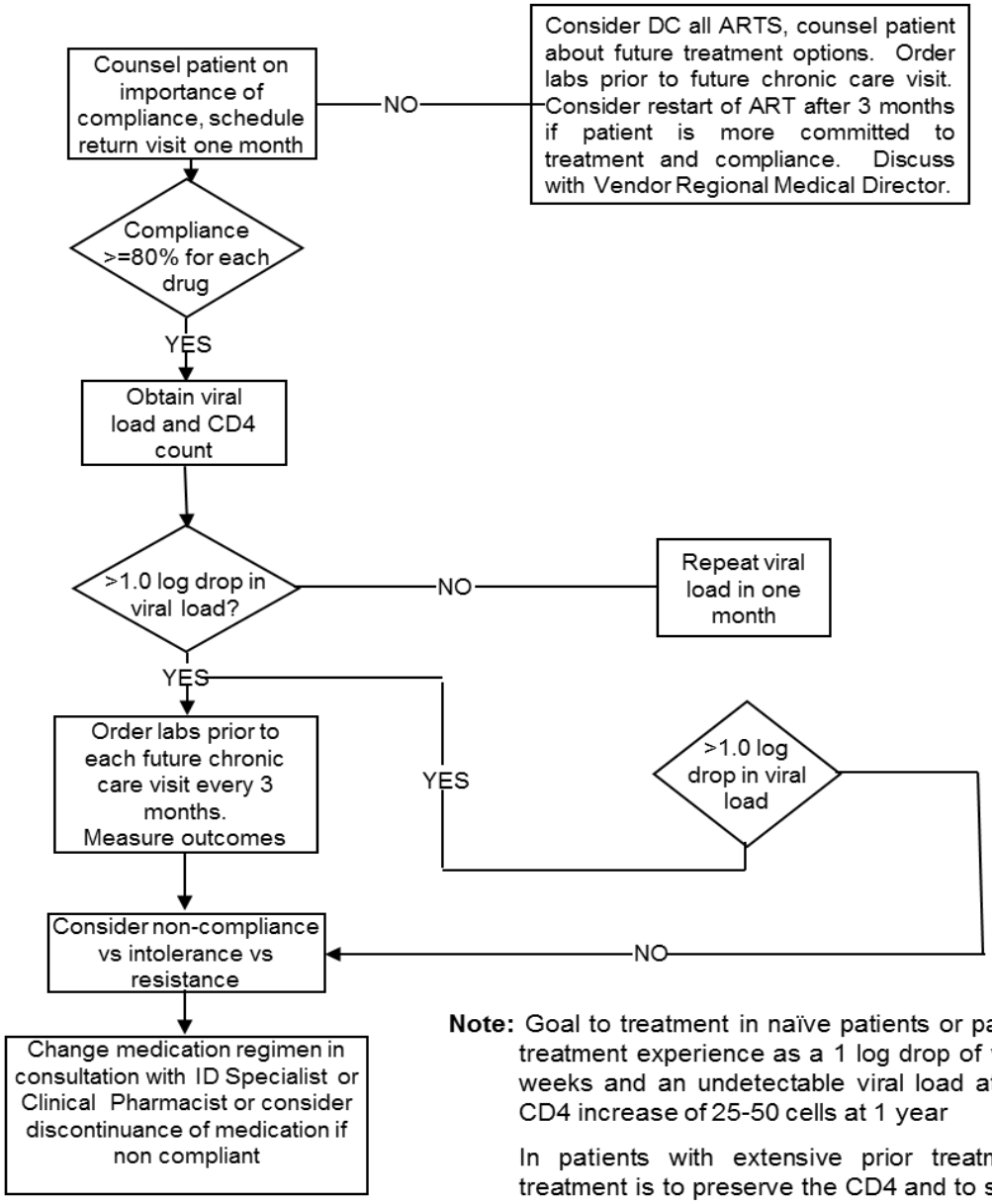
Appendix E, Sec. 8.0 Guidelines for the Evaluation and Treatment for Naïve HIV

Appendix E, 8.0. Guidelines for the Evaluation and Treatment for Naive HIV



Updated 1/1/2014

Appendix E, 8.0. Guidelines for the Evaluation and Treatment for Naive HIV Disease (cont.)



Note: Goal to treatment in naïve patients or patients with limited treatment experience as a 1 log drop of viral load in 4 to 8 weeks and an undetectable viral load at 6 months with a CD4 increase of 25-50 cells at 1 year

In patients with extensive prior treatment the goal of treatment is to preserve the CD4 and to suppress viral load at least 0.5 log below baseline.

Note: Genotype and phenotypic assays are available to determine resistance and failure of ART

Note: Outcomes must be measured at each HIV Chronic Care visit, whether or not on ART

Updated 1/1/2014

Appendix E, Sec. 8.1 Treatment Guidelines for the Initiation of ART in the Chronically Infected HIV patient

Treatment Guidelines for the Initiation of ART in the Chronically Infected HIV patient (Dept. Health and Human Services, AIDS Research Advisory Council, Federal Bureau of Prison 2/2013

Table 1

Clinical Category	CD4 Cell Count	Plasma HIV RNA	Recommendations
Symptomatic (AIDS or severe symptoms)	Any value	Any value	Treat
Asymptomatic AIDS	CD4 <200/mm^3	Any value	Treat
Asymptomatic	CD4 >200/mm^3 but <350/mm^3	Any value	Treat
Asymptomatic	CD4 >350//mm^3	Any Value	Treat Conditions where deferred therapy may be considered: Barriers to medication adherence; Presence of co-morbidities that may complicate or prohibit ART; Other medical problems with poor prognosis; Surgical procedures that may interrupt or delay treatment
		Antiretroviral therapy is recommended for all HIV-infected individuals to reduce the risk of disease progression and risk of disease transmission	Examples of ART regimens: NNRTI Or NRTI+ NRTI+ PI Or INSTI

NRTIs-Nucleoside reverse transcriptase inhibitors; NNRTIS-Non-nucleoside reverse transcriptase inhibitors PIs-Protease Inhibitors; Integrase Strand Transfer Inhibitors.

Risk Stratification for HIV-Related Complications by CD4 Cell Count

Table 2

500	200-500	<200	<100	<50
Acute retroviral syndrome, Candida, vaginitis, Generalized lymphadenopa -thy, Myopathy	Bacterial pneumonia, Pulmonary tuberculosis, Herpes zoster, Oral thrush, Oral hair leukoplakia, Kaposi's sarcoma, Lymphoma, Cervical intraepithelial neoplasis or cervical cancer, Anemia, Mononeuritis multiplex, Lymphoid interstital pneumonitis, Idopathic thrombocytopenic purpura	Pneumocystis carnii pneumonia, Disseminated or extra pulmonary tuberculosis, Disseminated histoplasmosis, Disseminated coccidioidomycosis, Progressive multifocal leukoencephalopathy, Wasting Dementia, Peripheral neuropathy, Vacuolar myelopathy, Cardiomyopathy, Polyradiculopathy	Disseminated herpes simplex, Disseminated herpes zoster, Central nervous system toxoplasmosis, Cryptococcosis (usually meningeal), Cryptosporidiosis Microsporidiosis, Candidal esophagitis	Disseminated Mycobactrium *avium* complex disease, Central nervous system lymphoma, Disseminated cytomegalovir al infection (*commonly* retinitis, colitis)

Laboratory and Diagnostic Tests (HIV)

Table 1

Baseline	Every 3 Months	Annual	Miscellaneous
CBC with differential/platelets, Chem panel HIV viral load, CD4 count, Hep A,B,C serology, Toxoplasma titer, Varicella titer, G6PD*, CXR PPD, Pap Smear	CBC with differential/platelets (more frequently for low values), Chem panel, CD4** HIV viral load**	Same as for every 3 months Toxoplasma titer, *** Pap smear, Influenza vaccine	Diphtheria/tetanus every 10 years, Hepatitis A+, Hepatitis B or TwinRix, Pneumococcal vaccine as early as possible in disease, (consider re-immunization if initial vaccine was given when CD4 count was <200 and increases to >200)

* In those patients with the following ancestry: African-American, Italian, Sephardic Jew, Arab, from India or Southeast Asia.

** Also with changes in ART for decisions regarding opportunistic infection.

*** Annually for those that are seronegative, when CD4 is <100.

THERAPEUTIC GOALS FOR HIV THERAPY:

Reduce HIV associated morbidity and prolong the duration and quality of survival.

Restore and preserve immunologic function.

Maximally and durably suppress plasma HIV viral load.

Prevent HIV transmission.

HIV-1 RNA (Viral Load) is the most important indicator of initial and sustained response to ART, and should be measured in all HIV infected patients at entry into care, at initiation of therapy and on a regular basis thereafter. Optimal viral suppression is defined as a viral load persistently, below the level of detection (HIV RNA <20-75 copies/ml depending on the assay used).

CD4 is the most important laboratory indicator or immune function in HIV-infected patients. It is also the strongest predictor of subsequent disease progression and survival for most patients on therapy. An adequate response is defined as on increase in CD4 count of 300-500 cell/mm^3. CD4 response in a patient with viral suppressor is rarely an indication for modifying an ART therapy.

Although uncommon, CD4 count declines can occur in a small percentage of virologically suppressed patients and may be associated with adverse clinical outcomes, such as cardiovascular disease, malignancy and death.

Appendix E, Sec. 9.0 Classification Management of Hypertension

Identifiable Causes of Hypertension

1. Sleep apnea
2. Drug induced or related causes (see table)
3. Chronic kidney disease
4. Primary Aldosteronism
5. Renovascular disease
6. Chronic steroid therapy or Cushings' disease
7. Pheochromocytoma
8. Coarctation of the Aorta
9. Thyroid or parathyroid disease

Table 1 Target Organ Damage

1. Heart
   Left ventricular hypertrophy
   Angina or prior MI
   Prior coronary revascularization
2. Brain
   Stroke or TIA
3. Chronic kidney disease
4. Peripheral Arterial Disease
5. Retinopathy

Table 2. Classification/Management of Hypertension

BP Classification	SBP[2] mmHg	DBP[2] mmHg	Lifestyle Modification	WITHOUT Compelling Indication	WITH Compelling Indication (Table 8)
NORMAL Prehypertension	<120 120-139	<80 0R 80-89	Encourage YES	No antihypertensive drug indicated.	Drug(s) for compelling indications.
STAGE 1 HYPERTENSION	140-159	OR 90-99	YES	Thiazide-type diuretics for most, May consider ACEI, ARB, BB, CCB or combination	Drug(s) for the compelling indications. Other antihypertensive drugs (diuretics, ACEI, ARB, BB, CCB) as needed.
STAGE 2 HYPERTENSION	>160	OR >100	YES	Two-drug combination for most (usually thiazide-type diuretic and ACEI or ARB or BB or CCB).	

DBP. Diastolic blood pressure,
SBP, Systolic blood pressure.
Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor;
ARB, angiotensin receptor blocker;
BB, beta-blocker;
CCB, calcium channel blocker.
Treatment determined by highest BP category.
Initial combined therapy should be used cautiously in those at risk for orthostatic hypotension
Treat patients with chronic kidney disease or diabetes to BP goal of <130/80 mmHg

Table 3. Clinical trial and Guideline basis for compelling indications

COMPELLING INDICATION	DIURETIC	BB	ACEI	ARB	CCB	ALDO ANT	CLINICAL TRIAL BASIS
Heart Failure	X	X	X	X		X	ACC/AHA Heart Failure Guideline, MERRIT-HF, COPERNIUS, CIBIS, SOLVD, AIRE, TRACE, ValHEFT, RALES
Post myocardial Infarction		X	X			X	ACC/AHA Post-MI Guideline, BHAT, SAVE, Capricorn, EPHESUS
High coronary disease risk	X	X	X		X		ALLHAT, HOPE, ANBP2, LIFE, CONVINCE
Diabetes	X	X	X	X	X		NKF-ADA Guideline, UKPDS, ALLHAT
Chronic kidney disease			X	X			KNF Guideline, Captopril Trial, RENNAL, IDNT, REIN, AASK
Recurrent stroke prevention	X		X				PROGRESS

Guidelines; the compelling indication is managed in parallel with the BP.
Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor;
ARB, angiotensin receptor blocker;
Aldo ANT, aldosterone antagonist;
BB beta-blocker,
CCB calcium channel blocker.
Conditions for which clinical trials demonstrate benefit of specific classes of antihypertensive drugs.

Table 4. Lifestyle Modifications

MODIFICATION	RECOMMENDATION	APPROXIMATE SBP REDUCTION (RANGE)
Weight reduction	Maintain normal body weight (body mass index 18.5-24.9 kg/m²)	5-20 mmHg/10 kg weight loss
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 gm sodium)	2-8 mmHg
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, Most days of the week).	4-9 mmHg

DASH, Dietary Approaches to Stop Hypertension.

For overall cardiovascular risk reduction, stop smoking.

The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.

Table 5. Causes of Resistant Hypertension

Improper BP Measurement
Volume Overload and Pseudo-tolerance • Excess sodium intake • Volume retention from kidney disease • Inadequate diuretic therapy
Drug-Induced or other causes • Non-adherence • Inadequate doses • Inappropriate combinations • Non-steroidal anti-inflammatory drugs; cyclooxygenase 2 inhibitors • Cocaine, amphetamines, other illicit drugs • Sympathomimetics (decongestants, anorectics) • Oral contraceptives • Adrenal steroids • Cyclosporine and Tacrolimus • Erythropoietin • Licorice (including some chewing tobacco) • Selected over-the-counter dietary supplements and medicines • (e.g., ephedra, ma haung, bitter orange)
Associated Conditions • Obesity • Excessive alcohol intake

Table 6. Classes Oral Antihypertensive Drugs

Class	Drug Name	Usual Daily Dose mg/day
Thiazide	Hydrochlorothiazide	12.5-50
Loop Diuretics	Furosemide	20-80
Potassium Sparing	Triamterene w/ HCTZ	
Aldosterone Receptor Blocker	Spironolactone	20-50
Beta-Blocker	Atenolol Propranolol	25-100 40-160
ACE Inhibitor	Captoril Enalopril	25-100 2.5-40
Calcium Channel Blocker (CCB)	Diltiazim ER Verapamil SR Nifedipine	180-420 120-360 30-60
Alpha 1 – Blocker	Prazosin	2-20
Direct Vasodilators	Minoxidil	2.5-80

Table 7. Special Conditions

COMPELLING INDICATIONS
Ischemic Heart Disease (IHD)
In patients with hypertension and stable angina the first drug of choice is a Beta-blocker; long acting Calcium Channel blockers can be used alternatively.
In patients with acute coronary syndromes (unstable angina or MI), hypertension should be treated first with Beta-blockers and ACE inhibitors, with the addition of other drugs as needed to control hypertension.
Post MI with hypertension can be treated with ACE inhibitors, Beta-blockers and Aldosterone Antagonists.
Intensive lipid management and low-dose aspirin (ASA) are also indicated.
Heart Failure (HF)
Tight BP control and lipid management is essential as primary preventative measures on those at risk for heart failure.
In asymptotic patients with demonstrable ventricular dysfunction, ACE inhibitors and Beta-blockers are recommended.
Systemic ventricular dysfunction or end stage heart disease should be treated with ACE inhibitors, Beta-blockers or Aldosterone blockers.
Diabetic Hypertension
Target BP is <130/80 (2013 guidelines <140/90). Combinations of two or more drugs are generally needed to reach target BP.
To reduce incidence of CVA and stroke, the recommended drugs are thiazides, beta-blockers and aldosterone receptor blockers.
To reduce progression of diabetic nephropathy and reduce albuminuria, ACE inhibitors and Aldosterone Receptor blocker are recommended.
Chronic Kidney Disease
Aggressive BP control is necessary to reduce progression of renal function and reduce incidence of CRF.
May take a combination of 3 or more medications to reach target BP of <130/80.
ACE inhibitors and Aldosterone Receptor blockers are recommended.
In advanced renal disease (GFR <30 ml/min)
Creatinine 2.5-3 mg/dl), increasing doses of loop diuretics are recommended.
Cardiovascular Disease
Decrease in recurrent stroke recurrence is obtained with a combination of ACE inhibitor and thiazides.

Table 8. Other Special Considerations

Metabolic Syndrome
Defined by the presence of 3 or more of the following: 1. Abdominal obesity (waist >40 inches in men and >35 inches in women) 2. Glucose intolerance (FBS > 100 mg/dl) 3. BP >130/85 4. Elevated triglycerides 5. Low HDL (<40 mg/dl in men, <50 mg/dl in women) Lifestyle modification is indicated for each condition present, and drug therapy for each condition present should be instituted.

Left Ventricular Hypertrophy
Regression of LVH occurs with aggressive BP management, sodium restriction, and lifestyle modifications. All classes of BP medication may be used <u>except</u> direct vasodilators.

Peripheral Vascular Disease
PVD is equivalent in risk to CHD. Any class of antihypertensive drug may be used to control BP. ASA is indicated.

Outcome Measurement
Control and status assessment is required at each CC visit and is to be entered into the health record as part of the SOAPE note.

Outcome Measures

Clinical	Good Control	Fair Control	Poor Control
Cardiac / HTN	Systolic <140 mm/Hg Diastolic <90 mm/Hg	Systolic 140-160 mm/Hg Diastolic 90-105 mm/Hg	Systolic >160 mm/Hg Diastolic >105 mm/Hg
HTN + Diabetes	Systolic <130 mm/Hg Diastolic <80 mm/Hg	Systolic 130-150 mm/Hg Diastolic 80-95 mm/Hg	Systolic >150 mm/Hg Diastolic >95 mm/Hg

Status Assessment

Improved Status	Unchanged Status	Worsened Status
The patient's blood pressure reading is lower than at the previous C/C visit.	The blood pressure, weight, and/or baseline laboratory values have not changed since the previous C/C visit.	An increase in the patient's BP, weight, baseline laboratory values, non-adherence to treatment plan, or the development of more acute symptoms.
Pneumococcal and seasonal influenza vaccines are recommended as per package insert.		

Appendix E, Sec. 9.1 Hypertension Guidelines

HYPERTENSION GUIDELINES per JNC8, 2013

- In 2013, The Eighth Joint National Committee (JNC 8) released the 2014 Evidence-Based Guidelines for the management of High Blood Pressure in adults. Evidence was based on randomized controlled trials. Major recommendations include:
  - In patients age >60 years old, initiate pharmacological treatments in systolic BP >150mmHg or diastolic BP >90 mmHg and treat to goal systolic BP 150mmHg and goal diastolic BP <90mmHg (Strong recommendation-Grade A)
  - In patients <60 years, initiate pharmacological treatment at diastolic BP >90mmHg and treat to goal <90mmHg. (For ages 30-59 years, Strong Recommendations-Grade A; For age 18-29 years, Expert Opinion-Grade E)
  - In patients age <60 years, initiate pharmacological treatment at systolic BP > 140mmHg and treat to goal < 140mmHg. (Expert Opinion-Grade E)
  - In patients aged >18 years with Chronic Kidney Disease, initiate pharmacological treatments in systolic BP> 140mmHg or diastolic BP >90 mmHg and treat to goal systolic BP <140mmHg and goal diastolic BP <90mmHg (Expert Opinion-Grade E)
  - In patients aged >18 years with Diabetes, initiate pharmacological treatments in systolic BP >140mmHg or diastolic BP >90 mmHg and treat to goal systolic BP <140mmHg and goal diastolic BP <90mmHg (Expert Opinion-Grade E)
  - In the general nonblack population, including those with diabetes, initial antihypertensive treatment should include a thiazide-type diuretic or CCB (Calcium Channel Blocker), ACE inhibitor or ARB (Angiotensin Receptor Blocker). Moderate Recommendation–Grade B). This recommendation is different from JNC 7 in which the panel recommended thiazide-type diuretics as initial therapy for most patients.
  - In the general black population, including those with diabetes, initial antihypertensive treatment should include a thiazide-type diuretic or CCB. (For general black population: Moderate recommendation–Grade B; for black patients with diabetes: Weak recommendation-Grade C)
  - In the population aged >18 years with chronic kidney disease, initial (or add-on) antihypertensive treatment should include an ACE inhibitor or ARB to improve kidney outcomes. (Moderate Recommendation-Grade B)
  - If BP goal is not reached within a month of treatment, increase the dose of initial drug or add a second drug from one of the classes in Recommendation 6. If goal BP cannot be reached with two drugs, add and titrate a third drug from a different class. Do not use an ACE and an ARB together in the same patient. If goal BP cannot be reached using only the drugs in RECOMMENDATIONS 6 because of a contraindication or the need to use more than 3 drugs to reach goal BP, antihypertensive drugs from other classes can be used. (Expert Opinion-Grade E)
- Grade Strength of Recommendation

- Strong Recommendation: There is high certainty based on evidence that the net benefit is substantial.
- Moderate Recommendation: There is moderate certainty based on evidence that the net benefit is moderate to substantial or there is high certainty that the net benefit is moderate.
- Weak Recommendation: There is at least moderate certainty based on evidence that there is a small net benefit.
- Recommendation against: There is at least moderate certainty based on evidence that it has no net benefit or that risks/harms outweigh benefits.
- Expert Opinion ("There is insufficient evidence or evidence is unclear or conflicting, but this is what the committee recommends.") Net benefit is unclear. Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, but the committee thought it was important to provide clinical guidance and make a recommendation further research is recommended in this area.
- No Recommendation for or against ("There is insufficient evidence or evidence is unclear or evidence is conflicting.") Net benefit is unclear. Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, and the committee thought no recommendation should be made. Further research is recommended in this area.

NOTE: THERE IS CONSIDERABLE CONTROVERSY ABOUT THE RECOMMENDATION IN JNC 8 TO REDUCE THE LEVEL AT WHICH TREATMENT IS INITIATED IN PATIENTS 60 AND OLDER WITHOUT DIABETES OR CHRONIC KIDNEY DISEASE AS COMPARED WITH JNC 7.

Appendix E, Sec. 9.2 Hypertension Flow Charts

Appendix E. Section 9.2

Hypertension Flow Chart

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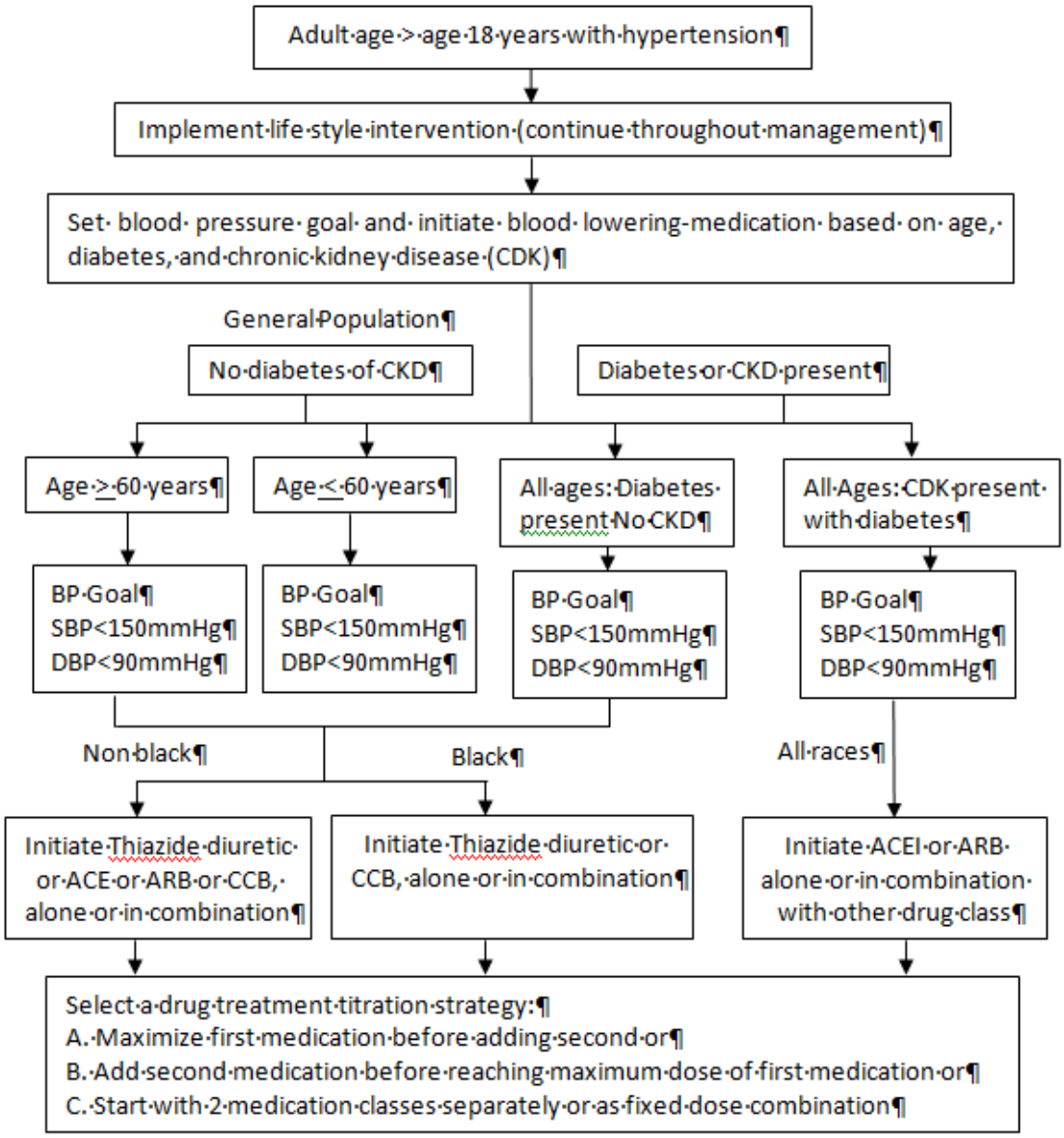

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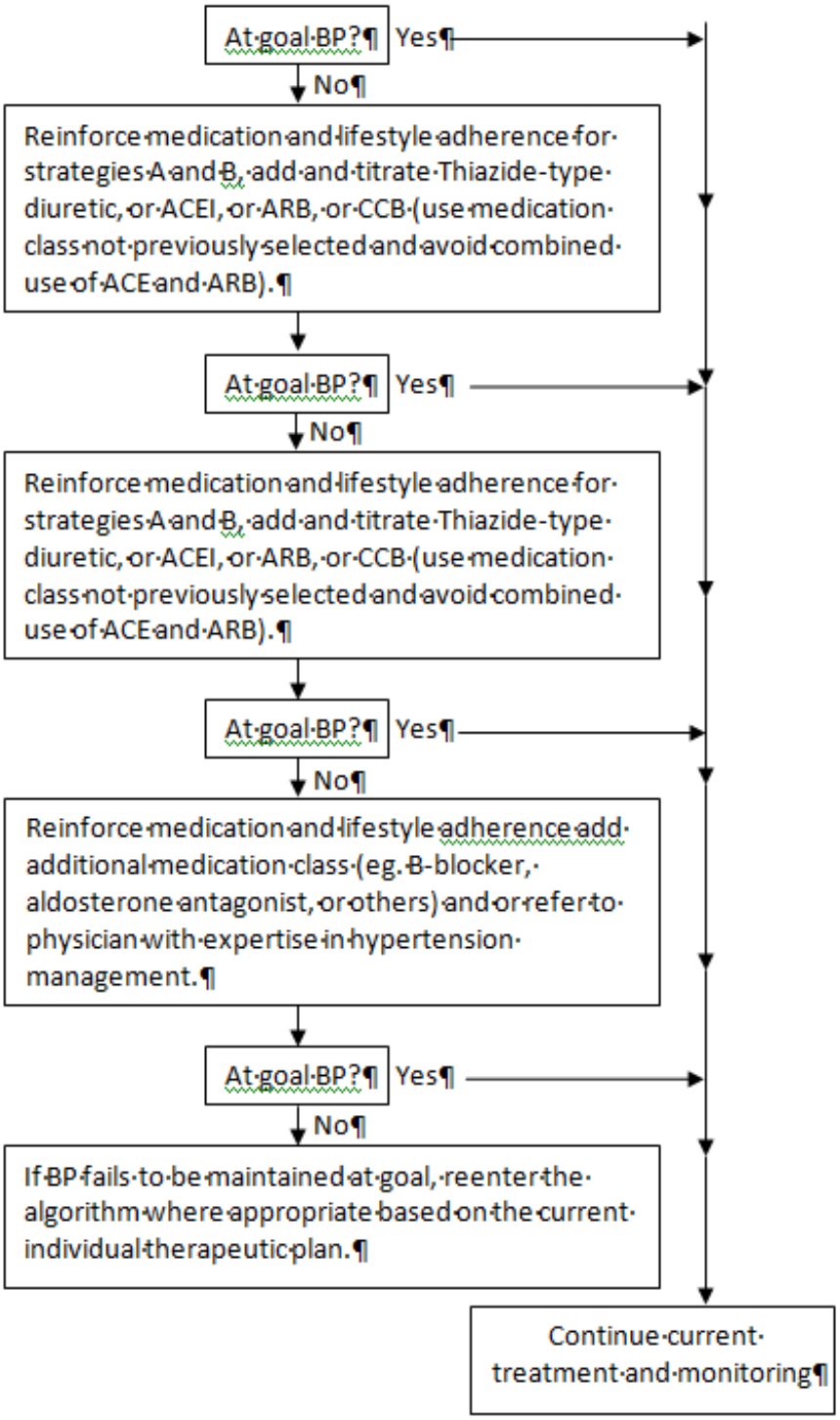
Appendix E. Section 9.2 Continued -- Hypertension Flow Chart



Adapted from JAMA
Dec. 18, 12013

Appendix E, Sec. 10.0 Anti-Epilepsy Drugs (AEDs)

As there is no formula to choose which seizure medication to use for a particular patient, no one medicine dominates for effectiveness, and all have side effects. AEDs are chosen after considering which side effects should be avoided in particular cases, convenience of use, cost and physician experience. An important start is to know which AED works for which seizure type. The narrow spectrum AEDS mostly work for specific types of seizures such as partial, focal or absence, and myoclonic. Broad spectrum AEDS additionally have some effectiveness for a wide variety of seizures.

Table (1)

Generalized	Complex-Partial	Simple Partial	Myoclonic
Carbamezapine	Carbamezapine	Carbamezapine	Carbamezapine
Phenytoin	Phenytoin	Phenytoin	Phenytoin
Valproic Acid	Valproic Acid	Valproic Acid	Tegretal
Felbamate	Felbamate	Tiagabine	Gabapentin
Lamotrigine	Lamotrigine	Levetiracetam	Levetiracetam
Topiramate	Gabapentin	Lamotrigine	Lamotrigine
Primidone*	Primidone		

Monitoring Parameters for AEDs

Table (2)

Drug	Baseline Labs	Annual Labs	Pertinent Warnings
Carbamezapine*	CBC with Platelets ACP, ECG if age > 40	CBC with Platelets ACP	Black box warning Regarding Aplastic Anemia
Phenytoin*	CBC, ACP, ECG > 40	CBC, ACP	
Valproic Acid	CBC with Platelets ACP, PT, INR, PTT	CBC, ACP, PT, INR, PTT	
Lamotrigine			Black box warning Rash including SJS when used with Valproate. Related to ^ dose changes
Topiramate			Warning associated with reduced heat tolerance and ^body temp especially in hot weather

*Phenytoin, Carbamezepine, and Phenobarbital should have therapeutic monitoring of serum concentrations every 3-6 months.

Outcome Measurement

Table (3)

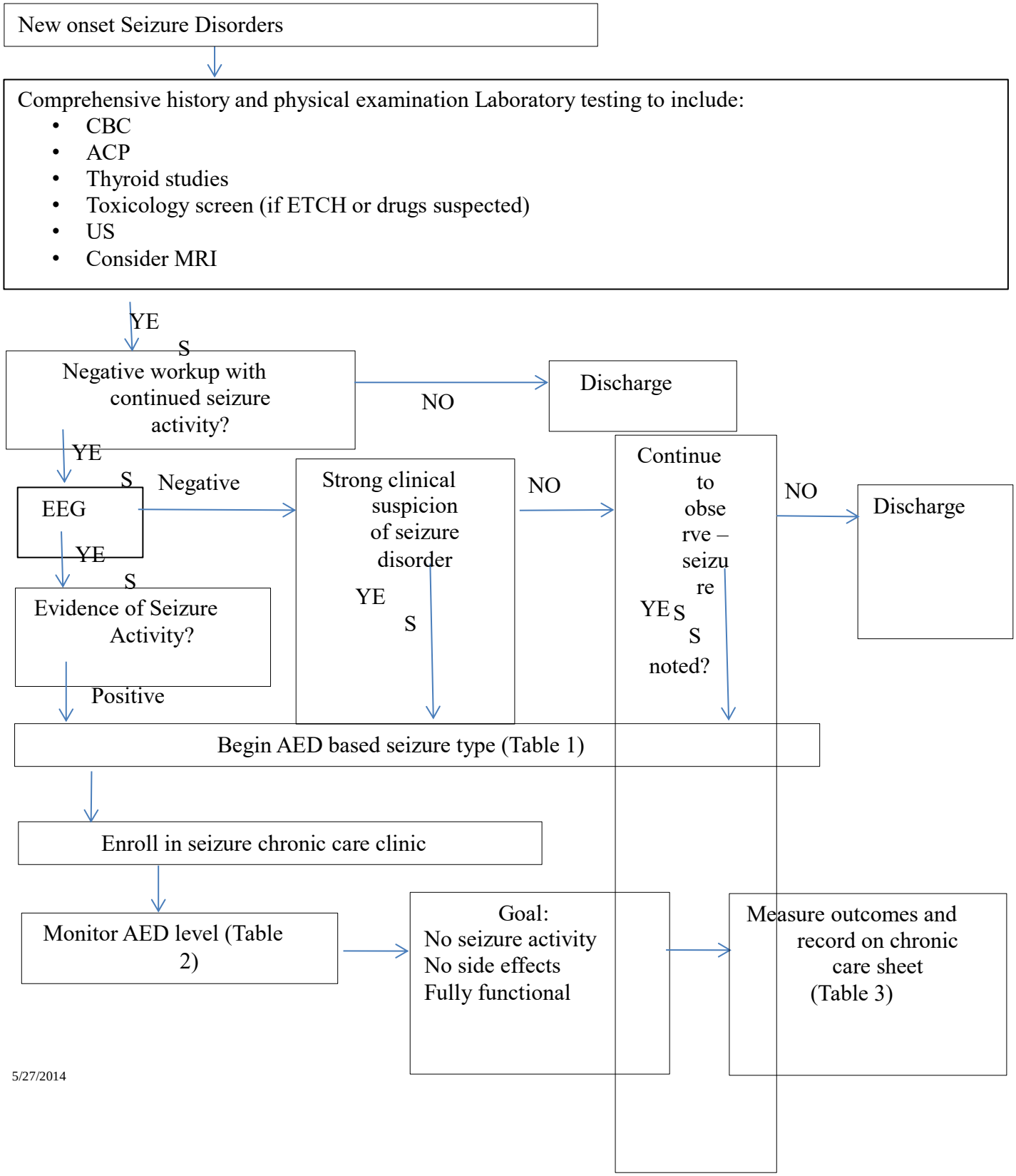
Good Control	Fair Control	Poor Control
No seizure activity since the previous CC visit	One Seizure since the previous CC visit	More than one seizure since the previous CC visit

Status

Improved	Stable	Worsened
Since last CC visit, the number of seizures have diminished.	Since the last CC visit the frequency of seizures have remained the same.	Since the last visit, the number of seizures have increased.

Deciding how to address a first seizure is a complex decision. In adults who have a first seizure, the risk for a second seizure is greater within the first 2-years. Taking anti-epilepsy drugs after the first seizure may reduce the risk of another seizure (2015 guidelines by American academy of Neurology and American Epilepsy Foundation).

Appendix E, Sec. 10.1 Guidelines for the Evaluation and Management of Seizure Disorders


New onset Seizure Disorders
Comprehensive history and physical examination Laboratory testing to include:
• CBC
• ACP
• Thyroid studies
• Toxicology screen (if ETCH or drugs suspected)
• US
• Consider MRI
YE
S
Negative workup with continued seizure activity?
NO
Discharge
YE
S
Negative
EEG
YE
S
Evidence of Seizure Activity?
Positive
Strong clinical suspicion of seizure disorder
YE
S
NO
Continue to obse rve – seizu re
YE S
S
noted?
NO
Discharge
Begin AED based seizure type (Table 1)
Enroll in seizure chronic care clinic
Monitor AED level (Table 2)
Goal:
No seizure activity
No side effects
Fully functional
Measure outcomes and record on chronic care sheet (Table 3)
5/27/2014

Appendix E, Sec. 11.0 Clinical Opiate Withdrawal Scale (COWS)

Ask and Observe	Ask and Observe
Resting pulse rate (record beats/min) measured after pt is sitting or lying down for one minute	Runny nose or tearing not accounted for by cold symptoms or allergies
0-pulse rate 80 or below	0-not present
1-pulse rate 80-100	1-nasal stuffiness or unusually moist eyes
2-pulse rate 101-120	2-runny nose or eyes tearing
4-pulse rate greater than 120	4-nose constantly running or tears streaming down cheeks
Sweating	GI upset over last ½ hr
Over past ½ hr not accounted for by room temperature or patient activity	0-no symptoms
0-no report of chills or flushing	1-stomach cramps
1-subjective report of chills or flushing	2-nausea or loose stools
2-flushed of observable moisture on face	3-vomiting or diarrhea
3-beads of sweat on brow or face	4-multiple episodes of diarrhea or vomiting
4-sweating streaming off face	Tremor-- observation of outstretched hands
Restlessness	0-no tremor
Observation during assessment	1-tremor can be felt but not observed
0-able to sit still	2-slight tremor observed
1-reports difficulty staying still, but is able to do so	4-gross tremor or muscle twitching
3-frequent shifting or extraneous movements of arms and legs	Yawning—observation during assessment
5-unable to sit still for more than a few seconds	0-no yawning
Pupil size	1-yawning once or twice during assessment
0-pupils pinpoint or normal size for light in room	2-yawning 3 or more times during assessment
1-pupils possibly larger than normal for light in room	4-yawning several times per minute
2-pupils moderately dilated	Anxiety or irritability
5-pupils so dilated that only the rim of the iris is visible	0-none

Bone or joint aches	1-pt reports increasing irritability or anxiety
If patient is having pain previously, only the additional component attributed to opiate withdrawal is scored	2-pt obviously irritable or anxious
0-not present	4-pt so irritable or anxious that participation in assessment is difficult
1-mild diffuse discomfort	Piloerection
2-pt reports severe diffuse aching of joints/muscles	0-skin is smooth
4-pt is rubbing joints or muscles and is unable to sit	3-piloerection of skin can be felt or hair standing up on arms
Maximum possible score 48 0-10 Mild	11-24 Moderate 25-48 Severe

(6/5/14)

Appendix E, Sec. 11.1 Clinical Institute Withdrawal Assessment-Alcohol revised (CIWA- r)

ASK and OBSERVE

Nausea and vomiting

0-no nausea and no vomiting
1-mild nausea with no vomiting
2
3
4-intermittent nausea with retching
5
6
7-constant nausea, frequent retching and vomiting

Tremor-Arms extended and fingers spread apart

0-notremor
1-not visible, but can be felt fingertip to fingertip
2
3
4-moderate with patient's arms extended
5
6
7-severe, even with arms not extended

Paroxysmal sweats

0-no sweat visible
1-barely perceptible sweating, palms moist
2
3
4-beads of sweat obvious on forehead
5
6
7-drenching sweats

ASK and OBSERVE

Agitation

0-normal activity
1-somewhat more than normal activity
2
3
4-moderately fidgety and restless
5
6
7-paces, or thrashes about most of the interview

Tactile disturbances: feelings of itching, pins & needles, burning, numbness or bugs crawling on or under skin

0-none
1-very mild itching, pins &needles, burning or numbness
2-mild itching, pins & needles, burning or numbness
3-moderate itching, pins & needles, burning or numbness
4-moderately severe hallucinations
5-severe hallucinations
6-extremely severe hallucinations
7-continuous hallucinations

Auditory disturbances: harsh or frightening sounds, hearing imaginary sounds

0-not present
1-very mild harshness or ability to frighten
2-mild harshness or ability to frighten
3-moderate harshness or ability to frighten
4-moderately severe hallucinations

Anxiety

0-no anxiety, at ease

Clinical Institute Withdrawal Assessment-Alcohol revised (CIWA- r) continued

ASK and OBSERVE

Nausea and vomiting

1-mildly anxious

2

3

4-moderately anxious, or guarded, anxiety is inferred

5

6

7-equivlent to acute panic states as seen in severe delirium or acute schizophrenic reactions

Headache, fullness in head

0-not present

1-very mild

2-mild

3-moderate

4-moderately severe

5-severe

6-very severe

7-extremely severe

5-severe hallucinations

6-extremely severe hallucinations

ASK and OBSERVE

Agitation

7-continuous hallucinations

Visual disturbances: light sensitivity seeing things that isn't there

0-not present

1-very mild sensitivity

2-mild sensitivity

3-moderate sensitivity

4-moderately severe hallucinations

5-severe hallucinations

6-extremely severe hallucinations

7-continuous hallucinations

Orientation and clouding of sensorium

0-oriented and can do serial additions

1-cannot do serial additions or is unclear about dates

2-disoriented for date by no more than two calendar days

3-disoriented for date by more than two calendar days

4-disoriented for place and/or person

Maximum Possible Score 67: 0-9 Mild; 10-19 Moderate; 20-67 Severe

6/5/14

Appendix E, Section 11.2

Benzodiazepine Withdrawal Scale for Corrections (BWS-C)

ASK and OBSERVE

Appears irritable
0-not at all 1 2 3 4 very much so

Appears fatigued
0-not at all 1 2 3 4 unable to function

Appears tense
0-not at all 1 2 3 4 very much so

Appears to have difficulty concentrating
0-not at all 1 2 3 4 unable to concentrate

Fails to finish their meals because of loss of appetite, nausea or vomiting
0-not at all 1 2 3 4 no appetite unable to eat

Do you have numbness or burning on face, hands or feet?
0-not at all 1 2 3 4 intense burning/numbness

Is your heart racing (palpitations)?
0-not at all 1 2 3 4 constant palpitations

Does your head feels full or achy?
0-not at all 1 2 3 4 severe headache

Do you feel muscle aches or stiffness?
0-not at all 1 2 3 4 severe stiffness or pain

Do you feel anxious, nervous or jittery?
0-not at all 1 2 3 4 very much so

Appears upset
0-not at all 1 2 3 4 very much so

Do you have any nightmares?
0-not at all 1 2 3 4 not at all restful

Maximum possible score 80
0-2 Mild 21-40 Moderate 41-80 Severe

ASK and OBSERVE

Do you feel weak?
0-not at all 1 2 3 4 very much so

Did you get enough sleep last night?
0-very much 1 2 3 4 not at all

Do you have any visual disturbances? (sensitivity to light/blur vision
0-not at all

1 2 3 4 very sensitive to light/blur vision

Are afraid of anything?
0-not at all 1 2 3 4 very much so

Are you worried about possible misfortunes lately?
0-not at all 1 2 3 4 very much so

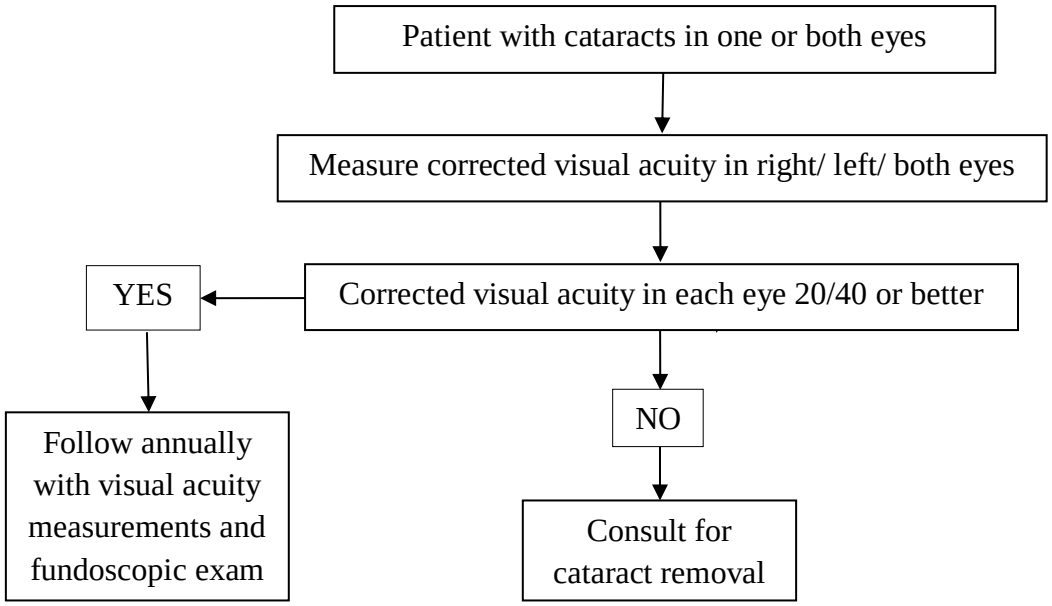
Observe behavior for restlessness
0-not at all
1 2 restlessness 3 4 paces back & forth

Observe tremor
0-no tremor
1 not visible, can be felt in fingers
2 visible but mild
3 moderate with arms extended
4 severe even with arms not extended

Observe for sweating feel palms
0-no sweating visible
1-barely perceptible sweating,
2-palms & forehead moist, armpit sweating
3-beads of sweat visible on forehead
4-severe drenching sweats

6/5/14

Appendix E, Sec. 12.0 Guidelines for the Evaluation and Treatment of Cataracts



Appendix E, Sec. 13.0 Substance Abuse

SUBSTANCE ABUSE

Moderate Alcohol withdrawal Close Observation (INFIRMY) IF:		Barbiturate Withdrawal	
Risk of withdrawal, injury and/suicide		Although tolerance develops to sedative and euphoric	
Patient risk of medical problems, occult trauma		effects of barbiturates, little tolerance develops to	
Medical intervention is indicated		Respiratory depression.	
Add sedatives:		Due to the potential severity of barbiturate WD, a low	
Lorazepam (Ativan) or Diazepam (Valium) for 3 days		Threshold should exist for hospital admission.	
or longer		Valproic acid (Depakote) may increase PB levels	
Dosages based on patient history, symptoms and substance used.		Betablockers and clonidine will mask barbiturates WD symptoms	
Severe Alcohol Withdrawal ER transfer is required		Meprobamate itself can be used to detoxify inmate.	
Consider ER transfer for any patient if:			
Urgent or level of care beyond site's capability		Barbiturate Early withdrawal Symptoms	
Significant dehydration	Significant injury	Increased pulse and/BP	Restlessness
Status Epilepticus		Anxiety	Apprehension
		Panic attacks	Uneasiness
Benzodiazepine and Opioid withdrawal General			
See plan above		Barbiturate Mild to Severe Withdrawal Symptom	
Treatment is individualized		Tremor	Muscular weakness
Meds are based on reported and observed symptoms		Fever	Coarse tremor
		Diaphoresis	Postural hypotension
Benzodiazepine Withdrawal		Insomnia	Anorexia
Varies on the half-life of substance abused		Diarrhea	Vomiting
Symptoms similar to that of alcohol withdrawal		Myoclonic jerks	
Mild Benzo Withdrawal (BWS-C-20)		Barbiturate Late Withdrawal Symptoms (In hospital care)	
Increased pulse and blood pressure		Changes in consciousness-delirium days 314	
Anxiety	Restlessness	Profound agitation	Autonomic instability
Panic attacks	GI upset	Hallucinations	Grand mal seizures days 28
Moderate Benzo withdrawal (BSW-C-21-40)		Opioid Abuse Withdrawal	
In addition to the above, may progress to include:		May last for days to weeks	
Tremor	Insomnia	Goal is to reduce symptoms of withdrawal.	
Fever	Anorexia	Withdrawal from opioids is very unpleasant.	
Diaphoresis	Diarrhea	Pregnant women may need maintenance therapy	
		Consider referral to high risk OB care	

Severe Benzo Withdrawal (BWS-C41-80)			
Requires Medical Intervention		Mild Opioid Withdrawal (COWS0-10)	
Delirium with hallucinations Autonomic instability		Rhinorrhea	Yawning
Changes in consciousness	Seizures	Diaphoresis	Dilated Pupils
Profound agitation	Death	Lacrimation	Increased body temp
Barbiturate Withdrawal		Moderate Opioid Withdrawal (COWS 11-24)	
Use CIWAar scale		Requires Medical Intervention:	
Symptoms and severity are essentially identical to those of Alcohol and Benzo.		Anorexia Nausea	Increased BP and pulse Agitation
Unlike Benzo, barbiturates have a very narrow therapeutic		Vomiting	Restlessness
margin, above which toxicity and respiratory depression quickly develop		Diarrhea	Severe muscle and bone pain
		Piloerection	Tremors
		Severe Opioid Withdrawal (COWS 25-48)	
		Increasing severity of moderate symptoms	

Appendix E, Sec. 14.0 Substance Withdrawal

General

- Alcohol withdrawal syndrome symptoms may occur before the patient starts to withdraw from other substances
- Onset of clinical symptoms usually begin 8-24 hrs after last drink
- Tremulousness usually starts first
- Severe withdrawal symptoms, whether from alcohol, benzodiazepines or opioid drugs requires infirmary or ER placement based on NCCHC guidelines
- Symptoms peak at 24 hrs and usually last 4-5 days
- Fevers (T>100.4) are not generally normal in withdrawal

Physical Signs of Intoxication

- Ataxia
- Dizziness
- Vomiting and/or dry heaves
- Sluggish reflexes
- Decreased motor coordination
- Decreased respirations and pulse (increase rates in withdrawal)
- Lowered blood pressure (BP tends to increase in withdrawal)

Mild Alcohol Withdrawal (CIWA-AR 0-9

- Tremors felt in fingers
- Moist palms, mild sweating
- Mildly anxious, fidgety or restless
- Mild nausea, no vomiting
- Mild headache
- Light sensitivity or visual changes
- Mild itching, pins and needles/needles, burning or numbness

Moderate Alcohol Withdrawal (CIWA 10-19)

- Tremors visible
- Beads of sweat visible on forehead
- Moderately anxious, fidgety or restless
- Intermittent nausea, dry heaves or vomiting
- Tactile hallucinations, moderate (skin crawling)
- Auditory or visual hallucinations
- Visual hallucinations more common than auditory

- Moderately severe headache
- Elevated pulse and blood pressure

Assessment Scales

- Alcohol-Use CIWA-Ar
- Mixed-Use CIWA- Ar
- Benzo-Use BWS-C
- Opioid-Use COWS

Severe Alcohol Withdrawal (CIWA 20-67)

- Typically begins 2-5 days after last drink
- Can occur while still drinking or as late as two weeks after stopping
- Symptoms can last as long as five days
- Requires close pharmacological management and management of dehydration and electrolytes
- Mental status changes: disorientation, confusion, delusions and hallucinations
- Severe tremors
- Drenching sweats
- Agitation and panic, unable to sit still
- Constant nausea, vomiting and dry heaves

Goals

- Avoid self-harm or harm to or from others
- Clinical stability without worsening of co-morbid conditions (HTN, seizures, cardiac, etc.)
- Maintain hydration
  - Depends on hydration status when arrested
  - Dehydration may take 24-48 hrs to develop
  - By day 4-5, intake should be returning to normal

Special Considerations

- Suicide assessment
- Occult head injury
- Diabetes: Agitation, tremors, anxiety, and nausea can be signs of withdrawal or hypoglycemia
- Lower bunk/lower tier

Withdrawal Seizures

- Increased risk with history of heavy or daily alcohol intake for greater than 5 yrs
- About 10 % of patients will experience a seizure
- Past occurrence increases future risk
- Seizures occurring while on Benzodiazepines for withdrawal may require increased dosing of Benzodiazepines or adding an anticonvulsant
- Seizures lasting longer than 5 minutes (Status Epilepticus) require prompt ER transfer

Plan Regardless of Substance Used

- Fingerstick blood sugar
- Pregnancy test if applicable
- Encourage aggressive hydration
- Feed patient if P.O. is tolerated
- Vitamin supplementation
- Multi-vitamin, Thiamine, & Folic Acid
- Consider Thiamine before glucose for alcohol withdrawal
- Antacids prn
- Antiemetic prn

- Antidiarrheal prn

Mild At Risk of Alcohol withdrawal-continue to assess

- Alert and oriented x3
- No injury or trauma
- No medical problems
- Occasional user, under influence when arrested

Appendix E, Sec. 15.0 Treatment Guidelines for Myasthenia Gravis

- Current and emerging therapies for the treatment of Myasthenia Gravis
- Myasthenia gravis (MG) is an autoimmune disease in which auto antibodies to different antigen of the neuromuscular junction cause the typical weakness and fatigability. It is characterized by fluctuating muscle weakness and fatigability on exertion. MG is a chronic disorder, can be extremely severe, but is a treatable disease. Treatment includes anticholinesterase drugs, immunosuppression, immunomodulation, and thymectomy. The autoimmune response is maintained under control by corticosteroids frequently associated with immunosuppressive drugs, with, with improvement in the majority of patients. In case of acute exacerbations with bulbar symptoms or repeated relapses, modulation of antibody activity by plasmapheresis or IV immunoglobulins provide rapid improvement. Recently, techniques removing only circulating immunoglobulins have been developed for the chronic management of treatment-resistant patients. The rationale for thymectomy relies on the central role of the thymus. Despite the lack of controlled studies, thymectomy is recommended as an option to improve the clinical outcome or promote complete remission. New videothoracoscopy techniques have been developed to offer the maximum surgical approach with minimal invasiveness and hence patient tolerability. The use of biological drugs such as anti CD20 antibodies is still limited but promising. Studies performed with animal model of MG demonstrated several more selective or antigen-specific approaches ranging from mucosal tolerazation to inhibition of complement activity or cellular therapy might be feasible. Investigation of the transfer of these therapeutic approaches to human disease will be the challenge for the future.
- Treatment of Myasthenia Gravis (MG)
  Effectiveness of treatment in MG must rely on definite outcomes as was clearly defined by the Myasthenia Gravis of America Task Force in 2000. The ultimate goal is to achieve complete stable remission, defined as no myasthenia gravis symptoms or signs without any on-going treatment for at least 1 year.
- Drugs used in the treatment of Myasthenia Gravis:
  Oral acetylcholinesterase (AChE) inhibitor is the first-line treatment for MG. They are symptomatic drugs improving neuromuscular transmission by prolonging the availability of Ach at the neuromuscular junction (NMJ) and do not interfere with the immune process that cause and perpetuate MG. AChE inhibitors have a short-term benefit due to their short half-life. Pyridostigmine bromide (PB) is the most commonly used AChE inhibitor.
- PB is available as:
  An oral standard tablet, dose 60 mg; this is the most commonly used preparation.

  A sustained-release preparation (180 mg); usually prescribed at bedtime for patients Symptomatic during the night or in early morning.

  PB is also available for IM or IV administration. Parenteral administration is useful when patients cannot take therapies orally. Significant, sometimes fatal cardiac arrthymias can occur with IV administration; hence IM administration should be preferred.

- Other AChE inhibitors:
  Neostigmine is an analog of PB and can be administered orally. Compare with PB, Neostigmine has a shorter action, is less effective and more frequently cause muscarinic side effects.
- Conventional and emerging therapies able to interfere with immunopathogenetic processes underlying MG comprise the following:

  Steroids

  Oral steroids are widely used in MG and are recommended as first-choice drug when immunosupression is required.

  A variety of steroids has been used in the treatment of MG: the most commonly used is PREDNISONE because of its potent immosuppressive activity and half-life compatible with an alternate-day schedule.

  The initial dose for treatment of generalized MG is 1 mg/kg/day. Patient with moderate-to-severe generalized MG are usually hospitalized to initiate steroid therapy because of the risk of a drug-induced exacerbation of the disease; exacerbation may start within the first two weeks of steroid treatment and may be extremely severe
- Immunosuppressants
  Several immunosuppressive drugs are used in the treatment of MG. They can be used as single drugs, as an alternative therapy to steroids or in combination with corticosteroids.

  Azothioprine (AZA) is the most frequently used immunosuppressive drug for MG, because of its preferential effect on T cell replication. The daily dose is 2-3 mg/kg/day. It is generally well tolerated but liver and bone marrow toxicity is not infrequent.

  Cyclosporine (CYA) is effective but its use is hampered by the onset of hypertension and nephrotoxicity. CYA is considered third-line therapy and should be used only in patients intolerant or unresponsive to other immunosuppressives; monitoring of kidney function and blood pressure is necessary.

  There are newer immunosuppressives drugs that may have some benefit as second-line immunosuppressive therapy, although these have not been supported by recent systematic review.

References NIH

Appendix E, Sec. 16.0 Management of Patients with Multiple Sclerosis

Multiple Sclerosis is a debilitating neurological disorder that affects nearly 2 million adults, mostly in the prime of their youth. An environmental trigger, such as a viral infection, is hypothesized to initiate the abnormal behavior of host immune cells; to attack and damage the myelin sheath surrounding the neurons of the central nervous system. While several other pathways and disease triggers are still being investigated, it is nonetheless clear that MS is a heterogeneous disease with multifactorial etiologies that works independently or synergistically to initiate the aberrant immune responses to myelin. Although there are still no definitive markers to diagnose the disease or cure the disease per se, research on management of MS has improved many fold over the past decade. New disease-modifying therapeutics are poised to decrease immune inflammatory responses and consequently decelerate the progression of MS disease activity, reduce the exacerbations of MS symptoms and stabilize the physical and mental status of individuals.

MS Therapeutics involves treatment using disease modifying therapeutics (DMT) and immunomodulating agents.

Primary immunomodulating therapeutics:

- Goal of MS is to reduce relapses and postpone progression of disability.
- Short term treatment to help reduce the accumulation of disease burden after an acute relapse.
- Sustained treatment aimed at stabilizing the disease process.
- Long term disease management is largely directed toward suppressing the immune inflammatory response that promote demyelination and neuronal degradation in an effort to prevent any significant changes in the status of patients.

CURRENTLY APPROVED MULTIPLE SCLEROSIS DISEASE-MODIFYING THERAPEUTICS (DMT)

DMT	Route of admin	Frequency	Dosage	Common side effects	Severe adverse Effects
Interferon beta 1b	subcut. inj.	Every other Day	250 mcg	Flu-like symptoms, urticaria, depression, injection-site reactions, leukopenia, headache	Hepatic injury CHF, seizures
Interferon beta 1a	IM inj.	Once/wk	30 mcg	Flu-like symptoms, urticaria, fever, myalgia	Hepatic injury, depression, anemia, CHF, anaphylaxis
Glatiramer	subcut. Inj.	Daily	20 mg	Injection-site reactions, palpitations, urticaria, dyspnea, chest pain	Injection site lipoatrophy and necrosis
Interferon beta 1a	subcut. Inj.	3x/wk	22 mcg 44 mcg	Influenza-like symptoms, depression, injection-site reactions, urticaria, myalgia, fever, abdominal pain, elevated liver enzymes	Hepatic injury, anaphylaxis
Natalizumab	IV infusion	Q 4 wks	300 mg	H/A, UTI, lung infections, abdominal pain, fatigue joint pain, depression gastroenteritis, urticaria arthralgia	PML, anaphylaxis hepatoxicity
Fingolimod	PO capsule	Daily	.5 mg	H/A, influenza, GI discomfort, back pain, angina abnormal LFTs	Macular edema, bradyarrthymia, PML, hypotension
Teriflunomide	PO capsule	Daily		Dyspnea, HTN, GI discomfort, leukopenia, urticaria, alopecia, paresthesia	Hepatoxicity, peripheral neuropathy, ARF
Dimethyl	PO capsule	2x/d	120 mg	GI disorders	Lymphopenia
Fumarote			240 mg	(abd. Pain, diarrhea etc) Flushing, pruritis, rash, erythema	

References: NIH; Rocky Mountain Research Group, Salt Lake City, UT

Appendix E, Sec. 17.0 Treatment Guidelines for Parkinson's Disease

- Parkinson's disease (PD) is a neurodegenerative disease that usually affects persons over age 50, and is the result of the loss of dopamine-producing brain cells. The main symptoms of PD are tremor, rigidity, bradykinesia and postural instability. Other symptoms may include emotional changes such as depression; difficulty swallowing, chewing, and speaking; urinary problems or constipation; skin problems; and sleep disruption. Symptoms severity occurs gradually, increasing more rapidly in some persons than others. As PD progresses, symptoms may interfere with activities of daily living (ADLS).
- Risk Factors and Diagnosis: The biggest risk factor for PD is advancing age. In addition, persons who have a parent or sibling with PD have an approximate double risk for developing the disease. As there are no specific tests for diagnosing PD, diagnosis is determined when at least two primary symptoms are confirmed on a neurological exam. A careful medical history should be obtained, including past exposure to medications that can block dopamine function in the brain (certain antipsychotics.
- Drugs used in Parkinson's disease: The recent advances in the treatment of Parkinson's disease have made for significant improvements in the quality of life and mortality rate of those who suffer from this neurodegenerative disease. At the same time, the number of options and the complexity of multi-drug regimens have posed a great challenge for clinician caring for patient with PD.
- In patients requiring treatment in the early stages of the disease, especially with predominance of tremor, Anticholinergics or Amantadine should be considered initially. It would also be reasonable to add Selegiline for both therapeutic and possibly neuroproctective effects. As patients become more affected by the disease and additional therapy is necessary, starting with either a Dopamine agonist (e.g., Bromocriptine) or Levodopa would be a rational choice with continuation of Selegiline and possibly Amantadine for neuroprotective reasons. Titration in Levodopa therapy (controlled-release or standard Levodopa) to higher levels necessitates the addition of a Dopamine receptor agonist if one has not been started previously.
- If a patient is receiving only a Dopamine receptor agonist and is becoming progressively disabled, Levodopa should be added to the regimen.
- Fluctuations in motor abilities may be improved further by the use of a COMT (Catechol-o-methyltransferase) inhibitor (Entacapone) with each dose of L-Dopa.
- Patients with uncontrollable motor fluctuations should be considered for surgery.

References: Consultant 360 Journal Vol 13l 2005; NIH; National Hospital for Neurology and Neurosurgery

Appendix E, Sec. 18.0 Evaluation and Management of Coccidioidomycosis (Valley Fever)

- Evaluation and Management of Coccidioidomycosis (Valley Fever)
- Coccidioidomycosis (also known as valley fever) results from inhaling the spores of Coccidioides species. Most infection in the United States are acquired within the major regions of southern Arizona, central or other areas of California, southern New Mexico, and West Texas. Travelers who have recently visited the region of endemicity or previously infected patients with immunosuppression who experience reactivation of latent infections can develop clinical disease and require medical management outside of the region of coccidioidal endemicity.
- The most common clinical presentation of coccidioidomycosis is a self-limited acute or subacute community-acquired pneumonia that becomes evident 1-3 weeks after infection. Such illnesses are usually indistinguishable from bacteria or other infections without specific laboratory tests such as fungal cultures or coccidioidal serological testing. For such patients, symptoms--especially fatigue interfering with normal activities—may last for weeks to many months. Approximately 5%-10% of infections result in residual pulmonary sequelae, usually nodules or peripheral thin-walled cavities. An even smaller proportion of all infections result in illnesses related to chronic pulmonary or extrapulmonary infection.
- Management of coccidioidomycosis first involves recognizing that a coccidioidal infection exists, defining the extent of the infection, and identifying host factors that predispose to disease severity. After these assessments, patients with localized acute pulmonary infections and no risk factors for complications often require only periodic reassessment to demonstrate resolution of their self-limiting process. On the other hand, patients with extensive spread of infection or who are at high risk of complications because of immunosuppression or other preexisting factors require a variety of treatment strategies that may include antifungal drug therapy, surgical debridement, or a combination of both.
- MEDICATIONS: Azole antifungals, primarily Fluconazole and Itraconazole, have replace Amphotercin B as initial therapy for most chronic pulmonary or disseminated infections. Amphotercin B is now reserved for patients with respiratory failure due to infection with Coccidioides species, those with rapidly progressive coccidioidal infections, or women during pregnancy. Therapy often ranges from many months to years in duration, and in some patients, lifelong suppressive therapy is needed to prevent relapse.
- MANAGEMENT OF CLINICAL ENTITIES
- Primary Respiratory infection: Most frequently manifest as community acquired pneumonia 1-3 weeks after exposure.
- How best to manage primary respiratory cocci. Infection is an unsettled issue because of lack of prospective controlled trials.

Initiate therapy for:

- Patients who are immunocompromised (HIV, organ transplant recipient, patients on dose corticosteroids, therapy with TNF such as Entercept)

- Patients with co-morbid conditions such as Diabetes, Cardiopulmonary diseases.
- Primary infection during pregnancy especially third trimester.

References: Valley Fever Center for Excellence University of Arizona, Mayo Clinic

Appendix E, Sec. 19.0 Management of End Stage Liver Disease

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function as part of normal physiology. Generally, liver damage from cirrhosis cannot be reversed, but treatment could stop or delay further progression and reduce complications. In patients with previous stable cirrhosis, decompensation may occur due to various causes such as constipation, infection, increase alcohol intake, medications, bleeding esophageal varices or dehydration. Patients with decompensated cirrhosis generally require hospital admission.

COMPLICATIONS OF CIRRHOSIS: There are major complications of cirrhosis:

ASCITES - Most common of the major complications. Approximately 50% of patients with "compensated" cirrhosis develop ascites and is the most common that leads to hospital admission. Approximately 1500 mL of fluid must be present before flank dullness is detected. An abdominal ultrasound may be required to determine with certainty if fluid is present. Ascites usually is present for only a few weeks before the patient seeks medical attention. In contrast, a slowly enlarging abdomen over months to years is most likely due to obesity and not ascites. Abdominal paracentesis with appropriate ascetic fluid analysis is probably the most rapid and cost-effective method of diagnosing the cause of ascites. In addition, abdominal paracentesis can provide significant therapeutic benefit to the patient.

TREATMENT RECOMMENDATIONS FOR ASCITES: Appropriate treatment of patients with ascites depends on the cause of the fluid retention. The mainstays of treatment of patients with cirrhosis and ascites include:

(a) Avoidance of alcohol,
(b) Education regarding dietary sodium restriction,
(c) Oral Diuretics. Diuretic options include aldosterone antagonist (Spironolactone) and loop diuretics (Furosemide) beginning with 40 mg of the former and 100 mg of the latter.

The doses of both oral diuretics can be increased simultaneously every 3-5 days (maintaining 40:100mg ratio) if weight loss and diuresis are inadequate. Maximum dosages are 400mg/day Spironolactone and 160mg/day of furosemide.

ESOPHAGEAL VARICES - Cirrhosis, the end stage of any chronic liver disease, can lead to portal hypertension. Portal pressure increases initially as a consequence of an increased resistance to flow mostly due to architectural distortion of the liver secondary to fibrous tissue and regenerative nodules. Gastroesophageal varices is the most relevant portosystemic collaterals because their rupture results in variceal hemorrhage, the most common lethal complications of cirrhosis. The gold standard in the diagnosis of varices is esophagogastroduodenoscopy (EGD). EGD SHOULD BE PERFORMED ONCE THE DIAGNOSIS OF CIRRHOSIS IS ESTABLISHED. In patients with compensated cirrhosis who have no varices on screening endoscopy, the EGD should be repeated in 2-3 yrs. In those who have small varices, the EGD should be repeated in 1-2 yrs. In the presence of decompensated cirrhosis, EGD should be repeated at yearly intervals. EGD is expensive and usually can be avoided in patients with cirrhosis who are already on a nonselective B-blocker for other reasons.

TREATMENT RECOMMENDATIONS FOR ESOPHAGEAL VARICES:

- In patients with cirrhosis who DO NOT have varices, non-selective B-blockers CANNOT be recommended to prevent their development (Class III, Level B).
- In patients with cirrhosis and small varices that have not bled but have criteria for increased risk of hemorrhage (Child/Pugh B/C* or presence of red wale marks on varices per endoscopy) nonselective B-blockers should be used for prevention of first variceal hemorrhage (Class II a, Level C).
- In patients with small varices that have not bled and have no criteria for increased risk of bleeding, B-Blockers can be used, although their long term benefit has not been established.
- In patients with medium/large varices that have not bled but have a high risk of hemorrhage, (Child B/C), nonselective B-blockers Propranolol or Nadolol or ENDOSCOPIC VARICEAL LIGATION (EVL) may be recommended for the prevention of first variceal hemorrhage (Class I, Level A).
- In patients with medium/large varices that have not bled and are not at the Highest risk of hemorrhage (Child /Pugh A), nonselective B-blockers are preferred and EVL should be considered in patients with contraindications or intolerance or non-compliance to B-Blockers. Patients on nonselective B-blocker therapy should have the dose adjusted to the maximum tolerated dose.
- Patients with cirrhosis who survive an episode of active variceal hemorrhage should receive therapy to prevent recurrence of variceal hemorrhage (secondary therapy). Combination of nonselective B-blockers plus (EVL) is the best option for secondary prophylaxis of variceal hemorrhage. The nonselective B-blocker should be adjusted to the maximum tolerated dose. EVL should be repeated.
- Transjugular Intrahepatic Portosystem Shunting (TIPS) should be considered in patients who are Child-Pugh A or B who experience recurrent variceal hemorrhage despite combination pharmacological and endoscopic therapy.

HEPATIC ENCEPHALOPATHY—Syndrome observed in patients with cirrhosis. It is characterized by personality changes, intellectual impairment, and depressed level of consciousness. It is not clear as to the exact cause of hepatic encephalopathy. It is theorized that neurotoxic substances, including ammonia and manganese, may gain entry into the brain in the setting of liver failure. Ammonia has multiple neurotoxic effects but may not be the only cause of hepatic encephalopathy.

TREATMENT RECOMMENDATIONS FOR HEPATIC ENCEPHALOPATHY:

- Most current therapies are designed to treat the hyperammonemia that is a hallmark of most cases of hepatic encephalopathy.
- Treatment options include rifaximin or lactulose.
  In the 20th century, low protein diets were routinely recommended for patients with cirrhosis, in hopes of decreasing intestinal ammonia production and thus prevent exacerbation of hepatic encephalopathy. Recent studies show that this assumption is incorrect, and high protein foods are even encouraged to maintain adequate nutrition.

SPONTANEOUS BACTERIAL PERITONITIS (SBP)—The diagnosis of SBP is made when there is a positive ascitic fluid bacterial culture and an elevated ascetic fluid absolute PMN count. Risk factors for the development of SBP include variceal hemorrhage and prior episode of SBP.

TREATMENT RECOMMENDATIONS FOR SBP: Patients who have survived an episode of SBP should receive long-term prophylaxis with daily Norfloxacin (or Trimethoprim/Sulfamethoxazole) because this is the most data-supported indication for long-term outpatient prophylaxis.

Intermittent dosing of antibiotics to prevent SBP may be inferior to daily dosing due to the development of bacterial resistance, thus daily dosing is preferred.

Hepatocellular Carcinoma - More common in patients with cirrhosis. Patients with known cirrhosis are screened intermittently for early signs of liver cancer:

(a) Asian men over 40
(b) Asian women over 50
(c) Patients with HBV and cirrhosis
(d) African and American blacks
(e) These patients are screened every 6 months with abdominal ultrasound, AFP and or abdominal CT.

Table 1. Child-Pugh Classification of the Severity of Cirrhosis*

Points*	1	2	3

Encephalopathy	None	(or precipitant-induced)	Grade1-2 (Chronic)	Grade 3-4
Ascites	None	Mild/Moderate	Tense	
Bilirubin (mg/dL)	<2		2-3	>3
Albumin (g/dL)	>3-5		2.3-3.5	<2.8
PT (sec prolonged or INR)	<1.7	<4 1.7-2.3	4-6 >2.3	>6

*5-6 points: Child A; 7-9 points: Child B; 10-15 points: Child C

Reference: American Association for the Study of Liver Diseases Practice Guidelines 2014

Appendix E, Sec. 20.0 Evaluation and Management of Hyperlipidemia

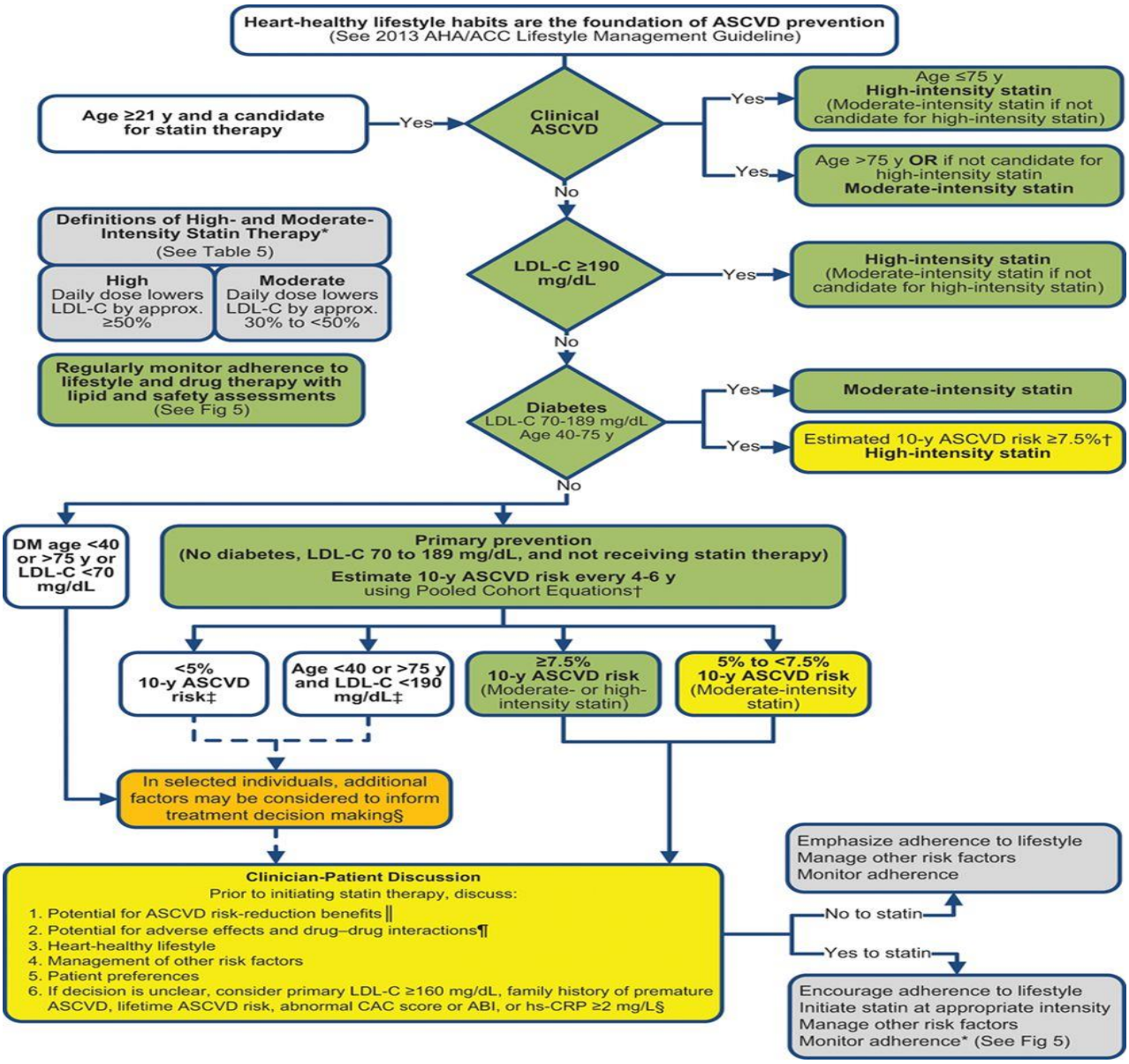


Figure5/Table 5

High intensity statin therapy	Moderate intensity statin therapy	Low intensity statin therapy
Lowers cholesterol by > 50%	Lowers cholesterol by 30-50%	Lowers cholesterol by 30%
Atorvastatin 40-80Mg/day	Atorvastatin 10-20mg/day	Simvastatin 10mg/d
Rosuvastatin 20-40mg/d	Rosuvastatin 5-10mg/d	Pravastatin 10-20mg/d
	Simvastatin 20-40mg/d	Lovastatin 20mg/d
	Pravastatin 40-80mg/d	Fluvastatin 20-40mg/d
	Lovastatin 40mg/d	Pitavastatin 1mg/d
	FluvastatinXL 80mg/d	
	Fluvastatin 40mg twice/d	
	Pitavastatin 2-4mg/d	

Risks factors for adverse effects from statin (consider lower intensity therapy)

- Multiple or serious comorbidities, including impaired kidney function
- History of previous statin intolerance or muscle disorders
- Unexplained ALT elevations >3 times upper limit of normal
- Patients characteristics or concomitant use of drug affecting statin metabolism
- Age > 75 years of age
- History of hemorrhagic stroke Asian ancestry

MONITORING STATIN THERAPY

- Cholesterol:
  - Recheck cholesterol 4-12 weeks after starting therapy. If response is appropriate (≥ 50% reduction with high intensity therapy or 30-50% with moderate intensity therapy), then check in 3-12 months.
- Liver Function Tests:
  - Baseline ALT should be measured before starting therapy.
  - During statin therapy, it is reasonable to measure hepatic function if symptoms suggesting hepatotoxicity arise (e.g., unusual fatigue, loss of appetite, abdominal pain).
- Muscle Toxicity:
  - CK should NOT be routinely measured
  - Baseline measurements of CK is reasonable for individuals believed to be at increased risk for adverse muscle events based on personal or family history of statin intolerance or muscle disease, clinical presentation, or concomitant drug therapy that might increase the risk for myopathy.
    During statin therapy, it is reasonable to check CK in patients with muscle symptoms, including pain, tenderness, stiffness, cramping, weakness, or generalized fatigue.
  - Managing Myalgias (muscle pain)
  - Discontinue statin. If symptoms resolve, retry statin to develop a causal relationship.
  - If causal relationship exists, discontinue original statin. Once muscle symptoms resolve, use a low dose of a different statin.

References: 2013 American College of Cardiology/American Heart Association Guidelines

Appendix E, Sec. 21.0 Guidelines for Management of Chronic Kidney Disease (CKD)

- Chronic Kidney Disease (CDK) is defined as glomerular filtration rate (GFR) of less than 60 mL/min or structural/functional kidney abnormalities with a preserved GFR (90 mL/min or higher). In 2002 a National Kidney Foundation work group defined 5 stages of CDK and delineated management goals for each stage. Once CDK has been diagnosed, aggressively pursue interventions to prevent progression of the disease. Especially in patients with diabetes or hypertension, early interventions can improve outcome.
- The major outcomes of CDK are loss of kidney function, leading to complications and kidney failure and the development of cardiovascular disease.
- Patients with CDK should be evaluated to determine:
  - Diagnosis (type of kidney disease);
  - Comorbid conditions;
  - Severity, assessed by level of kidney function;
  - Complications, related to level of kidney function;
  - Risk for cardiovascular disease;
- A clinical action plan should be developed for each patient, based on the stage of disease as defined by CKD classification, (Table 1)
  - STAGES OF CHRONIC KIDNEY DISEASES - Table 1.

Stage	Description	GFR mL/min/1.73m^2
1.	Kidney damage with normal or increase GFR	>_90
2.	Kidney damage with mild or decrease GFR	60-89
3.	Moderate to decrease GFR	30-59
4.	Severe decrease GFR	15-29.
5.	Kidney Failure	<15 or dialysis

- Review of medications should be performed at all visits for the following:
  - Dosage adjustment based on level of kidney function;
  - Detection of potentially adverse effects on kidney function or complications of chronic; kidney disease;
  - Detection of drug interactions;
  - Therapeutic drug monitoring if possible.
- Self- management behaviors should be incorporated into the treatment plan at all stages of CDK;
- Patients with CDK should be referred to a specialist for consultation and co-management. In general, patients with GFR <30mL/min/1.73 m^2 should be referred to a Nephrologist.
- Some individuals without kidney damage and with normal or elevated GFR are at increased risk for development of CDK. Such individuals should undergo testing for markers of kidney damage and to estimate the level of GFR.
- Treatment of CDK should include:

- Specific therapy, based on diagnosis;
- Intensive glucose control in diabetics;
- Blood pressure control using multiple agents as needed;
- Aggressive use of lipid lowering agents;
- Evaluation and management of co-morbid conditions;
- Aggressively counsel patients on smoking cessation;
- Slowing the loss of kidney function;
- Prevention and treatment of cardiovascular disease;
- Prevention and treatment of complications of decreased kidney function;
- Replacement of kidney function by dialysis if signs and symptoms of uremia are present.

- Treatment of CDK can slow progression to end-stage renal disease (ESRD). However, the therapies remain limited. Blood pressure control using angiotensin-converting enzyme (ACE) inhibitors or angiotensin II blockers (ARBs) has the greatest weight of evidence. Glycemic control in diabetes seems likely to retard progression.

References: National Kidney foundation; Treatment of chronic kidney disease, Case Western University School, Kidney International 2011

Appendix E, Sec. 22.0 Management of Coagulation Disorders

Hereditary bleeding disorders are a diverse group of diseases that include abnormalities of primary and secondary hemostasis.

The most common congenital bleeding disorders include:

- Von Willebrand disease
- Hemophilia A (factor VIII deficiency)
- Hemophilia B (factor IX deficiency)

Less common congenital bleeding disorders include:

- Factor I (fibrinogen deficiency)
- Factor II (prothrombin deficiency)
- Factor V deficiency
- Factor VII deficiency
- Factor X deficiency
- Factor XI deficiency
- Factor XIII deficiency
- Platelets disorders

Mechanism

- Primary hemostasis involves formation of the platelet plug which involves platelets, the blood vessel wall and von Willebrand factor; abnormalities can include problems in platelet number, adhesion or aggregation.
- Secondary hemostasis involves the formation of fibrin through the humoral coagulation cascade; abnormalities include deficiencies of coagulation factors or contact factors, deficiencies or abnormalities of fibrinogen or connective tissue diseases.
- Mutations can be inherited in an autosomal dominant, recessive or x-linked pattern.

Clinical Features: Symptoms may include: bleeding associated with surgery, trauma, dental extractions, postpartum, circumcision or umbilical stumps, GI bleeding, intracranial hemorrhage, hemarthrosis soft tissue hematomas, easy bruising, epistaxis, menorrhagia, hematuria.

Laboratory: Basic screening tests include CBC, PT/PTT, bleeding time, or platelet function assay, thrombin time peripheral blood smear review. Testing for von Willebrand include factor VIII activity, von Willebrand factor antigen, von Willebrand factor activity.

Treatment: Specific treatment recommendations are dependent on type and severity of bleeding disorder, but generally, factor replacement therapy for factor deficiencies is the mainstay of treatment with the exception of factor II, factor and factor X deficiencies, which are treated with fresh frozen plasma and cryoprecipitate (Hemophilia 2008).

Differential Diagnosis: Acquired factor deficiencies, due to liver diseases, DIC, lupus anticoagulants, heparin, warfarin or other anticoagulants, are more common than hereditary deficiencies and should be ruled out first. Acquired platelet defects due to anti-platelet medications (aspirin, clopidogrel, ticlopidine) are much more common than inherited platelet abnormalities.

References: Pathology Online 2013

Appendix E, Sec. 23.0 Guidelines for the Management of Warfarin Therapy

Initiation of Warfarin Therapy

CONSIDER CONTRAINDICATIONS:

Prior to initiating Warfarin treatment, consider the contraindications as indicated below. All contraindications are relative to patient risk for thrombosis weighed against the risk for bleeding.

Absolute Contraindications	Some Relative Contraindications
1. The presence of a severe or active bleeding diasthesis	1. Uncontrolled hypertension (greater than 180/100 mm Hg)
2. Non-adherence to medications and International Normalized Ratio (INR) monitoring	2. Severe liver disease
3. Pregnancy (avoided at least during the first trimester and about 2 to 4 weeks before delivery)	3. Recent surgery and procedures involving the nervous system, spine, or eye
4. Allergy or intolerance to Warfarin	

ESTABLISH BASELINE INR-This should be done in every case and will guide further therapy.

INITIAL DOSE-Initial dose of Warfarin is typically 5 mg/day in most patients. A starting dose of less than 5 mg may be considered for patients greater than 70 years of age, elevated baseline INR greater than 1.1, hypoalbuminemic patients (e.g., malnourished, liver disorders, post-operative), impaired nutrition (weight less than 45 kg), heart failure, known to take medications that increase sensitivity of warfarin, or previously documented sensitivity to Warfarin.

Note: Patients should take their Warfarin once a day at the same time in the evening and have their INR test perform in the morning. This limits diurnal variations and provides the Practitioner with a same day window for dosage adjustment in the event of an unanticipated INR change.

INR TARGET AND FREQUENCY OF MONITORING-The optimal maintenance dose for Warfarin to enable a therapeutic INR varies from patient to patient and at different times in the same patient. There is no maximum or minimum dose to maintain a therapeutic range. Two therapeutic ranges are recommended, depending on the indication for anticoagulation.

Under- coagulation can result in recurrent venous or arterial thrombosis, while over coagulation produce minor or major hemorrhagic complications. The narrow therapeutic index and high risk to benefit ratio necessitates close and long term monitoring. During the first few days of treatment, the INR rises without

concomitant clinical anticoagulation effect. Moreover, during the maintenance, dose changes may not be reflected in INR for 4-5 days.

During the initiation phase, it is recommended that INR be monitored every 2-4 days until the INR is in the patient's target range for two consecutive values. Once the INR is stabilized within the patient's target range, it can be monitored weekly. The interval can be gradually increased up to every 4 weeks if the INR remains stable and within the therapeutic range.

DOSAGE ADJUSTMENT AND MAINTAINANCE THERAPY – Dosage adjustment is not required for minor fluctuations of INR as long as the results remain within the patient's target range. Fluctuations of INR beyond the patient target range should always prompt communication with the patient to determine cause.

Target INR is 2.5 with range of 2.0-3.0 for most indications for warfarin therapy.

Target INR is 3.0 with range of 2.5-3.5 for the following indications:

- Mechanical heart valve in mitral position
- Mechanical heart valve in aortic position

Patient Education-Warfarin is more likely to be used safely by a patient who has been counseled and is aware of the potential for drug and diet interactions, understands the need for monitoring, and can recognize the signs of over- and under-anticoagulation.

Table 2. Dosage adjustments for Patients on Warfarin Maintenance Therapy (Target INR 2.0-3.0 or 2.5-3.5, No Significant Bleeding)

INR INTERVENTIONS

≤1.5 Give one time top- up equal to 20% of weekly dose, increase weekly dose by 10-20%.

1.5 <INR<Therapeutic range

No change in dose. Repeat test.

If two consecutive INRs are low, increase weekly dose by 10-20%.

INR in therapeutic range No change

INR >therapeutic range, but <5.0

Lower weekly dose (10-20 %) or consider omitting one single dose.

Increase frequency of INR monitoring and resume therapy at 10-20%

lower weekly dose when INR therapeutic.

NOTE: If INR is only minimally elevated (.1-.4 above upper limit of therapeutic range), dose reduction may not be necessary.

INR 5.0-9.0 - Omit 1-2 doses (or more as necessary) then recheck INR.

- Increase the frequency of INR monitoring and resume the therapy at 10-20% lower weekly dose when INR therapeutic

NOTE: Bleeding risk increase exponentially from INR 5.0-9.0 and should be monitored closely.

INR >9.0 Discontinue warfarin temporarily, consider administering vitamin K 2-5 mg orally then recheck INR.

NOTE: The effect of a single dose of vitamin K on the INR can be expected between 8-24 hours. Increase the frequency of INR monitoring and resume therapy at 20% lower weekly dose when INR therapeutic.

Give additional vitamin K if INR is not substantially reduced by 24 hrs.

NOTE: If the patient clinical status is compromised due to bleeding or if Vitamin K is not available; admit to an acute care facility.

Reference: Agency for Healthcare Research and Quality, 2011, (AHRQ); Institute of Medicine

Appendix E, Sec. 24.0 Management Guidelines for Hereditary Hemochromatosis

Hereditary Hemochromatosis: Although widely regarded as a rare disorder, hereditary hemochromatosis is the most common genetic disease in Caucasians. It is also the most common cause of primary iron overload. Persons with this disease are predisposed to absorb excess iron from the GI tract; the excess iron deposits in the parenchyma of organs and produce such clinical manifestations as diabetes, cirrhosis, and heart failure. (In secondary iron overload, excess iron results from cirrhosis, siderblastic anemias that cause ineffective erythropoiesis, multiple transfusions, or other exogenous sources.). The diagnosis of hereditary hemochromatosis may be frequently overlooked because:

- Affected patients may have no obvious symptoms.
- The clinical manifestations are protean; they include osteoarthritis (OA) and diabetes.
- Hereditary hemochromatosis is often not considered in the differential diagnosis because of its perceived rarity.

Early diagnosis is crucial—before irreversible tissue damage occurs.

Clinical Manifestations: Most patients with hereditary hemochromatosis do not present with the classic finding "bronze diabetes", which is a late manifestation of the disease; many have nonspecific symptoms. The three most common complaints are:

- Fatigue
- Arthralgia
- Libido loss

Symptoms are often attributed to other diseases or functional entities and are usually present for an average of 10 years before diagnosis is made.

GI SYSTEM. Hereditary hemochromatosis commonly involves the GI system; the liver is most frequently affected. Excess iron may present with abdominal pain, particularly in the right upper quadrant. Aminotranferase levels are typically elevated. However, only 60% of patients with hereditary hemochromatosis have abnormal liver function test results at the time of diagnosis, so normal results cannot reliably exclude the disease. Ultimately, cirrhosis and its attendant problems, such as varices and ascites, develop in untreated patients. Hepatocellular carcinoma is one of the most serious complications of hemochromatosis and is a frequent cause of death.

MUSCULOSKELETAL SYSTEM. More than 50% of patients with hereditary hemochromatosis have musculoskeletal complaints; arthralgia is the most common of these symptoms. The arthritis of hereditary hemochromatosis results from calcium pyrophosphate deposition in the joints. The joints most frequently involved are the wrists, distal interphalangeals, and metacarpals (particularly the second and third); however, it is not unusual to see knee, hip, or even shoulder arthritis.

Radiographic findings are similar to those of OA-joint space narrowing, subchrondral bone cysts, and sclerosis. Another clue that suggests hereditary hemochromatosis is OA in non-weight bearing joint, particularly the shoulder, when there is no history of trauma. Patients in whom arthritis develops before age

50 years, especially those who require early joint replacement, may have underlying hereditary hemochromatosis.

CARDIOVASCULAR SYSTEM. Cardiac manifestations occur in about 15% of affected patients. Bradyarrhythmias are common; of patients who have the arrhythmias, up to 20% have underlying hereditary hemochromatosis. Diastolic dysfunction with restriction occurs early in the disease; systolic dysfunction with dilated cardiomyapathy occurs later.

ENDOCRINE SYSTEM. Endocrine problems are also common in patients with hereditary hemochromatosis. These include decrease libido, erectile dysfunction, testicular atrophy, amenorrhea, sterility and even osteoporosis secondary to gonodal failure.

Diabetes mellitus occurs in up to 50% of symptomatic patients with hereditary hemochromatosis. Hyperglycemia results from iron deposition in pancreatic parenchyma and seems to be selective for pancreatic beta cells.

SKIN. The classic dermatological presentation, hyperpigmentation, is seen late in the course of hereditary hemochromatosis.

NERVOUS SYSTEM. Neuropsychiatric symptoms can also occur; depression is the most common. In patients with advanced hereditary hemochromatosis, a dementia-like illness and peripheral neurophy have been seen.

IMMUNE SYSTEM. Affected patients are more susceptible to severe Vibrio, Yersinia, and Listeria infections.

LABORATORY TESTING. Transferrin Saturation (TS) a common misconception is that measuring of ferritin or serum iron is the most appropriate screening test for hereditary hemochromatosis. However, ferritin levels rise only after parenchymal cells are overloaded. The first expression of hereditary hemochromatosis is an elevated transferring saturation (TS). A random blood sample may be used for the initial TS testing. If the initial level is high, obtain a second TS level after fasting. Any TS level greater than 45% is indicative of hereditary hemochromatosis.

Serum Ferritin: Ferritin levels greater than 300ug/L are suspect. However ferritin concentration may be increased in other liver diseases, such as chronic viral hepatitis, alcoholic liver disease and nonalcoholic steatohepatitis.

Liver Biopsy: Liver biopsy may help to rule out other causes of liver disease and will help confirm the diagnosis of hereditary hemochromatosis.

TREATMENT: Phlebotomy. The most widely used treatment is therapeutic phlebotomy. Initiate phlebotomy when the serum ferritin level is greater than 300 ug/L (200 ug/L for premenopausal women). Do not delay treatment until symptoms develop, because symptoms correlate with organ damage. Draw 1 unit of blood /week until mild hypoferririnemia occurs (approx.10 ug/L to 20 ug/L. Patients with high body mass index may tolerate up to 2 units drawn weekly. Continue phlebotomy for the patient's lifetime, with ferreting goal of less than 50 ug/L. After the target level has been achieved, phlebotomies may be needed only 2-6 times per year.

Problems improved by Phlebotomy	Problems not improve by Phlebotomy
Fatigue	Cirrhosis
Transaminasemia	Hepatoma risk
Hepatomegaly	Arthropathy
Abdominal pain	Increased risk of infection
Hyperpigmentation	Hypogonadism
Diabetes mellitus	Thyroid dysfunction
Cardiomyapathy	Hypeferrinemia
Hyperferritinemia	Hypertransferritinemia

Dietary Restrictions. Adherence to dietary guidelines is important. Patients with hereditary hemochromatosis need to limit their intake of red meat as it is the richest sources of bioavailable iron.

Vitamin C supplements must also be limited as ascorbic acid (Vit C), increases the intestinal absorption of iron.

Finally, vaccinate all patients with hereditary hemochromatosis against hepatitis A and B.

Reference: Consultant 360 Medical Journal, 2002

Appendix E, Sec. 25.0 Treatment Guidelines for Rheumatoid Arthritis

PATHOPHYSIOLOGY. Rheumatoid arthritis is characterized by synovial inflammation and progressive erosion of cartilage and bone. The process begins with activation of T cells, which results in proliferation of synovial cells, activation of proinflammatory cells from the bone marrow, and secretion of cytokines (including interleukin (IL)-1 and tumor necrosis factor a (TNF)-a) by macrophages and fibroblast-like synovial cells. Many therapies for RA-including corticosteroids and TNF and IL-1 antagonist-directly inhibit proinflammatory cytokine activities.

DISEASE PROGRESSION. Symptoms of RA typically develop between the third and sixth decades of life. Significant joint abnormality and disability occur within the first few years of disease. Frequently associated comorbid conditions that may be exacerbated by either the pathophysiologic mechanisms that underline RA or by its treatment include infection, renal insufficiency, cardiovascular disease, chronic pulmonary disease, peptic ulcer disease, and lymphoproliferative disease. Psychological distress also increase disability associated with RA; symptoms of anxiety, depression, and hopelessness need to be identified and treated.

Cigarette smoking is associated with increased risk of RA. Longer duration is linked to greater risk, and heavier use is associated more serious symptoms and bony erosions. Obesity is also a risk factor, since adipose tissue releases proinflammatory substances, including IL-6, TNF-a, and CRP.

INITIAL EVALUATION. The American College of Rheumatology (ACR) classification criteria (Table 1) can help guide clinical diagnosis.

Table 1

American College of Rheumatology and classification for acute rheumatoid arthritis*

- Morning stiffness of joints lasting ≥1hr
- Soft tissue swelling or fluid at 3 or more joints
- Swelling or fluid in hand joints
- Simultaneous arthritic changes in symmetric joints
- Subcutaneous nodules
- Positive serum rheumatoid factor
- Joint erosions or decalcification on radiographs

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*A positive diagnosis requires 4 of the above criteria.

Criteria 1-4 must be present for at least 6 weeks.

(Adapted from Arnett FC et al. Arthritis Rheu. 1988)

Laboratory. Laboratory testing is also useful in diagnosis, as well as in assessing prognosis and in monitoring the response to therapy. Rheumatoid factor–autoantibodies found in most patients with RA- may also be present in other rheumatologic conditions (lupus erythematosus and Sjorgren syndrome) and

infectious illnesses (malaria and rubella) a high rheumatoid factor titer in patients with RA is associated with more aggressive disease, greater joint destruction, and greater functional disability. The C-reactive protein (CRP) level and erythrocyte sedimentation rate (ESR) are markers of acute phase response. Elevations in CRP level and ESR also correlate with bone destruction.

DISEASE MANAGEMENT. Treatment involves a combination of therapies, consultation with a Rheumatologist, and medical management. Because the standard of care is moving from a more conservative to a more aggressive approach that involves early use of DMARDS, referral to a Rheumatologist is recommend at initial diagnosis. Following the initial rheumatology consultation, both the primary care Practitioner and the Rheumatologist should be actively involved in disease management. In general, consult a rheumatologist when patients present with persistent joint inflammation, require more intensive therapy, or manifest one or more of the following indicators of poor prognosis: genotype HLA-DRB1, high serum titer of rheumatoid factor, extra-articular manifestations, a large number of involved joints, age less than 30 years, female sex, or systemic symptoms.

Regularly monitor patients with evidence of active disease, such as joint inflammation, stiffness, and fatigue. Patients require periodic measurement of serum inflammatory markers (eg. ESR or CRP) and radiographs.

Medications include both symptomatic analgesics and disease modifying antirheumatic drugs (DMARDs). Early, aggressive management of RA and consistent use of DMARDs may result in reduced long-term disability. Non steroidal anti-inflammatory drugs (NSAIDs) and corticosteroids have no effect on disability.

Table 2

Key components of rheumatoid arthritis management

Monitor For Active Disease:

- Review of symptoms, including arthritic symptoms and comorbid illnesses
- Physical examination of the joints
- Measurement of serum inflammatory markers
- Radiographs
- Functional assessment questionnaires

Patient education:

- Education about the disease process and medications
- Physical therapy
- Rheumatology consultations

Medications:

- NSAIDs.
  Although effective for pain relief and reduction in inflammation, these agents do not prevent joint destruction. They are used only as adjunctive therapy for patients with active RA. Long term use of high doses of NSAIDs may result insignificant organ toxicity.
- DMARDs.
  These agents reduce or prevent joint destruction and subsequent disability. They include hydroxychloroquine, gold and D-penicillamine. ALL patients with active RA, even those who have achieved adequate analgesic relief from NSAIDs, are candidates for DMARD therapy.
  Rheumatoid factor-negative patients with mild disease may use hydroxychloroquine or sulfasalazine. In patients with severe RA, therapy is initiated with Methotrexate. Patients who do not achieve an adequate response with methotrexate may use a combination of DMARDs or alternative DMARDs, such as gold, which are usually prescribed by a consulting Rheumatologist.
  Therapy is generally initiated with NSAID and a DMARD. If patients fail to respond, consider adding a second DMARD or low-dose oral glucocorticoid (10 mg or less of prednisone daily).
  Targeted New Biologic Therapies.
  Biologic therapies are typically used in conjunction with methotrexate for patients who fail to achieve adequate benefit from this agent alone or in patients who have been inadequately helped by or cannot tolerate other DMARDs. The most effective new treatments are a class of biologics that include tumor necrosis factor alpha (TNF-a) antagonist therapies. Overall, these medications are

well tolerated. However, as with all immunosuppressives therapies, there is a theoretical increased risk of lymphoproliferative disease.

In recent years, the armamentarium of agents that combat RA has greatly expanded. New biologic therapies that specifically target the immune response are now available. Although disease-modifying antirheumatic drugs (DMARDs) such as methotrexate, remain the standard of care, these newer agents can be added to the regimen when monotherapy fails.

Reference: Consultant 360 Volume 42, 4/30/11; NIH

Appendix E, Sec. 26.0 Treatment Guidelines for Inflammatory bowel Disease

EPIDEMIOLOGY: About One third of cases of Inflammatory Bowel Disease (IBD) present in the second decade of life. The peak incidence occurs between 10 and 30 years of age. Currently IBD most commonly occurs in North America, Western Europe, and Australia (people of European descent.

PATHOGENESIS: IBD is a spectrum of entities ranging from mild to severe disease: ulcerative colitis (UC) and Crohn's disease (CD) are part of this spectrum. The normal gut experience local inflammation at times, but the key feature of IBD is failure to downregulate the immune system and control local inflammation. Epidemiologic data support a genetic component in the pathogenesis of IBD. Several environmental triggers contribute to the onset of disease and disease flares; they include infection, NSAIDs, antibiotics, diet, exercise, stress and smoking. These environmental triggers in conjunction with genetic and immunological factors are involved in the development of IBD.

DIAGNOSIS: The diagnosis of IBD is typically based on clinical manifestations along with radiographic, endoscopic, and pathologic findings. In addition, several serologic tests, stool protein tests, and unique imaging studies have been developed recently to aid in diagnosis.

- Serologic tests.
  - --- Three specific immune markers have been identified in the serum of patients with IBD:
    - (1) Antineutrophil cytoplasmic antibody with perinuclear highlighting (pANCA). About 60 % of patients with UC and 25 % of patients with CD are p ANCA positive.
    - (2) Anti-Saccharomyces cerevisiae (ASCA), form of baker's and brewer's yeast. ASCA is present in about one-half to two-thirds of patients with CD. ASCA is very specific for CD.
    - (3) OmpC and CBir1 are protein markers. A subset of patients with colonoscopy/histology-proven CD do not express ASCA antibodies. OmpC and CBir1 are more specific to CD.
  - --- These serologic tests are most helpful when the diagnosis of IBD is apparent but the type is in question, or when diagnostic certainty is needed. It is important to order these tests before planned colectomy. Diagnostic certainty is crucial before pouch formation because pouchitis is more likely to occur in patients with CD than those with UC. These tests can also aid in the diagnosis of IBD when extraintestinal manifestations, such as ankylosing spondylitis, arthritis, pyoderma gangrenosum, or uveitis, are the predominant symptoms.
- Imaging studies. Although traditional colonoscopy is typically used for diagnosis of CD, it limits the endoscopic evaluation to colon and terminal ileum. Because CD can affect any part of the GI tract, many lesions may be missed by colonoscopy. Several new imaging studies modalities have been developed to evaluate the small intestine in CD.

MEDICAL THERAPIES. IBD is characterized by acute flares separated by periods of quiescence. It is therefore important to develop maintenance strategies to prevent frequent flares, complications, and premature mortality. The primary goals of IBD therapy are to minimize symptoms, enhance patient well-being, and prevent the complications of IBD. Because corticosteroids do not prevent relapses in either UC or CD, they should not be used for long-term disease suppression, since these drugs are associated with long-

term toxicity. In patients with UC, even in the absence of overt disease, enough disease activity may be present to cause dysplasia and increase the risk of cancer; thus, a watchful waiting approach is inappropriate. In patients with CD, keeping disease activity under control may prevent strictures, fistulas, and other complications that could lead to surgery.

- **Ulcerative Colitis**. When selecting an agent to induce remission, consider the extent and severity of the disease. For UC, guidelines stress the importance of endoscopically determining the proximal extent of the disease: whether it is limited to the rectum, extends to the splenic flexure, or extends proximally beyond the splenic flexure (pancolitis). The cornerstone of therapy for mild to moderate UC is 5-aminosalicylic acid (5-ASA) drugs (including mesalamine, sulfasalazine, and balsalazide), either oral or topical formulations (rectal mesalamine enemas or suppositories), depending on the proximal extent of the disease. Because of the favorable safety profile of these drugs, up to 4.8 g/day can be used to treat active disease. It generally takes about 14 days to start to see a true effect, but patient may note a difference within a week. (NOTE: In about 7% of patients, their condition worsens with 5-ASA drugs; this is a hypersensitivity reaction that precludes the use of any of these agents.

  For more active disease, or when the 5-ASA drugs may not be sufficient to suppress symptoms rapidly, a short course of an oral corticosteroid at a moderate dosage (prednisone, 40-60 mg/d), with rapid taper once symptoms are controlled, is recommend. INFLIXIMAB also has FDA approval to control signs and symptoms of active UC in the outpatient setting. For localized rectal disease, hydrocortisone enemas, foams, or suppositories may be used. For sever disease, hospitalization for intravenous medications is necessary.

  Once remission has been achieved, maintenance therapy is indicated. If 5-ASA products have successfully induced remission, they are continued to maintain remission. Medications are not stopped just because a patient feels well. For patients who have a steroid-induced remission, corticosteroids do not maintain remission and should not be used because of toxicity. These patients whose condition worsens when their corticosteroid doses are reduced or stopped may truly be corticosteroid-dependent, and other therapy such as immunosuppression with AZATHIOPRINE 1.5-2.5 mg/kg/d or INFLIXIMAB should be considered.
- Table 1- Therapies to establish remission in UC

Severity of disease	Therapy
Mild to Moderate	Aminosalicylates
Distal disease	Topical or oral corticosteroids
Extensive disease	Oral or combination therapy
Moderate	Short course of corticosteroid therapy with rapid taper; Infliximab
Severe	Intravenous (IV) corticosteroids; IV cyclosporine or Infliximab

- Crohn's disease. In the treatment of CD limited to the colon, 5-ASA drugs can be effective in establishing and maintaining remission, particularly if given in high doses (4 g or more per day). Most patients, however, require innunosuppressants to induce remission, and this is often achieved in the short term with corticosteroids. Steroid-sparing immunomodulators, including azathioprine 2.5 mg/kg/d, 6-mercaptopurine (6MP) 1.5 mg/kg/d, or methotrexate 25 mg given subcutaneously once per week, have been effective both in inducing remission and in weaning patients with steroid-dependent CD from corticosteroids. Methotrexate works more quickly than other immunomodulators, but it requires monthly monitoring of liver enzymes as well as blood cell counts and is absolutely contraindicated in women who are considering childbearing. If there is no response to methotrexate after 12 weeks, consider an alternative.
  - Azathioprine and 6MP have been used for over 30 years and are considered the standard of care, but they are considered long-term management tools because they take 3 to 6 months to result in a benefit.
  - The anti-tumor necrosis factor (anti-TNF) agents including INFLIXIMAB, ADALIMUMAB, and CERTOLIZUMAB PEGOL. All three are FDA approved for treatment of moderate to severe disease. Because the data from controlled trials demonstrate comparable efficacy and safety for each of these agents, the selection of initial therapy is based on Medical Practitioner's experience.

Because of its more aggressive nature, Crohn's disease is treated with immunomodulaters more frequently than UC.

- Crohn's disease (fistulization disease). Antibiotics such as metronidazole and ciprofloxacin have been used to treat fistulas and can eliminate drainage and promote healing in about one-third of patients. Azathioprine and 6-MP are effective but take 3 to 6 months to heal fistulas. Anti-TNF agents are also effective. Corticosteroids, methotrexate, and 5-ASA agents DO NOT heal fistulas.
- Table 2-Therapies used to establish remission in Crohn's disease

Therapy	Comments
Aminosalicylates	Mild to moderate disease; target to disease location
Antibiotics	Mild to moderate disease; perianal, infectious complications
Corticosteroids	Moderate to severe disease
Immunomodulators Azathioprine, 6-MP, Methotrexate	Moderate to severe disease
Biologics Infliximab, Adalimumab, Certolizumab Pegol	Moderate to severe disease

- Table 3-Systemic complications of IBD

Eye inflammation
Lower bone density
Liver and bile duct inflammation
Gallstones
Kidney stones
Table 3-cont
Subfertility in females
Skin lesions
Arthritis and joint pain

OTHER MANAGEMENT CONSIDERATION

- Despite treatment, IBD is a relapsing and remitting disease. Within 6 months, 70% to 80% of patients with UC will have a relapse if they stop maintenance therapy. About 20% to 25% of patients with severe UC will require a colectomy.
- Relapses in CD tend to be less predictable. About 50% to 80% of patients with CD relapse within 18 to 24 months. At the site of surgical anastomosis, 70% to 90% of patients will have new CD lesions in previously uninvolved bowel. Clinical relapses will develop in 30% to 80% of patients.

Reference: Consultant 360 Medical Journal, vol. 51 2011

Appendix E, Sec. 27.0 Management Guidelines for Systemic Lupus Erythematosus

Systemic Erythematosus (SLE) is a chronic autoimmune disease that can affect almost any organ system. Its presentation and course are highly variable, ranging from indolent to fulminant. The classic presentation of triad of fever, joint pain, and rash in a woman of childbearing age should prompt investigation into the diagnosis of SLE. However, patients may present with any of the following types of manifestations:

- CONSTITUTIONAL - Fatigue, fever, arthralgia, and weight changes are the most common symptoms in new cases or recurrent active SLE flares.
- MUSCULOSKELETAL - Joint is one of the most common reasons for the initial clinical presentation of patients with SLE. In contrast to rheumatoid arthritis, SLE arthritis or arthralgia may be asymmetrical, with pain that is disproportionate to swelling. SLE arthropathy is rarely erosive or deforming. There is an increased prevalence of avascular necrosis in the SLE population relative to healthy individuals.
- DERMATOLOGICAL - Cutaneous manifestations of SLE include 3 American College of Rhuematology lupus diagnostic criteria: malar rash, photosensitivity, and discoid lupus.
- RENAL - The kidney is the most commonly involved visceral organ in SLE. Although only approximately 50% of patients with SLE develop clinically evident of renal disease, biopsy studies demonstrate some degree of renal involvement in most patients.
- NEUROPSYCHIATRIC - Because of the difficulty distinguishing causal SLE association with some neurological symptoms, only seizure and psychosis were typically included in the diagnostic criteria.
- PULMONARY - Pulmonary features of SLE may lead to multiple pulmonary complications, including pleurisy, pleural effusion, pneumonitis, pulmonary hypertension, and interstitial lung disease.
- CARDIAC - Heart failure or chest pain must be carefully assessed in patients with SLE. Percarditis is the most common feature of SLE, manifesting as positional chest pain that is relieved when the patient leans forward.
- HEMATOLOGIC - A history of multiple cytopenias such as leukopenia, lymphopenia, anemia, or thrombocytopenia may suggest SLE.

Diagnostic Considerations - Before making a diagnosis of SLE, ruling out drugs as the cause of the condition is important. Procaineamide, hydralazine, and isoniazid are some of the many drugs, associated with lupus like syndrome, that have been studied extensively. Many patients who take these medications have positive antinuclear antibody tests results and other serologic findings. Drug-induced lupus differs from SLE by the following features:

- Sex ratio are nearly equal
- Antibodies to histones are usually found in 80-90 %
- Nephritis and central nervous system features are not commonly present
- There are no antibodies to native DNA or hycomplimentemia

- Discontinuation of the drug leads to resolution of clinical manifestations and reversal of abnormal lab values to normal

Table 1. Drugs Associated With SLE

Definite Association	
Chloropromazine	Methyldopa
Hydralazine	Procainamide
Isoniazid	Quinidine
Possible Association	
Beta-blockers	Methimazole
Captopril	Nitrofurantoin
Carbamazepine	Penicillamine
Cimetidine	Phenytoin
Etosuximide	Propylthiouricil
Hydralazine	Sulfasalazine
Levodopa	Sulfonamides
Lithium	Trimethdione
Unlikely Association	
Allopurinol	Penicillin
Chlorthalidone	Phenylbutazone
Gold	Reserpine
Griseofulvin	Streptomycin
Methylsergide	Tetracyclines

American College of Rheumatology Diagnostic Criteria for SLE:

- Serositis-Pleurisy, pericarditis on exam or diagnostic ECG or imaging
- Oral ulcers-Oral or nasopharngeal, usually painless; palate is most specific
- Photosensitivity-Unusual skin reaction to light exposure
- Blood disorders-leukopenia ($<4x10^3$ cells/uL >1 occasion), lymphopenia (<1500 cells/uL > 1 occasion), thrombocytopenia ($<100x10^3$ cells/uL in the absence of offending medications) and hemolytic anemia
- Renal involvement-Based on presence of proteinuria (>0.5g/day or 3+ positive on dipstick testing) or cellular casts (including RBCs), hemoglobin, granular, tubular or mixed)
- Antinuclear antibodies-higher titers generally more specific (>1:160); must be in the absence of medications associated with drug-induced lupus
- Immunologic phenomena-dsDNA; anti-Smith antibodies, phospholipid antibodies (anticardiolipin; IgG or IgM or lupus anticoagulant) biologic false-positive serologic test result for syphilis; LE cells
- Neurological disorders-Seizures or psychosis in the absence of other causes
- Malar rash-fixed erythema over the cheeks and nasal bridge, flat or raised
- Discoid rash

Diagnostic Studies-Standard lab studies that are diagnostically useful when SLE is suspected:

CBC with differential	Serum creatinine
UA with microscopy	ESR or C-reactive protein
Complement levels	Liver function tests
Creatine kinase assay	Spot protein/spot creatinine ratio

SLE Management

- Management of SLE often depends on disease severity and disease manifestations. Hydroxychloroquine has a central role for long-term treatment in all SLE patients. The LUMINA study and other trials have offered evidence of a decrease in flares and prolonged life in patients given Hydroxychloroquine, making it the cornerstone or SLE management.
- In general, cutaneous manifestations, musculoskeletal manifestations, and serositis represent milder disease, which may wax and wane with disease activity. These are often controlled with nonsteroidal

anti-inflammatory drugs (NSAIDs) or low potency immunosuppression medication beyond Hydroxychloroquine and/or short courses of corticosteroids. More prolonged steroid use is generally reserved for patients with involvement of vital organs.

- No diet-based treatment of SLE has been proven effective. Patients with SLE should be reminded that activity may need to be modified as tolerated. Additionally, persons with SLE should wear sunscreen and protective clothing and minimize sun exposure to limit photosensitive rash or disease flare.

Biologic DMARD Therapy

- The monoclonal antibody inhibitor, Belimumab, has been found to reduce disease activity and possibly decrease the number of severe flares and steroid use in patients with SLE when used in combination with standard therapy. In March of 2011 the FDA approved the use of Belimumab in combination with standard therapies to treat active autoantibody-positive SLE.

Adjunctive Therapy

- Administer angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) to all patients with lupus nephritis, except pregnant women, who have proteinuria of 0.5 g or more per 24 hrs or proteinuria by protein/creatinine ratio on spot urine.
- Statin therapy is recommended in patients with LDL-C levels greater than 100mg/dL.

SLE in Pregnancy

- The incidence of spontaneous abortion, premature labor, early preeclampsia/eclampsia, fetal growth restriction, and intrauterine death are somewhat higher in women with SLE especially in those with SSA (Ro) SSB (La) antibodies or lupus nephritis.

Long-Term Monitoring

- Periodic follow-up and lab testing, including CBC with differential, creatinine, and urinalyses, are imperative for detecting signs and symptoms of new Organ-system involvement and for monitoring response and adverse reactions to therapies. Opportunistic infections can develop, most often in patients receiving chronic immunosuppressive therapy. Another less common complication is osteonecrosis, especially of the hips and knees after prolonged high-dose corticosteroid usage. More commonly, premature atherosclerotic disease and myocardial infarction are complications of chronic inflammation and steroids.

Education

Patients with SLE should be educated to avoid triggers that can cause flares. Persons with SLE should avoid UV light and limit sun exposure. Diet modification should be based on the disease activity. Many patients with SLE have low level of vitamin D because of less sun exposure, thus these patients should take vitamin d supplement. Exercise is important in SLE patients to avoid muscle loss, bone demineralization, and fatigue. Smoking should be avoided.

References: Medscape, Systemic Lupus Erythematosus Clinical Presentation; American College of Rheumatology; Lupus Foundation of America.

Appendix E, Sec. 28.0 Management Guidelines for Hyperthyroid Disorders

Management Guidelines for Hyperthyroid Disorders

Thyrotoxicosis is a condition having multiple etiologies, manifestations, and potential therapies. The term "thyrotoxicosis" refers to a clinical state that results from inappropriately high thyroid hormone levels. The term "hyperthyroidism" is a form of thyrotoxicosis due to inappropriately high synthesis and secretion of thyroid hormones by the thyroid.

Etiology of Hyperthyroid States

In general, thyrotoxicosis can occur if:

- the thyroid is inappropriately stimulated by trophic factors
- there is constitutive activation of thyroid hormone synthesis and secretion leading to autonomous release of excess thyroid hormone
- thyroid stores of preformed hormone are passively released in excessive amount owning to autoimmune, infectious, chemical, or mechanical insult
- there is exposure to extra-thyroidal source of thyroid hormone, which may either endogenous or exogenous

Mechanism of Action

- Subclinical hyperthyroidism (SH) is most often caused by release of excess thyroid hormone by the gland. This condition is defined as a low or undetectable serum thyroid stimulating hormone (TSH) with values within the normal reference range for both triiodothyronine (T_3) and free thyroxine (T_4) estimates. Both overt and subclinical disease may lead to characteristic signs and symptoms.
- Graves' disease (GD) is an autoimmune disorder in which thyrotropin receptor antibodies stimulate the TSH receptor, increasing thyroid hormone production. The natural history of nodular thyroid disease includes growth of established nodules, new nodule formation, and develops of autonomy over time. Hormone production may progress from subclinical to overt hyperthyroidism. GD is overall the most common cause of hyperthyroidism in the United States. Thyroid hormone influences almost every tissue and organ system in the body. It increases tissue thermogenesis and basal metabolic rate (BMR) and reduces serum cholesterol levels and systemic vascular resistance. Some of the most profound effects of increased thyroid hormone levels are on the cardiovascular system. The complications of untreated thyrotoxicosis include loss of weight, osteoporosis, atrial fibrillation, embolic events, and even cardiovascular collapse and death.
- The signs and symptoms of overt and mild, or subclinical, thyrotoxicosis are similar, but differ in magnitude. Overt thyrotoxicosis, whether endogenous or exogenous, is characterized by excess thyroid hormones in serum and suppressed TSH (<0.01mU/L). There are also measurable changes in BMR, cardiovascular hemodynamics, and psychiatric and neuropsychological function. Symptoms and signs

that result from increased adrenergic stimulation include tachycardia and anxiety and appear to be more pronounced in younger patients and those with large goiters Assessment of Disease Severity.

- The assessment of thyrotoxic manifestations, and especially potential cardiovascular and neuromuscular complications, is essential to formulating an appropriate treatment plan. All patients with known or suspected hyperthyroidism should undergo a comprehensive history and physical examination, including measurement of pulse rate, blood pressure, respiratory rate, and body weight. In addition, thyroid size, presence or absence of thyroid tenderness, symmetry, and nodularity, the presence or absence of peripheral edema, eye signs, or pretibial myxedema should be assessed.

Biochemical Evaluation

- Serum TSH measurement has the highest sensitivity and specificity of any blood test used in the evaluation of suspected hyperthyroidism and should be used as initial screening test. However, when hyperthyroidism is strongly suspected, diagnostic accuracy improves when both a serum TSH and free T_4 are assessed at the time of the initial evaluation. However, serum TSH levels are considerably more sensitive than direct thyroid hormone measurements for assessing thyroid hormone excess.
- The term "euthyroid hyperthyroxemia" has been used to describe a number of entities, mostly thyroid hormone-binding protein disorders that cause elevated total serum T_4 concentrations in the absence of hyperthyroidism. These conditions include elevations in T_4 binding globulins (TBG). TBG excess may occur as a hereditary x-linked trait, or be acquired as a result of pregnancy or estrogen administration, hepatitis, acute intermittent porphyuria, or during treatment with 5-fluorouracil, perphenenzine or some narcotics.
- Radiological Studies
- If a pituitary adenoma is suspected, MRI is indicated.
- A radioactive iodine uptake should be performed when the clinical presentation of thyrotoxocosis is not diagnostic of Graves' disease (GD); a thyroid scan study should be added in the presence of thyroid nodularity. In patients with a symmetrically enlarged thyroid, recent onset of ophthalmopathy, and moderate to severe hyperthyroidism, the diagnosis of GD is sufficiently likely that further evaluation of hyperthyroidism causation is unnecessary. A radioactive iodine uptake (RAIU) is indicated when the diagnosis is in question (except during pregnancy). The RAIU will be near zero in patients with painless, postpartum, or subacute thyroiditis, or in those with factitious ingestion of thyroid hormone or recent excess iodine intake. The RAIU may be low after exposure to iodinated contrast in the preceding 1-2 months or with ingestion of a diet rich in iodine such as seaweed soup or kelp.
- Ultrasonagraphy does not generally contribute to the differential diagnosis of thyrotoxicosis. When radioactive iodine is contraindicated, such as during pregnancy or breastfeeding, or not useful, such as following recent iodine exposure, ultrasound showing increased color Doppler flow may be helpful in confirming a diagnosis of thyroid hyperactivity.
- In most patients, the distinction between subacute and painless thyroiditis is not difficult. Subacute thyroiditis is generally painful, the gland is firm to hard on palpation, and the erythrocyte sedimentation rate (ESR) is almost always >50 and sometimes over 100mm/h. Patients with painless thyroiditis may present in the post-partum period, often have a personal or family history of autoimmune thyroid disease, and typically have a low to moderate concentration of antithyroid peroxidase antibodies.

Management Considerations

- Beta-adrenergic blockers (B-blockers) should be given to elderly patients with symptomatic thyrotoxicosis and to other thyrotoxic patients with resting heart rates in excess of 90 bpm or coexistent cardiovascular disease. B-blockers should be considered in all patients with symptomatic thyrotoxicosis. In patients whom the diagnosis of thyrotoxicosis is strongly suspected or confirmed, treatment with Propranolol, Atenolol, Metoprolol, or other B-blockers leads to a decrease in heart rate, systolic blood pressure, muscle weakness, and tremor, as well as improvement in the degree of irritability, emotional lability, and exercise intolerance.
- NOTE: Since there is not sufficient beta-1 selectivity of the available beta-blockers at the recommended doses, these drugs are generally CONTRAINDICATED in persons with bronchospastic asthma. However, in patients with quiescent bronchospastic asthma in whom heart rate control is essential or in

patients with mild obstructive airway disease or symptomatic Raynaud's phenomenon, a nonselective beta-blocker such as Nadolol can be used cautiously, with careful monitoring of pulmonary status. Occasionally, very high doses of beta-blockers are required to manage symptoms of thyrotoxicosis and to reduce the heart rate to near the upper limit of normal. Calcium channel blockers, both Verapamil and Diltiazem, when administered orally have been shown to effect rate control in patients who do not tolerate or are not candidates for beta-blocking agents.

- Patients with overt Graves' hyperthyroidism should be treated with any of the following modalities: ^{131}I therapy, antithyroid medication, or thyroidectomy. Once it has been established that the patient is hyperthyroid and the cause is GD, the patient and Physician must choose between three effective and relatively safe initial treatment options as indicated above. In the United States, radioactive iodine (^{131}I) has been the therapy most preferred by physicians. The long term quality of life following treatment for GD was found to be the same in patients randomly allocated to one the three treatment options.

FACTORS THAT FAVOR A PARTICULAR MODALITY AS TREATMENT FOR GRAVES' HYPERTHYROIDISM:

- ^{131}I Treatment Modality-Females planning a pregnancy in the future (in more than 4-6 months following radioiodine therapy, provided thyroid hormone levels are normal), individuals with comorbidities increasing surgical risk, and patients with previously operated or externally irradiated necks, or lack of access to high volume thyroid surgeons or contraindications to ATD use.
- ANTI-THYROID DRUGS (ATDs) Treatment Modality-ATDs may be considered in patients with high likelihood of remission (patients with mild disease, small goiters, and negative or low thyrotropin receptor antibodies (TRab); the elderly or others with comorbidities increasing surgical risk or with limited life expectancy; individuals in special care facilities who have limited longevity and are unable to follow radiation safety regulations; patients with previously operated or irradiated necks; patients with lack of access to a high volume thyroid surgeon; and patients with moderate to severe active GD.
- Anti-thyroid drugs have been employed for many years. The goal of therapy is to render the patient euthyroid as quickly and safely as possible. These medications do not cure Graves' hyperthyroidism. However, when given in adequate doses, they are very effective in controlling the hyperthyroidism. The major effect is to reduce the production of thyroid hormones and maintain a euthyroid state while awaiting spontaneous remission of GD.
- Methimazole should be used in virually every patient who choose antithyroid drug therapy for GD. Propylthiouricil is preferred (except during the first trimester of pregnancy), in the treatment of thyroid storm, and in patients with minor reactions to Methimazole who refuse radioactive iodine therapy or surgery. Before starting antithyroid drugs and at each subsequent visit, the patient should be alerted to stop the medication immediately and report any symptoms suggestive of agranulocytosis or hepatic injury (fever, pharyngitis, arthralgias, abdominal pain, nausea, rash, jaundice). Prior to initiating antithyroid drug therapy for GD, patients shall have baseline labs including complete blood count with white cell count and differential and chemistry panel to include liver profile testing.
- An assessment of serum free-T_4 should be obtained at about 4 weeks after initiation of therapy and the dose of medication adjusted accordingly. Serum T_3 may also be monitored, since the estimated serum free-T_4 levels may normalized with persistent elevation of serumT_3. Approximate monitoring intervals are every 4-8 weeks until euthyroid levels are achieved with the minimal dose of medication. Once the patient is euthyroid, biochemical testing and clinical evaluation can be undertaken at longer intervals of 3 months. An assessment of serum free-T_4 and TSH are required before treatment and at intervals. Serum TSH may remain suppressed for several months after starting therapy and is therefore not a good parameter to monitor therapy early in the course.
- Hyperthyroidism can itself cause mildly abnormal liver function tests, and PTU can cause transient elevations of serum transaminases in up to one-third of patients. Significant elevations of threefold above the upper limit of normal are seen in up to 4% of patients taking PTU, a prevalence higher than Methimazole. If on PTU, the medication should be discontinued if transaminase levels reach 2-3 times the upper limit of normal and fail to improve within 1 week on repeated testing. After discontinuing the

drug, liver function test should be monitored weekly until there is evidence of resolution. If resolution is not evident, prompt referral is warranted.

- Minor allergic side effects, such as a limited, minor rash, may occur in up to 5% of patients taking either Methimazole or Propylthiouricil. Minor cutaneous reactions may be managed with concurrent antihistamine therapy without stopping the antithyroid drug. Persisitent minor side effects of antithyroid medication should be managed by cessation of the medication and changing to radioactive iodine or surgery.
- If Methimazole is chosen as the primary therapy for GD, the medication should be continued for approximately 12-18 months, then tapered or discontinued if TSH is normal at that time. Measurement of thyrotropin receptor antibody levels prior to stopping antithyroid drug therapy is recommended as it aids in predicting which patients can be weaned from medication, with normal level levels indicating greater chance for remission. If a patient with GD becomes hyperthyroid after completing a course of Methimazole, consideration should be given to treatment with radioactive iodine or thyroidectomy. Low-dose Methimazole treatment for longer than 12-18 months may be considered in patients_in remission who prefer this approach.
- A patient is considered to be in remission if they have had a normal serum TSH, FT_4, and T_3 for one year after discontinuation of ATD therapy. Approximately 20-30% of patients will have a lasting remission after 12-18 months of medication. When Methimazole is discontinued, thyroid function testing should continue to be monitored at 1-3 month intervals for 6-12 months to diagnose relapse early.
- SURGERY Modality-If surgery is the primary therapy for GD, near-total or total thyroidectomy is the procedure of choice. Factors that favors surgery as a treatment modality include: symptomatic compression or large goiters, relatively low uptake of radioactive iodine, when thyroid malignancy is documented or suspected, large nonfunctioning, or hypofunctioning nodule, coexisting hypoparathyroidism requiring surgery and in patients with moderate to severe active GD.

References: American Thyroid Association; American Association of Clinical Endocrinologists; Thyroid, Vol. 21, 2011.

Appendix E, Sec. 29.0 Treatment Guidelines for Sickle Cell Disease

DEFINITION

Sickle cell anemia (SCA) refers to clinically similar disorders HbSS or HbSB0-thallasemia. Sickle cell disease (SCD) refers to all disease genotypes, including SCA and component heterozygous disorders, such as HbSC, HbSD, and HbSB+-thallasemia. The carrier state of hemoblobin S (HBAS or sickle cell trait) is NOT a form of SCD.

EPIDEMIOLOGY

- The sickle cell mutation results in substitution of the amino acid valine for glutamic acid at the sixth position of the beta globulin chain, causing formation of hemoglobin S. More than two million U.S. residents are estimated to be either heterozygous or homozygous for the genetic substitution. Most of those affected are of African ancestry or self-identify as Black; a minority are of Hispanic or southern European, Middle Eastern, or Asian Indian descent. It is estimated that between 70,000 and 100,000 Americans have sickle cell disease (SCD). Although SCD is associated with major morbidity, currently more than 90 percent of children with SCD in the United States and the United Kingdom survive to adulthood. However their lifespan remains shortened by two or three decades compared to the general population.
- The most prevalent SCD genotypes include homozygous hemoglobin SS (HbSS) and the compound heterozygous conditions hemoglobin SB^o-thallasemia ($HbSB^0$-thallasemia), hemoglobin SB^+-thallasemia ($HbSB^+$-thallasemia), and hemoglobin SC disease (HbSC). HbSS and $HbSb^0$-thallasemia are clinically very similar and therefore are commonly referred to as sickle cell anemia (SCA); these genotypes are associated with the most severe clinical manifestations.

HEALTH MAINTENANCE FOR PEOPLE WITH SICKLE CELL DISEASE

Individuals with SCD are at high risk for developing multisystem acute and chronic conditions associated with significant morbidity and mortality. Although treatment of SCD may ameliorate some of these complications, such therapies are often unsuccessful in completely preventing them. Therefore, the next best approach may be screening to identify risk factors and early signs of complications in order to implement measures to reduce morbidity and mortality in individuals with SCD.

- Prevention of Pneumococcal Infection.
  Case fatality is high and the risk is greatest in young people who lack humoral immunity against the specific pneumococcal serotype causing infection. People with HbSC and $HbSB^+$-thallasemia have a much lower incidence of life-threatening infection because their spleen function is normal or only minimally impaired during infancy. However, older children and adults with all SCD genotypes are at increased risk for invasive bacterial infection. Patients with SCD should be immunized with Pneumococcal vaccine.
- Screening for Renal Disease

Sickle cell nephropathy is a major complication of SCD causing tubular and medullary dysfunction. Preclinical markers of glomerular damage in other conditions associated with hyperfiltration and hyperperfusion such as diabetes mellitus can be measured as early predictors of progressive renal nephropathy. Microalbumin can be detected long before a positive urine test for proteinuria. Chronic renal failure (CRF) occurs with a variable frequency of 4-20 percent when significant proteinuria or azotemia is present. All patients with SCD should be screened at least annually for proteinuria. If the first morning void urine albumin-creatinine ratio is abnormal, consult with or refer to a renal specialist.

- Screening for Pulmonary Hypertension (PH)
  Chronic hemolytic anemia, including SCD may result in pulmonary vascular changes leading to pulmonary arterial hypertension (PAH). PAH occurs in 40-50 percent of patients with SCD. Initial assessment for PH in patients with SCD has been done with echocardiography evaluation to estimate pulmonary artery pressure, but diagnosis requires right heart catheterization. Both elevated tricuspid regurgitant jet velocity (TRV) and PH are risk factors for premature death in patients with SCD. Elevated TRV in adults with SCA is associated with an increased risk for all-cause mortality.
  Use of screening (testing asymptomatic individuals) to detect conditions in the presymptomatic stage is generally justified by the ability to impact the course to prevent or reduce morbidity and/or mortality.

MANAGING ACUTE COMPLICATIONS OF SICKLE CELL DISEASE (SCD)

- New clinical approaches and treatments have increased the survival of patients with SCD, but the average lifespan still remains about two to three decades less than for patients without SCD. The shorter lifespan is due in part to adverse outcomes related to acute SCD complications. The most common complications of SCD is an acute episode of severe pain referred to as acute vaso-occlusive crisis (VOC).
- In addition to VOCs, other common acute complications of SCD include fever related to infection, acute kidney injury, hepatobiliary complications, acute anemia, splenic sequestration, acute chest syndrome, and acute stroke. Patients with signs or symptoms of these complications require immediate evaluation and treatment to reduce or prevent morbidity and mortality. Priapism and acute ocular conditions such as central retinal artery occlusion also require urgent management to preserve organ function.

VASO-OCCLUSIVE CRISIS

- A VOC is the hallmark acute complication for persons with SCD and manifests as acute severe pain. Although VOCs are typically associated with excruciating pain of sudden onset, some people experience gradual onset of VOC. Nearly all individuals affected by SCD will experience a VOC during their lifetime. VOCs occur with variable frequency. VOCs and their accompanying pain most commonly occur in the extremities, chest and back. When they occur in other sites, they can be confused with, or can be prodromal stage of, other acute complications (e.g. head (stroke), flank (papillary necrosis) and abdomen (hepatic or splenic sequestration, constipation from opioid use, or other hepatobiliary complication). The etiology of pain must be determined in order to rule out potential causes of pain other than an uncomplicated VOC, such as acute chest syndrome (ACS), pneumonia, or other abdominal complications. VOC can still occur in the presence of other complications. There are no tests to rule in or rule out a VOC. Testing can potentially rule out other causes of pain. Patients with genotypes HbSS or $HbSB^0$ –thallasemia are likely to experience more frequent VOCs. Patients with HbAS (commonly referred as sickle cell trait) do not experience typical VOCs. Individuals with more than three hospitalizations for VOC in a year are at an increased risk of early death.
- Pain management must be guided by patient report of pain severity. The primary management of a VOC is analgesic treatment, typically with opioids. Best practice suggests rapid triage, placement, and administration of analgesics (within 30-60 minutes of onset of pain) should be encouraged.
  ACUTE RENAL FAILURE (ARF)
- Acute renal failure may occur during an acute VOC, most often in association with ACS or acute multisystem organ failure. Renal papillary necrosis due to medullary infarction from obstruction of the blood supply, affects up to 15-30 percent of patients with SCD. Signs and symptoms include flank pain and hematuria. If fever is present, superinfection should be suspected.

- ARF may also occur when patients with chronic sickle cell nephropathy or other chronic kidney diseases are exposed to nephrotoxic medications (e.g., NSAIDs or IV contrast dye) or become dehydrated. Patients with SCD often display a relative inability to maximally concentrate the urine, resulting in increased vulnerability to pre-renal azotemia. Due to increased renal tubular secretion of creatinine, serum creatinine values in SCD do not rise until significant renal impairment occurs (GFR of 30 mL/min or less. Since serum creatinine levels are generally low or low normal in individuals with SCD, the values in ARF may still be within normal limits even if they have doubled from baseline. It is important to consider non-SCD-related causes of ARF before simply attributing ARF to SCD.

PRIAPISM

- Priapism is a sustained, unwanted painful erection lasting 4 or more hours. Stuttering priapism is the occurrence of multiple self-limiting episodes of shorter duration (<4 hours) and can be a harbinger of sustained events. Priapism is a common complication of SCD, affecting 35 percent of boys and men. It is usually of the low flow ischemic type and characterized by pain and soft glans. Prompt recognition of priapism and initiation of conservative medical management may lead to detumescence and limit the need for more aggressive and invasive intervention. Delayed diagnosis and therapy can result in impotence.
- For an episode of priapism lasting more than 4 hours or longer, initiate interventions to include vigorous oral or intravenous (IV) hydration and oral or IV analgesia. Consultation with a Urologist is recommended for symptoms which do not remit with conservative medical management.

HEPATOBILIARY COMPLICATIONS

- Biliary abnormalities are common in patients with SCD in general and in those with HbSS in particular. These abnormalities include cholelithiasis, acute cholecystitis, biliary sludge, and acute choledocholithiasis. Hemolysis of any etiology results in increased secreted unconjugated bilirubin that tends to precipitate and leads to gallstones and sludge. In adults with SCD, the prevalence of gallstones can be as high as 70-75 percent. Although gallstones are usually asymptomatic, they can be associated with acute infection and inflammation involving the gallbladder, and they may also lead to obstruction of cystic or bile ducts and acute pancreatitis. Despite the high prevalence of gallstones in people with SCD, acute cholecystitis occurs in less than 10 percent of patients. It can occur with or without the presence of gallstones and can present as severe colicky pain in the right upper quadrant (RUQ) with abdominal tenderness on physical exam. Fever, leukocystosis, nausea, and vomiting are usually present.
- Acute cholecystitis in patients with SCD is treated with antibiotics and surgical consultation. Treat asymptomatic gallstones with watchful waiting in patients with SCD. In those who develop symptoms specific to gallstones, treat with cholecystectomy.

  CHOLEDOCHOLITHIASIS is the presence of gallstones in the common bile duct.
- Symptoms include dull pain in the RUQ, tender hepatomegaly, and rapid increasing jaundice.
- Endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy may be required to remove the offending stone.

  ACUTE HEPATIC SEQUESTRATION (AMS) and ACUTE INTRAHEPATIC CHOLESTASIS (AIC) are associated with SCD. AMS is marked by hepatic enlargement compared to baseline without other and a 2 g/dL or greater decline in hemoglobin concentration. In patients with signs and symptoms of AMS or AIC, provide hydration, rest, close observation, and consultation with Hematologist.

ACUTE INTRAHEPATIC CHOLESTASIS is characterized by sudden onset of RUQ pain, increasing jaundice, progressive enlarging and exquisitely tender liver, light colored stools extreme hyperbilirubinemia (both conjugated and unconjugated) usually without urobilinogenuria. The clinical picture suggest cholestatic jaundice or cholodocholithiasis but without evidence of common duct obstruction or cholangitis. AIC may prove fatal if not recognized and treated promptly.

ACUTE ANEMIA

- Nearly all patients with SCD have chronic anemia but individual baseline hemoglobin values vary widely depending on the hemoglobin genotype. It is important for the patient and the HCP to refer to the baseline or “steady state” hemoglobin value in order for ongoing monitoring and management during

acute complications. Acute anemia is defined as a decline by 2.0 g/dL or more in hemoglobin concentration below the patient's baseline value, can have diverse causes. During acute events, the reticulocyte count is an important addition to the CBC to assess whether diminished red blood cell production, accelerated hemolysis, or sequestration in the lungs, spleen, or liver is responsible for the acute anemia.

- APLASTIC EPISODE-An aplastic episode or "crisis" is a common feature of SCD. The usual clinical picture is gradual onset of fatigue, shortness of breath, and sometimes syncope. Fever is quite common as well. Physical exam may reveal lethargy, tachycardia, and occasional frank heart failure. The hemoglobin value is usually far below the patient's baseline, and reticulocyte count is reduced to zero.
- Acute splenic sequestration is a major cause of acute anemia. A decline in hemoglobin concentration below baseline is common feature of ACS and can be its initial manifestation in a patient experiencing a VOC. Acute anemia may also occur as a result of sequestration of blood in the liver or accelerated hemolysis due to a delayed hemolytic transfusion reaction, septicemia, or another serious infection. Some patients with SCD have a chronically enlarged spleen and may develop hypersplenism. This present a reduction in white blood cell and platelet count in addition to acute anemia. Such individuals are particularly prone to develop acute sequestration events.
- Patients with splenic sequestration must be monitored for recurrences. Individuals with recurrent sequestration or a single life-threatening sequestration event should be considered for a splenectomy. Patients with chronic splenic sequestration accompanied by local pain and hypersplenism are also managed with splenectomy.

ACUTE CHEST SYNDROME

- Acute chest syndrome (ACS) is one of the most common and serious acute complications of SCD. It is the second most frequent reason for hospitalization in patients with SCD and the most common cause of death. Clinically, ACS resembles pneumonia and can develop suddenly or insidiously, during hospitalization for a VOC, or after a surgical procedure, especially involving the abdomen. ACS occurs with increased frequency in patients with asthma or prior ACS events.
- A patient with ACS typically has sudden onset of signs and symptoms of lower respiratory tract disease (cough, shortness of breath, rales, etc.) and a new pulmonary infiltrate on chest radiograph. The most common well-defined etiology is infection (viral, bacterial, chlamydia, or mycoplasma), but the complication may also result from bone marrow fat embolism, intrapulmonary aggregates of sickled cells, atelectasis, or pulmonary edema.. There are no distinctive laboratory features of ACS, although the hemoglobin concentration often declines sharply below the patient's baseline value
- Patients with ACS generally improve within several days with treatment (Antibiotics, oxygen) but some develop rapid respiratory failure and/or involvement of other organs such as brain, kidneys and liver. Markers for an impending severe case of ACS are multilobe disease, increased work of breathing, inability to maintain oxygen concentration above 95 percent even with supplemental oxygen and pleural effusions.

ACUTE STROKE

- Stroke is one of the most common and devastating complications of SCD. This complication presents as sudden onset of weakness, aphasia and sometimes seizures or coma. Transient ischemic attack often precedes stroke. Overt stroke is generally secondary to stenosis or occlusion of the internal carotid or middle cerebral artery, but events may be precipitated by ACS, parvovirus infection, or other acute anemic events. In patients with SCD who present with severe headache, altered level of consciousness, seizures, speech problems, and/or paralysis, urgent hospitalization is required.

ACUTE OCULAR CONDITIONS

- In patients with SCD, acute ocular complications may occur secondary to trauma, infection, vaso-occlusive episodes leading to occlusion of the eye vasculature, or progression of proliferative sickle retinopathy (PSR). Hyphema, central retinal artery occlusion (CRAO), orbital and periorbital infections, orbital infarction, and orbital compression syndrome (OCS) all require urgent or emergent assessment and therapy. In patients with SCD, and even in healthy individuals with sickle cell trait, hyphema is

especially dangerous due to the hypoxic and acidotic nature of the anterior chamber which promotes sickling of red cells in the aqueous humor. Blood flow in the central retinal artery in the presence of high intraocular pressure (IOP) may result in central retinal artery occlusion (CRAO) and infarction of the optic nerve. Elevated IOP is poorly tolerated in patients with SCD. CRAO is a rare cause of blindness reported almost exclusively in children and young adults with SCA. Patient typically present with sudden, painless unilateral or bilateral loss of vision. CRAO has been observed in patients with SCD in association with IOP secondary to hyphema. Orbital infarction is another rare but serious complication of SCD, typically occurring during a VOC. Patients typically present with protrusion of the eye, pain, and/or orbital edema.

MANAGING CHRONIC COMPLICATIONS OF SICKLE CELL DISEASE

- Complications may occur early and span the entire life of patients affected by SCD. Direct SCD complications may include acute or chronic pain syndromes, significant anemia and its sequelle, as well as organ damage and failure. Other coexisting complications may include RA and peptic ulcer disease. Chronic complications of SCD can affect almost any organ, and certain acute complications, such as stroke and priapism, often evolve into chronic phases that require special approaches to management.

CHRONIC PAIN

- In SCD, pain is considered chronic if it lasts more than 3 months. Patients with SCD experience both nociceptive and neuropathic pain. Nociceptive pain is a hallmark of chronic pain. Chronic pain, including that described in people without SCD, is often associated with neuropathic pain.

  The major types of SCD-associated chronic pain include the following:
  - Chronic pain of unclear etiology. This type of chronic sickle cell pain may be an extension of recurrent acute painful episodes. Therefore, early and aggressive intervention in treating acute sickle cell pain may reduce the development of chronic pain.
  - Chronic pain a specific tissue or organ, such as avascular necrosis (AVN) of the hips, or leg ulcers. Chronic SCD pain is usually described as constant and deep, nagging, and achy in nature. It can occur in the chest, back, abdomen, extremities, neck or head and is difficult to treat.
  - Chronic neuropathic pain is usually described as burning, numb, tingling, lancinating, shooting, or paroxysmal in nature and is associated with sensation of pins and needles. The severity is also enhanced by exposure to either cold or heat. SCD-related neuropathic pain has two etiologies. The first is tissue damage secondary to occlusion of blood vessels that supply the nerves and spinal cord infarction. The second seems to be chronic pain. Persistent chronic pain, the resulting inflammation, may lead to neuropathic pain.
  - The pathophysiology, management, and goals of treating chronic pain differ from those related to acute pain. Whereas the aim of acute pain treatment is to heal the acute process, the aim of chronic pain management is to restore function and to improve the quality of life. With the onset of chronic pain of unknown etiology, there seem to be a process of “rewiring” in the brain, where the threshold of pain perception is lowered so that ambient environmental stimuli that are normally painless or mildly painful induce the perception of severe pain. Chronic pain is often associated with other conditions that enhance its chronicity. These include psychosocial factors such as depression, anxiety, feeling of despair, insomnia, loneliness, helplessness, PTSD, and dependence on pain medications.
  - Management of chronic pain in patients with SCD is a major challenge for Health Care Practitioner. The goals of providing adequate pain relief to improve functionality and quality of life must be balanced by the need to minimize the risk of abuse, misuse, or diversion of opioids (the mainstay in managing chronic pain in patients with SCD).
  - Believing the patient’s report of pain is critical in optimizing therapeutic outcomes and achieve adequate pain relief and maintaining or improving functionality and the patient’s quality of life.
  - Medications used to treat SCD related pain should be tailored to the individual. Medications including NSAIDs, opioids, antidepressants, and anticonvulsant medications. Management of all types of chronic pain associated with SCD may be enhanced by adding nonpharmocologic

approaches. These include psychological intervention, occupational therapy, behavioral and cognitive interventions and mild to moderate exercise.

AVASCULAR NECROSIS

- Avascular necrosis (AVN, also known as aseptic necrosis, osteonecrosis, or ischemic necrosis) is bone death due to compromised blood supply. The hip joint is the most common site of AVN. Involvement of the shoulder and other joints is less common. Risk factors for AVN of the femoral head include SCD genotype, age, frequency of painful episodes, hemoglobin level, and alpha-gene depletion. The overall prevalence of AVN in SCD is 10-50 percent.
- AVN of the femoral head causes chronic severe pain and disability. The pain is generally worse with walking, relieves by rest, and may be accompanied by moderate to severe limitation of motion when the patient bears weight. About 40-80 percent of cases of AVN of the hips are bilateral and, hence evaluation of patients with AVN should focus on both hips.

LEG ULCERS

- Leg ulcers are common complications of SCD in general and SCA in particular. Leg ulcers are more common in males and older patients and less common in patients with alpha-gene deletion, high total Hb level, and high levels of HbF. Trauma, infection, and severe anemia may predispose patients to ulcer formation. The ulcers occur most frequently on the medial or lateral surfaces of the ankles. Osteomyelitis may complicate chronic leg ulcers, especially deeper ones. A bone scan or MRI and bone biopsy are used to assess this complication. Multidisciplinary teams include wound care specialist may be needed in the management of recalcitrant leg ulcers.

HYDROXYUREA THERAPY IN THE MANAGEMENT OF SICKLE CELL DISEASE

- Hydroxyurea can reduce the frequency of sickle cell-related pain and the incidence of acute chest syndrome (ACS). It has been shown that a high level of fetal hemoglobin (HbF) have a favorable effect on preventing intra-erythrocytic hemoglobin S polymerization and vaso occlusion. Hydroxyurea, a ribonucleotide reductase inhibitor, was identified as a promising drug candidate to increase HbF levels in patients with SCD. Hydroxyurea is known to have rapid absorption and near complete bioavailability and to be therapeutic with once-daily dose oral dosing. Hydroxyurea also raises RBC volume and improve cellular deformability, which increases blood flow and reduces vaso-occlusion. In addition, nitric oxide released directly from hydroxyurea metabolism may contribute to local vasodilatation.
- The multicenter Study of Hydroxyurea in patients with sickle cell anemia (MSH) was a randomized double-blind, placebo-controlled trial involving adults with SCA. Summary of findings:
  - Lower annual rates of pain crises
  - Longer time to a first crisis on study and longer time to a second crisis
  - Lower incidence of ACS
  - Reduced need for blood transfusions
  - Increased total hemoglobin
  - Lower cost of hospitalization

HYDROXYUREA TREATMENT RECOMMENDATIONS

1. Educate patients about Hydroxyurea therapy.
2. In adults with SA who have who have three or more sickle cell-associated moderate to severe pain crises in a 12-month period, treat with Hydroxyurea.
3. In adults with SCA who have sickle cell-associated pain that interferes with daily activities and quality of life, treat with Hydroxyurea.
4. In adults with SCA who have a history of severe and/or recurrent ACS, treat with Hydroxyurea.
5. In adults with SCA who have severe symptomatic chronic anemia that interferes with daily activities or quality of life, treat with Hydroxyurea.
6. In adolescents with SCA, offer treatment with Hydroxyurea regardless of clinical severity to reduce SCD-related complications (e.g., pain, ACS, anemia.

7. In adults and children with SCD who have chronic kidney disease and are taking erythropoietin, Hydroxyurea can be added to improve anemia.
8. In females who are pregnant, discontinue Hydroxyurea therapy.
9. To ensure proper use of Hydroxyurea and maximize benefits and safety, use an established prescribing and monitoring protocol.
10. In patients with HbSB-thallasemia or HbSC who have recurrent sickle cell-associated pain that interferes with daily activities or quality of life consult with specialist for consideration of Hydroxyurea therapy.
11. In patients not demonstrating a clinical response to appropriate doses and duration of Hydroxyurea therapy, consult a specialist.

TREATMENT GUIDELINES FOR THE INPLEMENTATION OF HYDROXYUREA THERAPY

The following laboratory tests are recommended before starting Hydroxyurea therapy:

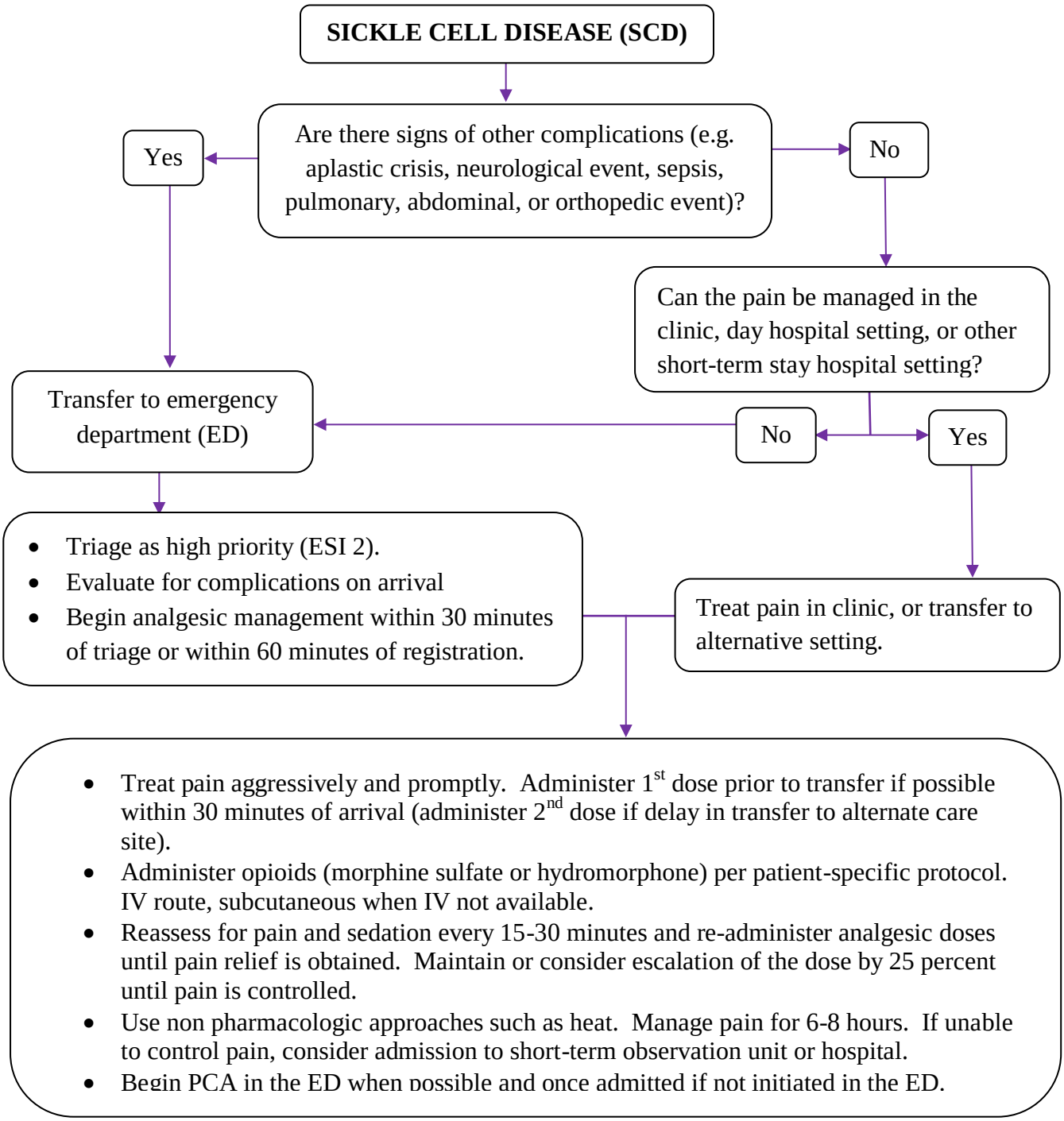
- Complete blood count (CBC) with white blood cell (WBC) differential, reticulocyte count, platelet count, and RBC MCV
- Quantitative analysis of HbF if available (e.g., hemoglobin electrophoresis, high performance liquid chromatography (HPLC).
- Comprehensive metabolic profile, including renal and liver function tests.
- Pregnancy test for females
- Initiating and Monitoring therapy
- Baseline elevation of HbF should not affect decision to initiate Hydroxyurea therapy.
- Both males and females of reproductive age should be counseled regarding the need for contraception while taking Hydroxyurea.
- Starting dose for adults (500 mg capsules): 15 mg/kg/day (round up to to the nearest 500 mg); 5-10 mg/kg/day if patient has kidney disease.
- Starting dose for children: 20mg/kg/day
- Monitor CBC and WBC differential and reticulocyte count at least every 4 weeks when adjusting dosages.
- Aim for a target absolute neutrophil count $\geq$ 2,000/uL; however, younger patients with lower baseline counts may safely tolerate absolute neutrophil counts down to 1,250/uL.
- Maintain platelet count $\geq$ 80,000/uL
- If neutropenia or thrombocytopenia occurs:
  - Hold Hydroxyuria dosing.
  - Monitor CBC and WBC weekly.
  - When blood counts have recovered, re-institute Hydroxyurea at dose 5mg/kg/day lower than the dose given before onset of cytopenias.
  - If dose escalation is warranted based on clinical and laboratory findings, proceed as follows:
    - Increase by 5mg/kg/day increments every 8 weeks
    - Give meds until myelosuppression (absolute neutriphil count 2,000/uL to 4,000/uL) is achieved, up to a maximum of 35 mg/kg/day.
  - Once stable dose is established, laboratory safety monitoring should include:
    - CBC with WBC differential, reticulocyte count, platelet count every 2-3 months.
  - A clinical response to treatment may take 3-6 months. Therefore, a 6-month trial on the maximum tolerated dose is required prior to considering discontinuation due to treatment failure, whether due to lack of adherence or failure to respond to therapy.
  - Monitor RBC MCV and HbF levels for evidence of consistent or progressive Laboratory response.
  - A lack of increase in MCV and/or HbF is not an indication to discontinue therapy.
  - For the patient who has a clinical response, long-term Hydroxyurea therapy is indicated.
  - Hydroxyurea therapy should be continued during hospitalizations or illnesses.

ALTITUDE AND SICKLE CELL DISEASE

- Patients with sickle cell disease and sickle cell anemia in particular, can have a sickle cell crisis at elevations as low as 4,900 feet. However the incidence of problems in patients with sickle cell trait, at this altitude is low.

References: National Institute of Health, National Heart, Lung and Blood expert panel report, 2014

High Altitude Medicine, Med Clinic North Am, 1992; American Family Physician 1998



Appendix E, Sec. 30.0 Management Guidelines for Cystic Fibrosis

Epidemiology

- Cystic Fibrosis (CF) is a lifelong, hereditary disease that causes thick, sticky mucus to form in the lungs, pancreas and other organs. In the lungs, this mucus blocks airways, causing lung damage and subsequently difficult breathing for the individual. In the pancreas, it clogs the pancreatic ducts and thus interfering with normal digestion. CF is the second most common inherited disorder in childhood in the United States, behind sickle cell anemia. The SWEAT TEST is the standard diagnostic test for cystic fibrosis. CF results in shortened life expectancy. Approximately 1,000 new cases are diagnosed each year.

Clinical Features

- The natural history of CF lung disease is one of chronic progression with intermittent episodes of acute worsening of symptoms frequently called acute pulmonary exacerbations. These exacerbations typically warrant medical intervention. Clinical features of an exacerbation may include increased cough, increased sputum production, shortness of breath, chest pain, loss of appetite, loss of weight and decline in lung function.

Treatment recommendations

- Once a decision has been made to intervene for pulmonary exacerbation, the clinician must then decide where that treatment can best be provided. There are various treatment options. Treatment depends upon the stage of the disease and organs involved. A variety of airway clearance techniques are used to clear mucus from the lungs. In fact, airway clearance therapy has long been considered a crucial aspect of treatment of pulmonary exacerbation. In general, airway clearance therapies should be intensified as part of the treatment of an acute exacerbation. This typically means increased time for each treatment as well as increase in the frequency of treatments.

Aerosol Therapy:

- Bronchodilators have helped to deal with chronic lung dysfunction and is a crucial aspect of chronic therapy.
- Drugs delivered by aerosol represent an important breakthrough in treatment of the lung-disease aspects of cystic fibrosis. One such drug being used is a genetically engineered enzyme called recombinant human deoxyribonuclease or DNase. The enzyme, administered in aerosol form, thins out the mucus that obstructs CF patients' airways, reducing the number of lung infection and improving lung function. This treatment option does not replace standard therapy, but is used in addition to standard therapy.

Antibiotic Therapy:

- Antibiotics are used to treat lung infections and are usually given intravenously. Because the most common pathogen identified in cultures of the CF patient's airways is Pseudomonas aeruginosa, antibiotic choices for treatment of acute exacerbation are typically directed at this pathogen. Once a

decision has been made to intervene for a pulmonary exacerbation, the clinician must then decide where that treatment can best be provided-on-site or in a hospital.

Corticosteroids

- The routine use of inhaled or oral corticosteroid therapy should be discouraged due to potential harm from side effects. However, a short course of systemic corticosteroids may offer benefit in the treatment of acute exacerbation without the long-term side effects, an approach that has been used in the treatment of acute exacerbations in chronic obstructive pulmonary disease.

Additional Considerations

- Patients with CF may demonstrate glucose intolerance during an exacerbation. CF patients with CF-related diabetes typically require increased insulin during treatment of an acute exacerbation. An additional concern includes patients with renal dysfunction who will need close observation for potential deterioration and drug monitoring.
- All patients with CF should be immunized against Pneumococcal pneumonia and annual influenza vaccine.

References: Cystic Fibrosis Foundation; Am J Respir Crit Care Med vol 180, 2009

Appendix E, Sec. 31.0 Treatment Guidelines Amendment Procedure

PROCEDURE: The Medical Treatment Guidelines are dynamic documents which must be reviewed and updated to keep abreast of improved diagnostic and therapeutic modalities.

Procedures exist for amendment and updating. Compliance with the treatment guidelines is required

Treatment Guidelines are dynamic documents which must be reviewed and updated to keep abreast with improved diagnosis and therapies. The succeeding procedure is to be followed for any requested change or amendment to ADCRR Treatment Guidelines. All proposed changes and amendments will be reviewed and considered by MSCMB Central Office personnel if:

- The proposal and requester are clearly identified in writing,
- Appropriate reference documents supporting the change or amendment are supplied with the request,
- There is a clear concise statement evidencing why the proposed change or amended pathway is superior to that of the original Treatment Guideline, and,
- The proposed changes and related documents have been submitted through the Vendor Regional Medical Director for initial review and comment before being forwarded to ADCRRCMB, Central Office, Medical Program Administrator.
- Upon completion of review by the Medical Program Administrator, a response to the proposed change/amendment will be furnished to the requester through the Vendor Medical Director.
- The Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau publishes its Medical Treatment Guidelines/Algorithms Manual (hereafter called Guidelines) as needed to reflect current treatment recommendations with further updates as necessary.
- The document represents a compendium of Medical Treatment pathways for individual conditions and disease states. The information is intended to be used as a guide for the Health Care Provider in identifying a logical, orderly treatment pathway for an individual patient.
- Medical Providers have historically delivered care to their patients based upon a unique treatment plan generally based upon the personal experience, training, and bias of the Practitioner/Provider. This "individualized" care plan pattern has become problematic as care options multiplied, patient geographical location changes became more common, and society demanded better management of resources.
- To provide a method to assist in the efficient management of the health care of our inmate population, the Contract Vendor Health delivery must function as an integrated team of Providers with common set of objectives. Our mobile population dictates that the Vendor provide consistent and continuous care throughout the correctional system. The principles of "managed care" afford a framework to facilitate the accomplishment of the mission.
- The establishment of health care guidelines will assist in the provision of quality, cost-effective medical treatment. With this availability of care guidelines at all inmate locations, continuity of care and treatment plans is assured in the correctional medical environment. Compliance with Treatment Guidelines is required. If an inmate's condition and circumstance precludes compliance with the

treatment plan, the Vendor medical Practitioner must clearly document the justification for noncompliance and outline the proposed alternative treatment plan in the inmate's health record. The medical Practitioner must also, prior to institution of any alternative treatment plan, submit the case for review to the Vendor UMMD or designee.

- If circumstances are of an urgent or emergent nature to ensure continuity of care an alternative treatment plan may be implemented by the Practitioner in direct consultation with the Vendor UMMD or designee.
- Compliance with Treatment Guidelines shall be closely monitored by the Vendor. Deviation from accepted treatment plans, unless clinically justified and documented as outlined, will be viewed as willful disregard of accepted medical standards and ADCRR directives.
- Suggestions for changes, additions, or deletions to the manual may be submitted for consideration to the Vendor Regional Medical Director, MSCMB Medical Program Administrator and MSCMB Assistant Director.
- Changes to the published document will be disseminated to the Vendor Health staff for inclusion in their official Medical Treatment Guidelines Manual as they occur.

Appendix F, Sec. 1.0 Forms and Stamps

HEALTH SERVICE CONTRACT MONITORING BUREAU FORMATS:

The standardization of Forms and stamps is a necessity since Health Service Contract Vendor encompasses multi-sites throughout the State of Arizona including the Private Prison facilities. When one introduces a site-specific form, it must be approved via the MSCMB. The circumvention of the Forms & Stamp Control process is not authorized. The success of ADCRR MSCMB and MS Contract Vendor's mission is dependent upon knowing what others have done, in the care of the patient, and where to look for information needed.

Multiple Forms frequently provide the same information that could and should be available on one form. Adherence to Form Control will decrease inefficiencies, duplicity of action and the frustration with the bureaucratic paper process.

Arizona Department of Corrections Rehabilitation & Reentry	Mental Health Services	OPR: MS Contract Vendor Medical Records Supervisor MSCMB Medical Records Monitor MSCMB Program Evaluation Administrator
Medical Services Technical Manual	MSTM Appendix G Section 1.0	SUPERSEDES: 08/15/2018 EFFECTIVE DATE: 07/01/2019

Appendix G, Sec. 1.0 Mental Health Services

PURPOSE: To provide guidance for the provision of Mental Health services.

PROCEDURE: Follow the guidance contained in Mental Health Technical Manual.

Appendix H, Sec. 10 Authorized Abbreviations

APPROVED MEDICAL AND DENTAL ABBREVIATION LIST

Reviewed and Approved for Publication January 1, 2014

Published by: Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau

FORWARD

The Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau publishes its Approved Medical and Dental Abbreviation List (hereinafter called the List) on an annual basis.

The document is the official legal listing of the medical and dental abbreviations, various symbols and acronyms which have been approved by the Assistant Director or designee of Medical Services Contract Monitoring Bureau for use in the Arizona Department of Corrections Rehabilitation & Reentry health records. Only those which are listed in this official approved list may be used in the health records.

Suggestions for changes, additions or deletions to this listing may be submitted for consideration to the MSMB Assistant Director or designee through the Contract Vendor Medical Records Supervisor or designee.

Changes to the published list will be disseminated to the ADCRR health staff for inclusion in the official Approved Medical and Dental Abbreviation List as they occur.

A new Approval Sheet will be disseminated to the users for inclusion in the official list annually as necessary.

- A -

A.	Assessment (as used in POMR)
aa	Of each
AAA	Abdominal Aortic Aneurysm
ab	Abortion
abd	Abdomen, Abdominal
ABG	Arterial Blood Gasses
ABHTF	Alhambra Behavioral Health Treatment Facility
ABR	Absolute Bed Rest
ac	Before meals
ACE	Angiotension Conventing Enzyme
ACTH	Adrenocorticotropic Hormone
ACW	Arizona Center for Women

AD	Right Ear
A.D.	Assistant Director
Ad lib	As Desired
ADA	Americans with Disabilities Act
ADCRR	Arizona Department of Corrections Rehabilitation & Reentry
ADMS	Arizona Department of Health Services
ADL	Activities of Daily Living
Adm	Admit, admitted, admission
Adv	Advisory
AFB	Acid Fast Bacilli(us)
A.Fib	Atrial Fibrillation
AHCCCS	Arizona Health Care Cost Containment System
AHF	Antihemophilic Factor
AIDS	Acquired Immune Deficiency Syndrome
AKA	Above Knee Amputation
aka	Also known as
Alb	Albumin
Alc	Alcohol
Alk Phos	Alkaline Phosphatase
Alt	Alternate, Alteration
AM, a.m.	Morning
AMA	Against Medical Advice
A.M.A.	American Medical Association
Amb	Ambulatory
AMI	Acute Myocardial Infarction
Amp	Ampule; Amputee
Amt	Amount
ANP	Adult Nurse Practitioner
Ant	Anterior
A/O	As of
A & O	Alert and Oriented
AODM	Adult Onset Diabetes Mellitus
AP	Anterior Posterior; Apical Pulse
AP & Lat	Anterior Posterior and Lateral
APAP	Acetaminophen (Tylenol)
APAP/Cod	Acetaminophen with Codeine
APC	Aspirin, Phenacetin, Caffeine
App	Appendectomy
Approx	Approximately, Approximate
Appy	Appendectomy
ARC	Alhambra Reception Center
ARTC	Alhambra Reception and Treatment Center

Art	Artery, Arterial
AS	Left Ear
ASA	Acetylsalicylic Acid, Aspirin
ASCVD	Arteriosclerotic Cardiovascular Disease
ASH	Arizona State Hospital
ASHD	Arteriosclerotic Heart Disease
ASO(T)	Antistreptolysin-O (titer)
ASP-FG	Arizona State Prison-Ft. Grant
ASPC-	Arizona State Prison Complex
ASPC-D	As above: Douglas (Units: Gila, Mohave, Maricopa, Papago (DWI)
ASPC-E	As above -Eyman (Units: Rynning, SMU I, Meadows, Cook, SMU II)
ASPC-F	As above: Florence (Units: CB-6, Central, East, North, South)
ASPC-PHX	Arizona State Prison Complex-Phoenix (Units: ACW, ARC, ABHTF, Globe)
ASPC-PV	As above -Perryville (Units:San Pedro, Santa Cruz, Santa Maria)
ASPC-S	As above -Safford (Units: Graham, Tonto)
ASPC-T	As above: Tucson (Units: Cimarron, Santa Rita, Rincon, Echo, Manzanita, Winchester)
ASPC-W	As above -Winslow (Units: Coronado, Kaibab North, Kaibab South)
ASPC-Y	As above -Yuma (Units: Cheyenne, Cocopah)
Asst	Assistant
AUB	Abnormal Uterine Bleeding
AST	Antibiotic Sensitivity Test
AU	Both Ears
Atty	Attorney
AV	Atrioventricular
AWOL	Absent Without Leave
Ausc	Auscultation
Ax	Axillary
AZT	Zidavudine

-B-

B.Mod.	Behavior Modification
Ba	Barium
Bact	Bacteria, Bacterial
BBB	Bundle Branch Block
BE	Barium Enema
Bfst	Breakfast
b.i.d.	Twice a day
Bil	Bilateral
Bili	Bilirubin
BKA	Below Knee Amputation
BM	Bowel Movement
BMR	Basal Metabolism Rate
BNDD	Bureau of Narcotics, Dangerous Drugs

BOM	Bilateral Otitis Media
BOMEX	Board of Medical Examiners
BP	Blood Pressure
BPH	Benign Prostatic Hypertrophy
BR	Bathroom
Brady	Bradycardia
BRP	Bathroom Privileges
BS	Bowel Sounds
B/S	Breath Sounds
BSC	Bedside Commode
BSO	Bilateral Salpingo-oophorectomy
BUN	Blood Urea Nitrogen
Bx	Biopsy

- C -

$\overline{c}$	With
C	Centigrade
C1, C2, etc.	Refers to Cervical Vertebrae
Ca	Carcinoma, Cancer
Cal	Calorie
CAMC	Central Arizona Medical Center
Cap	Capsule
Carbo	Carbohydrate
CAT	Computerized Axial Tomography
Cath	Catheter, Catheterization
CBC	Complete Blood Count
CBS	Chronic Brain Syndrome
c/c	Chief Complaint
cc	Cubic Centimeter
CCU	Coronary Care Unit
C & D	Clean and Dry
CDB	Cough and Deep Breathe
CDC	Center for Disease Control
CDE	Common Duct Exploration
CDU	Complex Detention Unit
CEA	Carcino-embryonic Antigen
CFT4	Calculated Free Thyroxide
CHF	Congestive Heart Failure
Chg	Change
CHO	Carbohydrate
Chol	Cholesterol
Chr, Ch	Chronic
Chrg	Charge

CI	Continuous Improvement
Circ	Circulation
Cl	Chloride
cm	Centimeter
CMHC	Community Mental Health Center
CMA	Correctional Medical Assistant
CMV	CytomegaloVirus
CNS	Central Nervous System
C/o	Complaint(s) of
C.O.	Central Office
CO	Correctional Officer
CO2	Carbon Dioxide
Coag.	Coagulation; Coagulase
COB	Close of Business
Cocci	Coccidioidomycosis
Cod.	Codeine
COE	Court Ordered Evaluation/Examination
COLD	Chronic Obstructive Lung Disease
Comf.	Comfortable, Comfort
Comm	Committee
Comp	Compound
Cond	Condition
Cone	Conization
Cont	Continuous, Continue
COPD	Chronic Obstructive Pulmonary Disease
Corr	Correctional
CPK	Creatinine Phosphokinase
CPO	Correctional Program Officer
CPR	Cardiopulmonary Resuscitation
CQI	Continuous Quality Improvement
Creat	Creatinine
CRN	Correctional Registered Nurse
CRNS	Correctional Registered Nurse Supervisor
C/S	Caesarean Section or C: Section
C & S	Culture and Sensitivity
CSF	Cerebral Spinal Fluid
CSO	Correctional Service Officer
Ct	Court
CTM	Chlortrimeton (Chlorpheninamine)
CVA	Cerebral Vascular Accident
CVL	Central Venous Line
CVP	Central Venous Pressure

CXR	Chest x-ray
Cysto	Cystoscopy

- D -

D	Dextrose
D4T	Stavudine
D & C	Dilatation and Curettage
DC	Discontinue
D/C	Discharge
DD	Deputy Director
DDC	Didanosine
DDI	Zalcitabine
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Administration/Agency
Decub	Decubiti(us)
Deg	Degenerative, Degeneration
Dept	Department
Diag	Diagnosis
Diff	Differential
Dig	Digitalis
Dil	Dilute
DIPJ	Distal Interphalangeal Joint
Dis	Disease
Disp	Dispense
Div	Division
DJD	Degenerative Joint Disease
D.M., DM	Diabetes Mellitus
DNA	Deoxyribonucleic Acid
D.O.	Doctor of Osteopathy
DOA	Dead on Arrival
DON	Director of Nursing
DPM	Doctor of Podiatric Medicine
DPT	Diphtheria, Pertussis & Tetanus
Dr.	Doctor
DT(s)	Delirium Tremens
DTR	Deep Tendon Reflexes
DUB	Dysfunctional Uterine Bleeding
D/W	Dextrose in Water
DUI	Driving under the influence
DWI	Driving while intoxicated
D-5W	5% Water in Dextrose
Dx	Diagnosis

- E -

E	Enema
ea	Each
EBL	Estimated Blood Loss
EBV	Epstein Barr Virus
ECG	Electrocardiogram
E.coli	Escherichia coli
ECT	Electroconvulsive Therapy
EDC	Expected Date of Confinement
EEG	Electroencephalogram
EENT	Eye, Ear, Nose, Throat
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
Elix	Elixir
EMG	Electromyogram
Emp	Employee
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	Ear, Nose, Throat
EPS	Extrapyramidal Side Effects
EOM	Extra Ocular Movement
EOS	Eosinophil
Eq	Equivalent
ER	Emergency Room
ERD	Esophageal Reflux Disorder
ESR	Erythrocyte Sedimentation Rate
Est	Estimated
ETA	Estimated Time of Arrival
et	and
et al	And Others
ETC., etc.	Etcetera
ETH	Elixir Terpin Hydrate
ETH c Cod	Elixir Terpin Hydrate with Codeine
Etiol	Etiology
ETOH	Alcohol, ethyl
EST	Electroshock Therapy
Eval	Evaluation
Exam	Examination
Exc	Excision
Exp	Expire(s), Expired, Expiration
Ext	External, exterior, extension, extensor, extremity

- F -

F.	Fahrenheit

f, F	Female
FB	Foreign Body
FBS	Fasting Blood Sugar
F & C	Fever and Chills
Fdg	Feeding
Fe	Iron
FEF	Forced Expiratory Flow
Fem	Femoral
FEV	Forced Expiratory Volume
FFP	Fresh Frozen Plasma
FHA	Facility Health Administrator
Fib	Fibrillation
Fld	Fluid
Flex	Flexion
FNP	Family Nurse Practitioner
FO	Foreign Object
FS	Frozen Section
Ft	Foot
F/U	Follow Up
Funct	Function
FUO	Fever of Undetermined Origin
FVC	Forced Vital Capacity
Fx	Fracture
FXN	Function

- G -

G	Gravida
GAF	Global Assessment Form
GAS	Global Assessment Scale
GB	Gallbladder
GBD	Gallbladder Disease
GC	Gonorrhea, Gonococcus
Gen	General, Generalized
GERD	Gastro-esophageal Reflux Disorder
GI	Gastrointestinal
Gluc	Glucose
gm	Gram
GP	General Practice, General Practitioner
GPC	Gram Positive Cocci
GNR	Gram Negative Rods
gr	Grain
Grav	Gravida (Number of Pregnancies)
GSW	Gunshot Wound

GTT	Glucose Tolerance Test
Gtt(s)	drop(s)
GU	Genitourinary
GYN	Gynecology, Gynecological

- H -

h, hr, hrs	hour, hours
(H), "H"	Hypodermic
H2	Hestamine “2" Blocker
HA	Headache
HAA	Hepatitis Associated Antigen
HASHD	Hypertensive Arteriosclerotic Heart Disease
HBD	Hydroxybutyrate Dehydrogenase
HBIG	Hepatitis B Immune Globulin
HBP	High Blood Pressure
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HbSAg	Hepatitis B Surface Antigen
HCG	Human Chorionic Gonadotropin
HCl	Hydrochloric Acid
HCP	Health Care Provider
Hct	Hematocrit
HCTZ	Hydrochorothiazide
HCVD	Hypertensive Cardiovascular Disease
HDL	High Density Lipoprotein
HE	Health Educator
HEAC	Health Education Advisory Committee
HEENT	Head, Eyes, Ears, Nose, Throat
Hemi	Half
Hep	Hepatitis
Hgb	Hemoglobin
H/H	Hemoglobin/Hematocrit
HIV	Human Immunodeficiency Virus
HNP	Herniated Nucleus Pulposus
HNR	Health Needs Referral
H/O	History of
Hosp	Hospital, Hospitalization
H^2O	Water
H^2O^2	Hydrogen Peroxide
HOB	Head of Bed
HP	Health Provider
H & P	History & Physical
HR	Heart Rate

MS, MS	Hour of Sleep (bedtime)
MSS	Health Services Staff
Ht	Height
HTN	Hypertension
Hypo	Hypodermic, Hypodermically
Hx	History

- I -

IBC	Iron Binding Capacity
IBS	Irritable Bowel Syndrome
Ibu	Ibuprofen
ICU	Intensive Care Unit
ID	Identification
IDDM	Insulin Dependent Diabetes Mellitus
I & D	Incision and Drainage
IM	Intramuscular
I/M	Inmate
Imm	Immunization
Imp	Impression
In	Inch
Inc	Incomplete
Incr	Increase
Inf	Inferior, infusion, infection
Info	Information
Infx	Infection
Inpt	Inpatient
Int	Internal
IOP	Intra Ocular Pressure
I & O	Intake and Output
IP	Interphalangeal
IPC	Inpatient Component
IPK	Intractable Plantar Keratosis
IPPB	Intermittent Positive Pressure Breathing
IQ	Intelligence Quotient
ISO	Isolation
IUD	Intrauterine Device
IUP	Intrauterine Pregnancy
IV	Intravenous
IVC	Intravenous Cholangiogram
IVCU	Intravenous Voiding Cystourethrogram
IVF	Intravenous Fluids
IVP	Intravenous Pyelogram
IVU	Intravenous Urogram

- J -

Jt	Joint
Juv	Juvenile
JVD	Jugular Venous Distention
JV	Jugular Vein
JVP	Jugular Venous Pulse

- K -

K 9	Canine
KCl	Potassium Chloride
K+	Potassium
K.O.P.	Keep on Person
Kg	Kilogram
KI	Potassium Iodine
Kite	Inmate Letter
KJ	Knee Jerk
KO	Keep Open
KUB	Kidney, Ureters, Bladder
KVO	Keep Vein Open

- L -

L	Liter
L1, L2, etc.	Refers to Lumbar Vertebrae
L & A	Light and Accommodation
Lab	Laboratory
Lap	Laparoscopy or Laparotomy
Lat	Lateral
lb	Pound
LBBB	Left Bundle Branch Block
LC	Living children
LD	Left Deltoid
L & D	Labor and Delivery
LDH	Lactic Dehydrogenase
Lg	Large
Li	Lithium
LiCO3	Lithium Carbonate
Liq	Liquid
LLE	Left Lower Extremity
LLL	Left Lower Lobe
LLQ	Left Lower Quadrant
L/M	Liters per Minute
LMP	Last Menstrual Period
LN	Lymph Node
LOA	Left occipito-anterior; Left occipital anterior

LOC	Loss of Consciousness
LOS	Length of Stay
LP	Lumbar Puncture
LPN	Licensed Practical Nurse
LR	Lactated Ringers
LRQ	Lower Right Quadrant
LS	Lumbosacral
LSD	Lysergic Acid Diethylamide
Lt.	Light
Lt. OM	Left Otitis Media
L/U	Lock up
LUE	Left Upper Extremity
LUL	Left Upper Lobe
LUQ	Left Upper Quadrant
LVH	Left Ventricular Hypertrophy
L, Lt.	Left
L/W	Living and Well
Lympms	Lymphocytes
Lytes	Electrolytes

- M -

M	Male
m	Meter
MCA	Motorcycle Accident
Manip	Manipulation
Masc	Masculine
Max	Maximum
Max Sec	Maximum Security
Mc	Millicurie
Mcg	Microgram
MCH	Mean Corpuscular Hemoglobin
MCHC	Mean Corpuscular Hemoglobin Concentration
MCL	Midclavicular Line
MCV	Mean Corpuscular Volume
MD	Medical Doctor
MDR	Multiple Drug Resistant
Med	Medicine, Medication; Medium
Med Rec	Medical Record(s)
mEq	Milliequivalent(s)
Mg.	Magnesium
Mg, Mgm	Milligram
Mgr	Manager
MH	Mental Health

MI	Myocardial Infarction
Min	Minute, Minimum, Minimal
Misc	Miscellaneous
ml	Milliliter
mm	Millimeter
MMC	Maricopa Medical Center
MMR	Measles, Mumps, Rubella
MN	Midnight
Mo(s)	Month(s)
Mod	Moderate
MOM, mom	Milk of Magnesia
Mono	Monocyte(s); Mononucleosis
MR	Medical Record
MR	Measles/Rubella (vaccine)
MRI	Magnetic Resonance Imaging
MRL	Medical Record Librarian
MRT	Medical Record Technician
MS	Morphine Sulphate
MSRA	Methicillin Resistant Staphylococcus Aureus
MTB	Mycobacterium Tuberculosis
MU	million units
MVA	Motor Vehicle Accident

- N -

N/A	Not Applicable
NA	Nursing Assistant
Na+	Sodium
NAD	No Apparent Distress
NB	Take Notice (Noto Bene)
N/C, n/c	No complaint(s)
NCCHC	National Commission on Correctional Health Care
Neg	Negative
Neuro	Neurologic, Neurological
NF	Non-formulary, National Formulary
NG	Nasogastric
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NLT	Not Later Than
NNRTI	Non Nucleoside Reverse Transcriptase Inhibitor
No.	Number
Noc	Night
Noct	Nocturnal

NOS	Not Otherwise Specified
NOS	No Observable Symptoms
NP	Nurse Practitioner
NPH	Type of Insulin
NPN	Nonprotein Nitrogen
NPO	Nothing by Mouth
NR, Non rep	Do not repeat
NRTI	Nucleoside Reverse Transcriptase Inhibitor
N/S	Normal Saline
NSR	Normal Sinus Rhythm
NS, NSS	Normal Saline Solution
NSAID	Nonsteroidal anti-inflammatory drug
NTG	Nitroglycerin
NTP	Nursing assessment and/or treatment protocols
N & V	Nausea and Vomiting

- O -

O.	Objective (As used in POMR)
O, O	Oxygen
OB	Obstetrics
OB/GYNNP	Obstetrics & Gynecology Nurse Practitioner
Obl	Oblique
Obs	Observation
OBS	Organic Brain Syndrome
Occ, Occas	Occasional
OCG	Oral Cholecystogram
O.D.	Right Eye, Doctor of Optometry
OD	Overdose
OJ	Orange Juice
OMT	Osteopathic Manipulation Therapy
OOB	Out of Bed
Op	Operation
OP, O/P	Outpatient
Ophth	Ophthalmology
OPS	Outpatient Surgery
OPT	Optometry
OR	Operating Room
ORC	Outside Review Committee
Ortho	Orthopedic(s)
Os	Mouth
O.S.	Left Eye
OSHA	Occupational & Safety Health Act (or Agency)
OT	Occupational Therapy

OTC	Over the Counter (Medications)
O.U.	Both eyes
Ox3	Oriented to person, time and place
Oz	Ounce

- P -

P.	Plan (as used in POMR) $\overline{p}$ After
P	(See Para)
PA	Posterior Anterior
PA and Lat	Posterior-Anterior and lateral (e.g. CxR)
P & A	Percussion and Auscultation
PA-C	Physician Assistant: Correctional
PAC	Premature Atrial Contraction(s)
Pacer	Pacemaker
PAP	Papanicolaou (smear)
Para	Number of Deliveries
PAT	Paroxysmal Atrial Tachycardia
Path	Pathology
p.c.	After Eating
pc	Packed Cells
PCO2	Carbon Dioxide Pressure
PCV	Packed Cell Volume
PDR	Physicians' Desk Reference
PE	Physical Examination
Peds	Pediatrics
PEEP	Positive End Expiratory Pressure
Per	By
Per os	By Mouth
Peri	Perineum, Perineal
Peri	About or Around (when used as adjective: eg: Peri-Orbital)
Perio	Periodontal
PERRLA	Pupils equal, round, react to light & accommodation
PFB	Pseudo Folliculitis Barbae
PG, pg	Pregnant
pH	Hydrogen Ion Concentration
Pharm D	Doctor of Pharmacy
Phys	Physician
Phys.Tx	Physical Therapy
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PIPJ	Proximal Interphalangeal Joint
PKU	Phenylketonuria
PM, pm	Post Meridian, Afternoon

Pn	Pneumonia
PO	By Mouth
Pol	Policy
Polio	Poliomyelitis
POMR	Problem Oriented Medical Record
Poss	Possible
Post	Posterior
Post-op	Postoperative; post-operative
PP	Post-partum
ppBS	Post Prandial Blood sugar
PPD	Purified Protein Derivative
PR	Pulse Rate
PRBC	Packed Red Blood Cells
Preg	Pregnant, Pregnancy
Pre-op	Preoperative; pre-operative
Prep	Prepare, Preparation
PRN	Psychiatric Registered Nurse
prn	As necessary
Prob	Probable; problem
Proc	Procedure
Pro-time	Prothrombin Time
Prox	Proximal
PSVT	Paroxysmal Supraventricular Tachycardia
Psych	Psychiatry, Psychiatric
Psychol	Psychologist, Psychological
Pt, pt	Patient
PT	Prothrombin Time
P.T.	Physical Therapy
PTT	Partial Thromboplastin Time
PUD	Peptic Ulcer Disease
Pulm	Pulmonary
PV	Parole Violator
PVC	Premature Ventricular Contracture, Contractions
Px	Physical Examination

- Q -

$\overline{q}$	Every
QA	Quality Assurance
qam	Every Morning
qd	Every Day
qh	Every Hour
qid	Four Time a Day
qms	Every Night at Bedtime

qnoc	Every Night
qns	Quantity(ies) Not Sufficient
qod	Every Other Day
qs	Quantity(ies) Sufficient
qt	Quart
q2h	Every 2 Hours
q3h	Every 3 Hours
q4h	Every 4 Hours
q6h	Every 6 Hours
q8h	Every 8 Hours
q12h	Every 12 hours
qwk	Every Week

- R -

RA	Rheumatoid Arthritis (slide test)
Rad. Tech.	Radiology Technician
RBBB	Right Bundle Branch Block
RBC	Red Blood Cells
RBS	Random Blood Sugar
RCV	Red Cell Volume
Re	Regarding
Rec	Recommend, Recommendation
Rec'd	Received
Reg	Regular
Resp	Respirations, Respiratory
Retic	Reticulocyte
RF	Rheumatoid Factor
Rh	Rhesus (factor)
RIA	Radioactive Iodine Assay
RL	Ringers Lactate
RLE	Right Lower Extremity
RLL	Right Lower Lobe
RLQ	Right Lower Quadrant
RM	Risk Management
RN	Registered Nurse
RNA	Ribonucleic Acid
R/O	Rule Out
ROA	Right Occiput Anterior
ROM	Range of Motion
RPG	Random Plasma Glucose
Rph	Registered Pharmacist
RPR	Rapid Plasma Reagin
RR	Recovery Room

R, Rt.	Right
R.T.	Respiratory Therapy
RTC	Return to Clinic
Rt. OM	Right Otitis Media
RUE	Right Upper Extremity
RUL	Right Upper Lobe
RUM	Radial Ulnar Median (Nerve)
RUQ	Right Upper Quadrant
Rx	Prescription

- S -

S.	Subjective (as used in POMR)
$\overline{s}$	Without
SACRC	Southern Arizona Correctional Release Center
S1, S2, etc.	Refers to Sacral Vertebrae
SA	Sino-atrial
Sch	Schedule
SC, sc	Sick Call
SCU	Special Care Unit
Scop	Scopolamine
SEAMC	Southeastern Arizona Medical Center
Sed	Sediment, Sedimentation
Sed Rate	Sedimentation Rate
Semi	Half
Sep	Separate
SF	Salt Free
SGOT	Serum Glutamic Oxaloacetic Transaminase (also, ALT)
SGPT	Serum Glutamic Pyruvic Transaminase (also, AST)
SH	Surgical History
sig	Let it be Labeled, Labeled
sl	slight
Sm	small
SMA	Special Management Area
SME	Subject Matter Expert
SMH(-T)	St. Mary's Hospital (-Tucson)
SMI	Serious Mental Illness
SMR	Submucous Resection
SMU	Special Management Unit
SOAP	Subjective/Objective/Assessment/Plan
SOB	Short of Breath
Sod Pent	Sodium Pentothal
Sol	Solution
SP	Suicide Precaution(s)

S/P	Status Post
SPA	Special Programs Area
Spans	Spansules
Spec	Specimen
Sp Ed	Special Education
Sp Gr	Specific Gravity
Spont ab	Spontaneous Abortion
SPU	Special Programs Unit
S/S	Signs and Symptoms
ss	Half
SSRI	Selective Serotonin Re-uptake Inhibitor
SS #	Social Security Number
SSE	Soap Suds Enema
Staph	Staphylococcus
Stat	Immediately
STD	Sexually Transmitted Disease
STE	Soft Tissue Examination
Strep,Strept	Streptococcus
STT	Soft Tissue Trauma
Subj.	Subject
Sub-q, sq	Subcutaneous
Sup	Superior
Supp	Suppository
Surg	Surgical
Svcs	Services
SVN	Small Volume Nebulizer
SVT	Supraventricular Tachycardia
Sx	Symptoms

- T -

T, Tbsp	Tablespoon
t, tsp	Teaspoon
T., Temp	Temperature
T1, T2, etc.	Refers to Thoracic Vertebrae
T RIA	Triiodothyronine Radioactive Iodine Assay
T4	Thyroxine, levo thyroxine, tetraiodothyronine
T & A	Tonsillectomy and Adenoidectomy
tab	Tablet
Tach	Tachycardia
TAH	Total Abdominal Hysterectomy
TAT	Tetanus Antitoxin
TB	Tuberculosis, Tubercule Bacillus
TCA	Tricyclic Antidepressant

TCDB	Turn, Cough, Deep Breathe
Td	Diptheria, Tetanus, Adult
TD	Tardive Dyskinesia
Tech	Technician
TF	To Follow
TIA	Transient Ischemic Attack
TIBC	Total Iron Binding Capacity
tid, TID	Three times a day
TIG	Tetanus Immune Globulin
tinct	Tincture
TKO	To keep open
TLC	Tender Loving Care; Total Lung Capacity
TM(s)	Tympanic Membrane(s)
TMJ	Temporomandibular Joint
TNTC	Too Numerous To Count
TO, T.O.	Telephone Order
TPR	Temperature, Pulse and Respirations
TQM	Total Quality Management
Transp	Transport, Transportation
TSS	Toxic Shock Syndrome
TUR	Transurethral Resection
TURP	Transurethral Resection of Prostate
Tx	Treatment

- U -

U	Unit
UA	Urine Analysis, Urinalysis
UGI	Upper Gastrointestinal
ULQ	Upper Left Quadrant
Unk	Unknown
UR	Utilization Review
URC	Utilization Review Committee
URI	Upper Respiratory Infection
URQ	Upper Right Quadrant
Ung	Ointment
U/S	Ultrasound
USP	U.S. Pharmacopeia
UTI	Urinary Tract Infection

- V -

Vag	Vagina, Vaginal
Vag Hyst.	Vaginal Hysterectomy
Vasc	Vascular
VD	Venereal Disease

vd	Void
vdg	Voiding
VDRL	A flocculation test for Syphilis
VEGAN	vegetable-based hypoallergenic alternative nutrition
Vent	Ventricular, Ventricle
Vit	Vitamin
VO, vo	Verbal Order, vocal order
vol	Volume
v/s	Vital Signs
vs	Versus
V. Tach	Ventricular Tachycardia

- W or w/ -

$\overline{w}$	With
WAIS	Weschler Adult Intelligence Scale
WBC, wbc	White Blood Cells
WC, w/c	Wheelchair
WDWM	Well developed white male
WDWF	Well developed white female
WDBM	Well developed black male
WDBF	Well developed black female
WDHM	Well developed hispanic male
WDHF	Well developed hispanic female
WDIM	Well developed Indian male
WDIF	Well developed Indian female
WHC NP	Womens Health Care Nurse Practitioner (Formerly OB/GYN NP)
wk	Week
WNL	Within Normal Limits
w/o	without
wt	Weight
w d	Wet to Dry (as in dressings)

- X -

x	Times

- Y -

Yd	Yard
Yr	Year
YTD	Year to Date

- Z -

ZDV	Zidovudine

Appendix I, Sec. 1.0 Approved Glossary

Published by: Arizona Department of Corrections Rehabilitation & Reentry
Medical Services Contract Monitoring Bureau

FORWARD

The Arizona Department of Corrections Rehabilitation & Reentry Medical Services Contract Monitoring Bureau (MSCMB) publishes its Approved Glossary.

The document is the official listing and definitions of most of difficult or specialized words and terms used in this Technical Manual and in MSCMB correspondence. The definitions have been approved by the MSCMB for use in the Arizona Department of Corrections Rehabilitation & Reentry correspondence.

Suggestions for changes, additions or deletions to this listing may be submitted for consideration to the MSCMB Program Evaluation Administrator through the Medical Records Program Monitor.

Changes to the published list will be disseminated to the ADCRR Contract Vendor health staff for inclusion in the official Approved Glossary as they occur.

A new Approval Sheet will be disseminated to the users for inclusion in the official list annually as necessary.

Approved Glossary

- A -

ACHIEVEMENT AGE: A person's educational proficiency as measured by standard achievement tests that compare the individual's academic scores to the median scores for persons of the same chronological age.

ACQUIRED IMMUNE DEFICIENCY (AIDS): A human disease characterized by a collapse of the body's natural immunity against disease. Because of this failure of the immune system, patients with AIDS are highly vulnerable to one or more unusual infections or cancers that usually do not pose a threat to anyone whose immune system is functioning normally. AIDS diagnosis is made when the person is HIV positive and has had an AIDS-related disease occur.

ADMINISTER: The direct application of a controlled substance, prescription-only drug, dangerous drug or narcotic, whether by injection, inhalation, ingestion, or any other means, to the body of patient or research subject by a practitioner or by his authorized agent or the patient or research subject at the direction of the practitioner.

ADMINISTRATIVE REVIEW COMMITTEE: A committee convened quarterly to review policy and procedure recommendations forwarded from the Medical Peer Review Committee.

ADMINISTRATIVE DETENTION: Inmates isolated from the general population for unacceptable behavior requiring further evaluation.

AFB: Acid fast bacillus; *M. tuberculosis* is an example of an AFB positive organism.

ACIS: (Arizona Inmate Management System) Online screen and batch report used to input data to track inmate population. Types of information are as follows, movement, medical status, medical holds, restrictions, etc.

ATTEMPTED SUICIDE: An intentional and voluntary act of attempting to take one's own life, which results in hospitalization or significant or life threatening injury.

AUTHORIZED RECIPIENT: For the purposes of the medical information release policies of this manual, only the Director and Assistant Directors, Wardens, and Deputy Wardens, who are authorized by A.R.S. 41-1606 to receive inmate medical history information and to use the information for correctional-related purposes.

- B -

BEHAVIOR MANAGEMENT/MODIFICATION: Services based on the principles of reward and reinforcement designed to modify/improve the inmate's ability to socialize, maintain acceptable hygiene, and develops general coping and living skills.

BOARDER: An inmate not requiring IPC or HU-8 level of care, but may require observation, infrequent medical treatment, administrative admission and or mental health observation without significant medical issues.

BOARD OF EXECUTIVE CLEMENCY (BOEC): The BOEC considers and grants parole to inmates certified as eligible by the Department of Corrections and who meet the legal criteria for a grant of parole and it recommends to the Governor appropriate clemency actions.

BODY FLUIDS THAT TRANSMIT HIV AND HBV:

¾ Blood

¾ Semen

¾ Vaginal Secretions

¾ Cerebrospinal Fluid

¾ Synovial Fluid

¾ Pleural Fluid

¾ Pericardial Fluid

¾ Peritoneal Fluid

¾ Amniotic Fluid

¾ Saliva (in dental setting)

¾ Unfixed tissue or organ (other than intact skin from a human, living or dead).

¾ HIV-containing cell or tissue cultures, organ cultures, and HIV or HBV containing culture medium or other solutions.

¾ Any bodily fluid with visible blood present.

- 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.

CASE: A person with a clinical syndrome of a communicable disease whose condition is documented by laboratory results that support the presence of the causative agent, by a physician's diagnosis based on clinical observation, or by epidemiologic associations with communicable disease, the causative agent or its toxic products.

CENTRAL CORRIDOR FACILITY: This is an internal designation for larger complexes capable of supporting more complex health issues. Central Corridor facilities are most often identified by their inpatient capability, proximity to major highways, robust health staffing, and access to specialty care.

CHARGE NURSE: The nursing staff member designated as the responsible Nurse for a given shift.

CHEST X-RAY: An x-ray photograph of the chest that may provide evidence of whether the examined individual has been infected or is currently infected with a communicable disease (e.g., tuberculosis).

CHEST X-RAY REPORT: A written report from a physician explaining the results of a chest x- ray.

CHRONIC CONDITIONS: Requiring Regular Examinations and/or as defined by Department Order 1101.

CLINIC STOCK/FLOOR STOCK: A minimum supply of essential medication/supplies not labeled for specific patient for the purpose of administration to an inmate by an authorized Arizona Department of Corrections Rehabilitation & Reentry Health Services Contract Vendor staff member.

CLINICAL ENCOUNTERS: Are interactions between inmates and health care providers that involve a treatment and/or exchange of confidential information.

CLOSE CONTACT: A person who lives with, works with or frequently is in close proximity in an enclosed environment to a person with infectious TB (TB disease). NOTE: Central Office- Health Services in consultation with the local or state health department will provide direction in defining a close contact.

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: Mortality Review shall be held at the deceased offender's institution. The Committee consists of the following members: Contract Vendor Facility Health Administrator, Vendor complex Medical Director, Vendor complex Director of Nursing, Vendor complex Lead Psychologist, and as appropriate, the institutional Warden and Deputy Warden of the offender's unit.

COMPLIANCE: An inmate diagnosed with a communicable disease (e.g., tuberculosis) complies with the guidance in this Technical Manual by taking medications as prescribed.

CONFIDENTIAL COMMUNICABLE DISEASE INFORMATION: Personal data that may be used to identify a particular patient, e.g., the patient's name, social security number and housing location, and which is derived from the patient's medical record or other source.

CONTACT: An individual (inmate or employee) who has shared air and/or living space with a person who has a communicable disease, resulting in the probability that the transmission of a communicable disease may have occurred.

CONTACT INVESTIGATION: The process of identifying, screening and evaluating individuals who are considered recent close contacts of a TB case or suspect.

CONTAMINATION: The presence of an infectious agent on a body surface; also on or in any object.

CONTROLLED SUBSTANCE: Any prescription drug which has been deemed by the Drug Enforcement Administration (DEA) or Arizona State Board of Pharmacy to require a higher degree of accountability, and therefore is subject to Federal and State restrictions. May also be any other medication which has been identified by the Pharmacy and Therapeutics Committee as a security risk or hazard to the health of the inmate.

CONVERTER: An inmate 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: Counselor assigned to an inmate(s) who meet regularly to ensure that the inmate understands the rules and regulations and understands treatment plans. Provides feedback to other members and serves as primary contact and resource.

CORRECTIONAL-RELATED PURPOSE: For the purposes of the medical records policies contained within this Manual, the reasons that an authorized recipient may receive inmate medical history information and appropriate uses of the information in the management and operation of a correctional facility.

CURRENT AUTHORIZATION: An authorization that has been signed within the prior 365 days.

-D -

DECLARATION: A "Declaration of Intent to Limit Extraordinary Life-Support Procedures" form signed by an inmate and two witnesses. A completed Declaration establishes the inmate's intent to limit extraordinary life-support procedures intended only to prolong the dying process that would otherwise be administered were they to have an incurable and terminal medical condition.

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 actual, constructive or attempted transfer from one person to another whether or not there is an agency relationship.

DESIGNEE: For the purpose of the information release policy, an individual, who is not a relative and clACIS to have an interest in an inmate's medical condition, treatment, or outcome.

DEVELOPMENTALLY DISABLED/RETARDATION: A congenital abnormality, traumatic injury or disease that impairs normal intellectual functioning and prevents a person from participating normally in activities appropriate for the person's particular age group. This disorder is characterized by deficient intellectual functions which impair the ability of the individual to learn and adapt socially.

DIRECT CONTACT: When a body fluid of one person comes into contact with the mucous membrane, body fluid or broken skin of another person.

DIRECT OBSERVED THERAPY (DOT): Recommended method of administering TB medication(s) or other designated medications, where medical staff hands the medication and watches the person swallow this medication. See Unit Dose and Watch Swallow.

DISPENSE: To deliver a chemical or chemical compound (pharmaceutical) to an ultimate user by or pursuant to the lawful order of a Practitioner, including the prescribing, administering, packaging, labeling or compounding necessary to prepare for that delivery.

DISTRIBUTE: To deliver, other than by administering or dispensing.

DOCUMENTED HISTORY OF A POSITIVE TB SKIN TEST: Any written documentation or verbal information which includes the year and location of skin testing and duration of INH treatment.

DNA BLOOD SAMPLE: Blood withdrawn from an offender, from which a DNA Profile can be extracted for identification purposes.

DNA BUCCAL SWAB: Swabbing the inside of the mouth (cheek) to obtain a specimen to submit for a DNA profile.

DNA-OFFENDER TO BE TESTED: Any inmate, or offender under community supervision (except those being supervised pursuant to an interstate compact agreement), who was convicted of one or more of the offenses pursuant to Article 13, Chapter 14, Sexual Offenses and Title 13, Chapter 36, Family Offenses.

DNA TEST: A mandatory process in which a DNA blood sample or a buccal swab is collected and fingerprints are taken from new commitments and offenders who have been convicted of an offense specified in A.R.S. 13-4438 and who are to be released on or after August l, 1993. (The sample and the fingerprints are evidentiary items).

DRUG UTILIZATION REVIEW COMMITTEE: A combined Pharmaceutical and Therapeutics (P&T) Committee comprised of Arizona Department of Corrections Rehabilitation & Reentry Contract Monitoring Bureau members and Contract Vendor Practitioner(s)/Provider(s) and Pharmacist(s) whose purpose is ensuring the inmate population receives appropriate drug therapy, by following Drug Utilization Evaluation standards.

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, is used by psychiatrists and certified psychologists to diagnose mental disorders. Any references to axes and classes of mental illness in ADCRR manuals are intended to be and shall be interpreted by psychologists and psychiatrists to be consistent with the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

- E -

EMERGENCY: For the purposes of the policies contained in this manual, the inmate's current disorder or condition that involves a clear threat of death or physical injury to the inmate, other inmates or staff.

EPIDEMIOLOGICAL INFORMATION: The number of occurrences and distribution of a disease, which is released for statistical or public health purposes only after confidential medical record information has been deleted in a manner that prevents an individual from being identified.

EXPOSURE INCIDENT: As defined by OSHA, an incident in which visible blood or specific bodily fluids enter through an opening in the skin or mucous membranes.

- F -

FLOOR STOCK: A minimum supply of essential medication/supplies not labeled for specific patient for the purpose of administration to an inmate by an Arizona Department of Corrections Rehabilitation & Reentry Contract Vendor provider Nurse.

FOOD BORNE/WATER BORNE: Means food or water serves as a source for the spread of disease or illness.

FOOD HANDLER: Any inmate who prepares or serves food or who has direct contact with food.

FORMULARY: A basic list of drugs accepted/approved for use in the Arizona Department of Corrections Rehabilitation & Reentry, MS Contract Vendor. The written compendium of prescription medications approved for use in ADCRR and which are available from ADCRR Contract Vendor Pharmacy.

- G -

- H -

HAZARDOUS MATERIALS: Substances and/or materials that are a potential threat to human health and well-being.

HEALTH CARE PROFESSIONAL: A Physician, Physician's Assistant, Licensed Practical Nurse, Registered Nurse or Nurse Practitioner who is licensed in the State of Arizona and authorized by law to prescribe or administer medication which has been dispensed by a pharmacist.

HEALTH NEEDS REQUEST (HNR) FORM: The means by which an inmate can request non- emergency health care services.

HEALTH CARE PROVIDER (HCP): Department/contract Physicians, correctional Registered Nurses, Physician's Assistants, Nurse Practitioners.

HEALTH STAFF MEMBER: The registered and/or licensed person who provides the direct health care ordered by written, verbal or standing medical order of the health care provider. Individuals having direct patient contact.

HIGH EFFICIENCY PARTICULATE APPARATUS (HEPA): Respiration mask that filters out 95% of microns that are .1 to .5 microns in size.

HIGH-HAZARD PROCEDURES: Tasks identified by OSHA that require employees to wear HEPA respirator while performing the following tasks: Entering inmate rooms/cells; Performing nursing procedures on inmates, such as aerosolized medication treatment, bronchoscopy, sputum induction, endotracheal intubation and suctioning procedures; Transporting inmates in a vehicle.

HIPAA: The first comprehensive set of Federal Regulations of Health Information, the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), came into effect in April 2003.

HUMAN IMMUNODEFICIENT VIRUS (HIV): A virus that infects and destroys certain white blood cells, thereby undermining that part of a person's immune system that normally combats infections and disease. HIV is the cause of AIDS.

HOUSING UNIT 8: A housing unit for housing of inmates with long term care needs, not requiring the inpatient component level of care, but not able to be cared for through the individual health units. Located at ASPC-Florence Central Unit and at ASPC-Tucson Rincon Unit.

- I -

IGRAs (Gamma interferon release assays): Blood assays developed as an alternative to the tuberculin skin test (TST) for diagnosis of Latent Tb Infection (LTBI).

INFECTION CONTROL LIAISON: An "Authorized Representative" designated by a Physician or health care administrator to perform specific tasks for the prevention, investigation, or reporting of a disease.

INFECTIOUS MATERIALS: Those items that are contaminated with blood, body fluids or other infected media that pose a potential health risk to employees or others, should they come in contact with them i.e. extracted teeth, bloody gauze, dirty gloves, etc.

INFIRMARY CARE/Inpatient Component (IPC): Area in the facility accommodating patients for 24-hours or more expressly set up and operated for the purpose of caring for patients who need skilled nursing care, but does not need hospitalization.

INFORMED CONSENT: Permission obtained from a patient to perform a specific test, procedure or treatment after an explanation to the patient of all the material facts concerning the nature, consequences, risks and alternatives of the proposed procedure/treatment/test by the Health Care Provider.

INPATIENT: An inmate admitted to the IPC for medical treatment.

INPATIENT COMPONENT (IPC): Provides for transitional level of nursing care of a limited duration and scope, for those inmates whose medical care needs are above the level of care available in the individual health units.

INTERACTIVE REAL TIME: A medical case presentation utilizing video conferencing.

INVOLUNTARY ADMISSION: The court-ordered commitment of an inmate, releasee, or parolee to a Departmental mental health inpatient treatment facility, or to the Arizona State Hospital for females whose behavior constitutes a danger to themselves or others.

INVOLUNTARY ADMINISTRATION OF PSYCHOTROPIC MEDICATION: Administering any psychotropic medication to an inmate without the inmate's agreement to take the medication, following an explanation by the psychiatrist, in terms and language the inmate can understand, of material facts regarding the consequences of taking and not taking the medication, and any risk to the inmate's health status.

IMMUNOCOMPROMISED: A condition where immune response is reduced or absent. Conditions that can compromise the immune system include cancer, HIV/AIDS, organ transplantation, renal dysfunction, end stage liver disease, uncontrolled diabetes, persons receiving prednisone $\geq$ 15mg/day for $\geq$ 1 month, etc.).

- J -

JOINT MORTALITY REVIEW COMMITTEE: Combined Mortality Review Committee consisting of: MS Contract Vendor personnel and MSCMB personnel chaired by MS Contract Vendor. Committee members: Contract Vendor Clinical Staff as deemed necessary, MSCMB Assistant Director or designee as deemed necessary, MSCMB Medical Program Administrator, MSCMB Coordinator (Nurse Monitor) or designee as deemed necessary MSCMB Program Evaluation Administrator or designee as deemed necessary and other subject expert guests as deemed necessary. The Contract Vendor Regional Medical Director and MSCMB Medical Program Administrator may constitute a committee.

- K -

KEEP ON PERSON MEDICATION (KOP): Medications that may be kept on person by the inmate, for self-administration.

- L -

LATENT TB INFECTION (LTBI): Presence of Mycobacterium tuberculosis as evidenced by a positive test result from an approved test for tuberculosis in an individual who: has no symptoms of active tuberculosis, has no clinical signs of tuberculosis other than the positive results from the approved test for tuberculosis, is not infectious to others.

LEAD PSYCHOLOGIST: MS Contract Vendor Psychologist who oversees the mental health program for that facility.

LICENSED MENTAL HEALTH FACILITY: For adult male inmates/releases/parolees, the Alhambra Behavioral Health Treatment Facility (licensed as a Level 1 Behavioral Health Treatment Facility by the Arizona Department of Health Services) which includes B Ward and Flamenco; for adult female

inmates/releasees/parolees, the Arizona State Hospital or the Alhambra Behavioral Health Treatment Facility, and for all juvenile inmates/releasees/parolees, the Arizona State Hospital.

LICENSURE: Documented confirmation that an individual is qualified and licensed by the appropriate Arizona Licensure Board. See Licensure/Certification in Administrative Technical Manual.

LIFE SUPPORT SYSTEM: Devices or machines such as mechanical ventilators that provide necessary bodily functions for medical patients.

LIFE THREATENING: A medical condition that could, in a Medical Provider's opinion, lead to an inmate's death, if not treated.

LIKELIHOOD OF SERIOUS HARM: For the purposes of this order, a substantial risk that physical harm will be inflicted by an inmate upon the occurrence of at least one of the following:

¾ His or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm to one's self.

¾ Another, as evidenced by behavior which has caused such harm or places another person or persons in reasonable fear of sustaining such harm.

¾ The property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

LOCAL HEALTH AGENCY: State or County Health Department.

LOCKDOWN MEDICAL LOGS: Documentation of Nursing encounters with individuals who are in a segregated housing unit.

- M -

MEDICAL HISTORY INFORMATION: For the purposes of the policies contained in this technical manual, information in psychological, mental health and medical records that is confidential pursuant to A.R.S. and Department Order #901, Inmate Records Information Court Action System.

MEDICAL HOLD: An inmate who is undergoing current specialty treatment that will have an eventual termination at which time the medical hold is removed, a medical hold is temporary.

MEDICAL ISOLATION: Isolation of one or more individuals, or groups from the general population.

MEDICAL ORDER: An order signed by the attending physician that outlines the type of medical treatment to be given an inmate. The Medical Order becomes part of the patient's hospital record.

MEDICAL PRACTITIONER/PROVIDER: Licensed Correctional Health Providers, including Physicians, Psychologists, Correctional Mid-level Providers (Nurse Practitioner or Physician Assistants).

MEDICAL RECORDS: (also known as "Health Records"): Includes all documents officially entered into a folder or in an electronic format by an ADCRR Contract Vendor Medical Records Librarian, ADCRR Contract Vendor medical staff member or MSCMB Monitor. Documents include but are not limited to orders and results for laboratory, radiology, hospitalization, specialty care received while in custody, and official copies of records of prior treatment received through clinical channels.

MEDICAL RECORD REQUEST (MRR): Request generated from Central office for copies of Medical Records to be used for Release of Information purposes, or for use when responding to inmate letters or inmate grievances. MRR's are faxed or e-mailed to the MRL to handle.

MEDICAL RESTRICTION: Is a permanent restriction to a unit, facility(ies) because of medical or psychiatric limitations or disorders.

MEDICAL SEGREGATION: Inmates isolated from the general population in order to safeguard others, or, to protect them from acquiring a contagious disease.

MEDICATIONS: All prescription-only and over-the-counter (OTC) drugs prepared and issued by an ADCRR Pharmacy for delivery to an inmate.

MENTAL AGE: The age level at which a person functions intellectually, as determined by standardized psychological and intelligence tests which interpret functional abilities as the age at which that level of function is normally achieved.

MENTAL DISORDERS: A substantial disorder of a person's emotional processes, thought, cognition or memory.

MENTAL HEALTH PROFESSIONAL: A staff member who is a certified Clinical Psychologist, a Psychiatrist, a Psychiatric Social Worker, a Psychology Associate, a Psychiatric Nurse or a Psychotherapist.

MENTAL HEALTH STAFF: Department/contract Psychiatrists, Psychologists, Psychology Associates and/or psychiatric Nurses.

MENTAL ILLNESS: A substantial disorder of a person's emotional processes, thought, cognition or memory. More specifically, for the purposes of the policies contained in this technical manual, a diagnosis by a licensed psychiatrist or psychologist that is consistent with one or more classes of mental disorders in axes I of 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 hallucinosis 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 axes I of the DSM-IV.)

MODALITY: A method of therapy, e.g., treatment as an inpatient in a long-term care facility, or partial hospitalization.

- N -

NURSE'S LINE: The means by which an inmate is seen for routine services such as annual TB testing, vital sign checks, educational services, wound care, and other follow-up services.

NURSING ENCOUNTER TOOLS (NETS): A specific set of guidelines developed to be used by MS Contract Vendor nursing staff when treating specified illness/complaints in the absence of an onsite vendor Health Care Provider.

NURSING TREATMENT PROTOCOLS: A set of guidelines developed to be used when treating specified illness/complaints in the absence of an on-site Health Care Provider.

- O -

OBSERVED ADMINISTRATION: Direct observation of a medication being consumed by the inmate.

OBSERVATION RECORD: A documented record of all visual health and welfare checks conducted by staff during a suicide watch on a specific inmate.

OBSERVATION BEDS: Beds designed for medical or mental health observation for specific purposes, such as watching the patient’s response to medications, restriction of oral intake prior to a medical test, allow patients to recover from day surgery, or watch the general behavior of patients.

- P -

PACKAGING: The act or process of placing a drug item or device in a container for the purpose or intent of dispensing or distributing the item or device to another.

PAROLEE: An adult offender who has been granted a parole and is under community supervision.

PATIENT: For the purposes of the policies contained in this technical manual, an inmate receiving health treatment services from a health care professional.

PERSONAL PROTECTIVE EQUIPMENT (PPE): All protective equipment and devices that are used in universal precautions. The list includes, but is not limited to, vinyl or rubber gloves, impermeable gowns, splash face-plates or goggles, and Certified Particulate Respirators approved by the National Institute of Occupational Safety and Health (NIOSH) for high-risk tasks, or other respirators approved by OSHA for low-risk procedures.

PHARMACY: The ADCRR Contract Vendor facility pharmacy, licensed by the Arizona State Board of Pharmacy.

PHARMACY AND THERAPEUTIC COMMITTEE: A committee composed of ADCRR MSCMB and MS Contract Vendor Physicians, Pharmacist and other members of the health staff as selected by MSCMB Assistant Director. The committee shall compile, review and update the ADCRR Contract Vendor Formulary annually or more frequently if indicated.

PHARMACY URGENT CARE AREA (PUCA): NOTE: This definition is provided for historical reasons only. Until the Pharmacy was privatized, this was an area, within the pharmacy, where starter packaged medications were made available, accessible by nursing staff, after normal pharmacy working hours, to address the needs of inmates when waiting until the next working day could cause an increase in morbidity or mortality to the inmate patient.

PREVENTIVE THERAPY: A course of TB treatment given to someone with LTBI to prevent the infection from becoming an active TB disease.

POSITIVE PPD TEST: Evidence that may result from a PPD test that the tested inmate has been infected or is currently infected with mycobacterium tuberculosis. A reaction greater than 5 mm in duration (temporary hardening and redness of the injection site) is considered positive in persons who have had close recent contact with an infectious person, in persons who have an abnormal chest x-ray consistent with tuberculosis, and in persons whose immune systems are suppressed or who are known to be infected with the human immunodeficiency virus. A reaction greater than 10mm induration is considered positive for inmates and corrections staff. A reaction of 15mm or greater is considered positive for the general public. Organ transplant recipient or is immunocompromised (e.g., organ transplantation renal dysfunction, end stage liver disease, uncontrolled diabetes, HIV+/AIDS, cancer, persons receiving $\geq$ 15mg/day of prednisone for $\geq$ 1 month).

POWER OF ATTORNEY: A legal document allowing another person to act in a specific written manner for the named individual.

POWER OF ATTORNEY HOLDER: Individual designated by the inmate or the court to make decisions for the inmate if he/she can no longer make their own decisions.

PPD CONVERTER: A person who is now testing PPD positive after a previously negative PPD.

PPD TEST: Mantoux tuberculin skin test consisting of an intradermal (within the skin) injection of five tuberculin units (0.1 cc) of purified protein derivative (PPD) to determine if antibodies to mycobacterium tuberculosis are present.

PRACTITIONERS: A Physician, Dentist, Physician's Assistant, Nurse Practitioner or any other health care Practitioner/Provider duly licensed-by the State of Arizona to write prescription orders.

PRESCRIPTION: A Practitioner's specific written, verbal or faxed order.

PROBLEM LIST: A chronological record of major health disabilities/problems as determined by the Health Care Provider.

PROTECTIVE SEGREGATION: Isolation of an inmate in order to safeguard from potential violence of others.

PRACTITIONER/PROVIDER: Any health care Practitioner employed by Arizona Department of Corrections Rehabilitation & Reentry MS Contract Vendor or by the Private Prisons, who has been duly empowered by the State of Arizona to write prescriptions.

PROVIDER APPOINTMENT: The means by which appropriate health care services for complaints that have been referred are provided by licensed/certified health services staff.

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 forced psychotropic medication.

- Q –

QUALIFIED HEALTH SERVICE STAFF: Registered and/or licensed person who provides the direct health care ordered by written, verbal or standing medical order of the Health Care Practitioners/Provider(s).

- R –

RVCT: Report of Verified Case of Tuberculosis; a report submitted to the state or local health department for each confirmed TB case.

REASONABLE COSTS: For the purposes of copying medical record information and in accordance with A.R.S. 12-351, fees of ten cents for each page copied and ten dollars per hour for costs incurred in locating and making documents available, which are charged to a requestor after providing documents in response to a subpoena, all other copy charges are 50 cents per page.

RECEIVING FACILITY: The Institution to which the inmate is transferred, and which will take over responsibility for the inmate's medical record and medication orders.

REGIONAL DIRECTOR OF NURSING: MS Contract Vendor Nursing staff member designated as the responsible regional nurse authority.

RELATIVE OR IMMEDIATE FAMILY: An inmate's spouse; parent or stepparent; grandparent; mother-in-law or father-in-law; sibling; natural, adopted or step child; aunt or uncle; godparent or any other person who had the primary responsibility of raising the inmate in the absence of parents (as defined in Department Order 911; Inmate Visitation).

RELEASEE: An adult offender who is on release status, e.g. mandatory, temporary, compassionate leave, provisional, under community supervision.

REMOTE DRUG STORAGE AREA (CLINIC STOCK STORAGE AREA): Any area of a Contract Vendor licensed pharmacy which lies outside the physical area of said pharmacy and which is used for the storage of medications.

REQUIRED TRAINING: Information and training for employees with occupational exposure that addresses the nature and transmissibility of communicable diseases; the risk factors for disease development; the signs, symptoms, diagnosis and treatment of communicable disease; reporting procedures relative to patient/inmate symptomatology; and the proper use of engineering controls, universal precautions and PPE appropriate to the workplace to reduce employee exposure.

RESPONSIBLE PHARMACIST: The Contract Vendor Pharmacist who is (designated as) responsible to the Arizona State Board of Pharmacy for a licensed pharmacy's compliance with the laws and regulations of this State and of the Federal government, pertaining to the practice of pharmacy, manufacturing of drugs and the distribution of drugs and devices. Nothing in this definition or in the definition set forth by the Board of Pharmacy relieves any other persons or pharmacists from their responsibility to comply with State and Federal laws and regulations.

ASSISTED LIVING: Care provided to patients whose health needs require a more protective environment than that in the general population housing areas.

- S -

SECLUSION CELL: A secure cell designed and organized to provide for the temporary care and observation of an inmate. The cell provides an environment with minimal stimuli, with security protection and with provisions for either direct or indirect staff observations.

SECURITY SHIFT SUPERVISOR: The security staff member designated as the responsible security officer for a given shift.

SEGREGATION: Separation of an inmate from the general population.

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, and wherein the inmate's medical record and medication(s) reside.

SERIOUS INJURY: A medical condition involving an inmate that, if not treated immediately, would result in serious medical complications, loss of life, or permanent impairment to bodily functions, e.g.,

uncontrolled bleeding, loss of consciousness, poisoning, severe shortness of breath, severe chest pain, paralysis, suspected overdose of medication, and apparent stroke.

SEX OFFENDER: An adult inmate whose primary or secondary conviction is a sexual offense or who has a history of sex offenses.

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. ie., needles, scalpels, broken glass, syringes, etc.

SHELTERED HOUSING: Protective environment that does not require direct 24-hours nursing care. (See Assisted Living).

SICK CALL: The health care delivery system by which each inmate requests legitimate and appropriate 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 inmate-patients. The format includes the following descriptive elements: Subjective; Objective; Assessment; Plan.

SPECIAL MANAGEMENT TREATMENT UNIT/AREA: A single and double bed cell, isolated area at ASPC-Perryville, Santa Maria, for females, or at ASPC-Eyman, SMU II for male inmates who have been identified as having a mental disorder or a syndrome associated with an organic brain dysfunction, who demonstrate assaultive or other significant enduring behavior problems, and whose mental disorder is not of an acuity requiring placement in a licensed behavioral health facility.

SPECIAL NEEDS INMATES: Inmates, who have a medical need above and beyond that of the average inmate.

SPECIAL NEEDS UNIT: Care provided that serves a broad range of health conditions and problems that require the Health Care Practitioner or other designated qualified healthcare professionals to design a treatment plan tailored to the patient’s needs.

SPECIAL PROGRAMS UNIT/AREA: An open yard, dormitory-style unit for inmates who have been identified as having a mental disorder or a syndrome associated with an organic brain dysfunction.

SPECIAL TOPIC EXPERT/SUBJECT MATTER EXPERT: A Practitioner/Provider, Dentist, Pharmacist or Nurse whose area of practice and experience qualifies them as an expert.

STATEMENT OF CONFIDENTIALITY: The following explanation, which the Department issues to the recipient of confidential communicable disease information: "This information has been disclosed to you from records that are required by law to be confidential. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. Any person who violates this rule by releasing or publicizing this confidential communicable disease information is guilty of a Class 3 Misdemeanor (A.R.S. 36-140)."

STARTER PACK: A pre-filled prescription, dispensed by an Arizona Department of Corrections Rehabilitation & Reentry pharmacy, to be delivered to the inmate for self-administration. The starter pack is issued upon a legal order from an Arizona Department of Corrections Rehabilitation & Reentry provider, in a quantity to insure the availability of medication in urgent/after hour situations.

STORE AND FORWARD: A medical case presentation utilizing either video, audio, video snapshot, or x-ray scan, or any combination thereof. The multimedia information is then transmitted, by the creation of a computer file, to another health care provider for interpretation

SUICIDAL BEHAVIOR: Deliberate behavior which is likely to result in one's death.

SUICIDE ASSESSMENT: An evaluation by mental health staff or, in their absence, health care staff, of an inmate's behavior, statements and history for signs that would indicate a suicide risk. The assessment shall include face to face contact with the inmate, a review of the inmate's health record, and an evaluation of the inmate's present life circumstance.

SUICIDE WATCH: Ordered for the immediate prevention of self-destructive or suicidal behavior by an inmate who is considered to be a high risk. Suicide watch is not used as an alternative to ongoing mental health treatment.

SUPPLIES: Those products (chemicals) used in the delivery of dental services that have potential for causing harm to employees and others, ie., Formo Cresol, Bleach, Acid, etc.

SUSPECTED TUBERCULOSIS DISEASE: When an inmate has been identified as having symptoms consistent with tuberculosis, which the Centers for Disease Control and Prevention have identified as productive cough, coughing up blood, weight loss, loss of appetite, lethargy, weakness, night sweats, or fever.

SYMPTOMS OF PULMONARY TUBERCULOSIS (PTB): Any of the following that cannot be attributed to a disease or condition other than tuberculosis.

- Productive cough that has lasted for at least three weeks
- Coughing up blood or hemoptysis
- Chest pain
- A combination of at least three of the following:
  - Fever
  - Chills
  - Night sweats
  - Easy fatigability
  - Loss of appetite
  - Unexplained weight loss

- 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 physical or chest X-ray findings suggestive of tuberculosis, but confirmation by sputum culture has not been completed.

TELEMEDICINE: The transmission of medical data and services, by electronic signals, from one site to another using telecommunications technology. A Telemedicine evaluation may include video conferencing, audio transmission, high resolution photographs, radiological images and medical records.

TRANSFER OF INMATES: The movement of inmates from one ADCRR Institution to another which results in an indefinite change of domicile.

TUBERCULOSIS DISEASE: A chronic pulmonary and extra pulmonary infectious disease caused by the tuberculosis bacillus, specifically pulmonary and laryngeal, are spread through the air. (Multidrug-resistant tuberculosis is a tuberculosis organism that is resistant to drugs prescribed for patients infected with tuberculosis).

TUBERCULOSIS INFECTION: Evidence that may result from a positive PPD test that the person has been infected or is currently infected with mycobacterium tuberculosis.

- U -

UNEXPECTED DEATH: Death in which the cause of death is not immediately known or anticipated.

UNIT DOSE: A single oral dose of medication for administration and immediate consumption.

UNIVERSAL PRECAUTIONS: Safety procedures that are designed to eliminate or minimize exposure incidents involving the transmission of pathogens through body fluids (i.e. blood, saliva & urine) air, or by direct person to person contact. These procedures include the appropriate use of good hand washing technique, personal protective equipment (PPE) such as gloves, masks, gown, when indicated. Universal precautions should be followed especially among individuals receiving treatment of any kind.

- V –

VOLUNTARY ADMISSION: The admission of either a female or male inmate/releasee/parolee to a Departmental mental health inpatient treatment facility or of a female to the Arizona State Hospital with the inmate/releasee/parolee's informed consent.

- W –

WATCHED SWALLOW: A correctional security term regarding the ingestion of medication by an inmate while being watched by a correctional professional until the medication has been swallowed and followed by a mouth check to be certain that the medication was actually swallowed. See Unit dose.

WEEKLY MEDICATIONS: Medications prepared and issued by a pharmacy in a seven (7) day supply, and which will be sent in successive weekly increments until the entire order or prescription has been delivered.

- X –

- Y –

- Z –