MEDICAL AND MENTAL HEALTH CARE PLAN

PROPOSED RECOMENDATIONS TO AMEND AND UPDATE THE ORDERS OF THE CORRECTIONAL HEALTH CARE PLANS

Correctional Health Services Corporation

May 2010

This document constitutes a thorough review of the Medical and Mental Health Care Plans that were adopted by the Honorable US District Court for the District of Puerto Rico in October 23, 1990, for the delivery of medical, dental and mental health care to the inmate population under the custody of the Administration of Corrections of Puerto Rico.

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MEDICAL AND MENTAL HEALTH CARE PLAN

I. RESPONSIBLE HEALTH AUTHORITY (RHA)

A. PRIMARY RESPONSIBILITY — ADMINISTRATION OF CORRECTIONS

1. The Agency designated by the Commonwealth of Puerto Rico to provide health care to the correctional population is the Administration of Corrections (AOC).[1] At this point in time, Correctional Health Services Corporation (CHSC) is the Responsible Health Authority (RHA) contracted by the AOC. The RHA arranges for all levels of health care and assures quality, accessible and timely health services for inmates under the care and custody of the AOC.[2,3] In addition to this Medical and Mental Health Care Plan (MMHCP), the AOC and CHSC have executed a Comprehensive Management Agreement for the Provision of Health Care Services to the Correctional Population under the Custody of the Administration of Corrections ("CMA"), which clarifies the authority and mutual obligations concerning the delivery of health care by the AOC and CHSC. The CMA, which has been submitted to the Court, includes, but is not limited to, mutual responsibilities for the development, construction, renovation and designation of space for medical care and services, including the coordination of medical and correctional aspects of the intake screening process, mutual responsibilities for classification and housing of inmates with medical, surgical and mental health problems,

[1] Federal Court Order of January 26, 2004, pages 48-49.

[2] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-02 (E), Responsible Health Authority, p. 3

[3] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-02 (E), Responsible Health Authority, p. 4

ongoing health training of correctional officers, equipment, guarantee that no inmate will be transferred to another institution without medical/mental health clearance or without his complete health records, transportation and movement of inmates for medical care, payment for prostheses and medical apparatuses, (e.g., walkers, crutches and braces), confidentiality of health records, and reporting mechanisms. The CMA also states that CHSC, as the RHA, shall comply with the provisions of this MMHCP.

2. The AOC and the RHA shall establish and maintain policies and procedures that address the joint operation of all protective housing or treatment areas, including but not limited to Psycho-social Units (PSU's), Residential Units for the Treatment of Addictive Behavior, Medical Dormitories, Infirmaries, Emergency Room, and the Psychiatric Correctional Hospital (PCH). Because these units provide medical and mental health services, classified, sentenced inmates, in addition to pre-trial detainee, may be housed in these treatment areas regardless of their age, custody levels and statuses. At a minimum, they shall address the following issues: admissions policy of treatment units, inmate discipline, freedom of internal movement by patients for medical or therapeutic activities, staffing and training, and the extent to which a redefinition of the role and functions of correctional officers will be necessary. These health care units shall be staffed by correctional officers specially trained for these health areas in order to fulfill their specific roles. Furthermore, the following areas shall be jointly encompassed: (1) transfer of patients, including to the PCH, (2) escort of patients within the institutions and facilities, (3) security of patients and staff during health examinations, and (4) disciplinary measures of inmates housed in mental health care units or treatment areas to

ensure that the discipline, if any, of these inmates occur only after consultation with the qualified health care professionals. [4]

3. All health care provided to inmates in the AOC shall be delivered by appropriately qualified health care professionals according to the licensure, certification and registration requirements of the laws of Puerto Rico.

4. Clinical decisions and actions regarding health care provided to inmates to meet their serious health needs are the sole responsibility of qualified health care professionals. Correctional and administrative staff support and do not interfere with the implementation of clinical decisions. [5,6]

5. Inmates shall not be housed in the health care units for reasons other than clinical criteria. [7]

6. The RHA may establish collaborative agreements with the Department of Health, and any other agencies or entities, public or private, for the provision of care within or outside the AOC facilities, according to the needs of the inmate population. [8]

7. All inmates at each institution shall have access to mental health care to meet their serious mental health needs. The RHA shall ensure that

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[4] Orders related to the recommendations related to Report 188 of the Court Monitor to be implemented as ordered by the Court February 18, 1993, order #11.

[5] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-03 (E), Clinical Autonomy, p. 5

[6] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-03 (E), Medical Autonomy, p. 5

[7] Recommendations related to Report 188 of the Court Monitor to be implemented as ordered by the Court December 28, 1992, order #5.

[8] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-05 (I), Hospital and Specialty Care p. 54

adequate mental health services exist and shall identify and eliminate any barriers that would preclude inmates from receiving these services in a timely manner. [9]

8. The RHA shall establish and maintain an appropriate and timely grievance mechanism that addresses inmates' complaints about health services. [10,11]

B. TABLE OF ORGANIZATION

9. The RHA shall establish and maintain an updated table of organization for the delivery of health care services. The RHA may modify the table of organization and the supervisory relationships required by this MMHCP, or both, when deemed necessary for reasons of administrative efficiency or effectiveness.

C. COOPERATION

10. The RHA and AOC shall meet regularly to discuss issues of health care in the AOC. Said meetings shall be adequately documented and accompanied with follow-up recommendations, if applicable, for subsequent meetings. At least quarterly the RHA shall meet with the Administrator of Corrections. Complete health care statistics (e.g., numbers of sick call visits, specialty clinic appointments, and hospitalizations, incidence of emergency transportation outside each facility, inmate mortalities, prescriptions, dental contacts and x-ray

[9] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-01 (E), Access to Care, p. 3.

[10] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-11 (I), Grievance Mechanism for Health Complaints, p. 18

[11] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-11 (I), Grievance Mechanism for Mental Health Complaints, p. 17.

examinations) shall be provided to the AOC on a quarterly basis and delivered annually to the Court for as long as this Court retains jurisdictional oversight of the medical areas pursuant to the *Morales Feliciano* case. The relevant statistics shall also be provided to each Superintendent and Regional Director on a quarterly basis.

11. At each correctional facility, the Clinical Services Director, Health Administrator, Correctional Superintendents and other members of the health and correctional staff, as appropriate, shall meet no less than quarterly to discuss issues of health care in that specific facility. Minutes or summaries of the discussions, as well as recommendations and actions resulting from these discussions, shall be kept and distributed to all involved parties, with copies forwarded to the regional and central offices of the AOC and the RHA.

12. Complete health care statistics for the facility are made at least monthly.

13. The RHA shall submit a statistical report to the Medical Compliance Office of AOC for each correctional facility at least on a quarterly basis, showing the statistics of all services provided.

14. Health staff meetings at each correctional facility occur at least monthly and are documented. [12]

15. The RHA shall prepare a comprehensive report detailing their progress toward compliance with the MMHCP and a summary of the yearly statistics at least on an annual basis. Copies of these compliance

[12] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-04 (E), Administrative meetings and reports, p. 6

reports will be delivered to the Court and the parties in the *Morales Feliciano* litigation.[13]

II. OBJECTIVES OF THE HEALTH CARE DELIVERY SYSTEM

16. All inmates within the AOC shall have access to and be provided with medical, mental health and dental services designed to maintain and restore their basic health. The objectives of the correctional health system are the following: (1) to integrate health care services in the correctional institutions throughout Puerto Rico; (2) to provide necessary health care services which meet contemporary standards of professional practice, emphasizing prevention services to the entire inmate population; (3) to create a system that guarantees accessibility to health care services for all inmates; (4) to establish a health education program designed to improve the level of understanding of sound health; (5) to establish a program designed to monitor, diagnose and treat communicable diseases, including tuberculosis and sexually transmitted diseases, with special emphasis on HIV infection; and (6) to establish and maintain programs for the diagnosis and treatment of substance use disorders.

17. Although formal accreditation by the National Commission on Correctional Health Care (NCCHC) and/or the American Correctional Association (ACA) shall not be required by the MMHCP, the RHA shall strive to achieve accreditation with either or both of these organizations, at the RHA's discretion. The RHA will coordinate with AOC any attempts to have one or more of its facilities or operations accredited by either of these organizations, and AOC will render all assistance necessary in the pursuit of said accreditation. Following a

[13] Mental Health Plan, Order 40, p. 23

finding by the Court that defendants have achieved compliance with this MMHCP, monitoring of defendants' continued compliance by the Court will not be required if (a) defendants actually achieve compliance with NCCHC of all of the Intake Facilities and of at least 50 percent of the remaining correctional facilities and (b) defendants maintain this accreditation for two successive accreditation periods.

18. A comprehensive manual of written policies and procedures governing health care services in accordance with this MMHCP shall be established and maintained by the RHA. The procedures shall include written protocols for the delivery of medical, dental and mental health services within the correctional system including protocols for the management of severe chronic, acute, and infectious illness. Each policy, procedure and programs shall be reviewed annually and revised as necessary by the RHA. Any policy, procedure or program that requires changes in AOC policies or practices shall be reviewed and duly executed by the AOC.

III. ORGANIZATION OF THE HEALTH CARE DELIVERY SYSTEM

A. INTAKE FACILITIES – OVERVIEW

19. The RHA shall establish and maintain policies and procedures for new admissions within the AOC's intake facilities. Each intake facility shall provide enhanced on-site health care services which shall be fully detailed within each intake's policies and procedures, at a minimum, shall include the following:

    a. 24 hour per day intake medical and mental health screening capability by trained, licensed health care personnel;

b. 24 hour per day physician staffing (for selected intake facilities the RHA may submit an acceptable alternative plan which ensures reasonable and timely access to a physician);

c. 24 hour per day graduate (registered) nurse staffing;

d. a convalescent unit or infirmary (but see, paragraph 46, intra);

e. at least weekly on-site specialty clinics in internal medicine;

f. obstetrics-gynecology at any facility housing females;

g. timely referral for other clinical needs to off-site specialty clinics, considering that clinical need dictates the time required to receive the ordered service. Specialty clinics with high utilization rates (e.g. general surgery, dermatology, orthopedics, urology, podiatry, ophthalmology, ENT, neurology, etc) should not exceed average waiting times in private/public community practices. Specialties that consistently have waiting times of more than 2 months for urgent (not emergency) referrals and for more than 6 months for elective referrals should be consider to be provided within the correctional health system;

h. physician-staffed ambulatory care clinic five days per week, and access to a physician by inmates (including new admissions) 24 hours a day, 7 days a week for emergency medical care;

i. mental health ambulatory clinics, five days a week, to ensure reasonable and timely access to a mental health professional;

j. detoxification services seven days a week in the appropriate level of care according to inmates' needs;

k. access to timely laboratory services, seven days per week;

l. access to timely pharmacy services seven days per week;

m. Health Record Department supervised by a fulltime Health Information Administrator;

n. a dental clinic staffed by an appropriate number of dentists and dental assistants five days per week;

o. radiology services staffed by a qualified radiology technologist. Onsite radiology shall be staffed for as many hours as needed depending on inmates' needs and the size of the facility. Procedures for the timely provision of offsite emergency radiology services must be developed and implemented;

p. visits to all living units by a physician at least once monthly for the purpose of eliciting and reviewing inmate requests for medical care;

q. at least two (2) full-time administrative secretaries/office clerics;

B. INTAKE AND INITIAL HEALTH SCREENING - INTAKE FACILITIES

20. The RHA shall establish and maintain policies and procedures that allows for initial health receiving (intake) screening to be performed by qualified, licensed health care personnel on all new admissions as soon as possible at the intake facility to ensure that emergent and urgent health needs, including those pertaining to mental health issues, are met.[14,15] Persons who are unconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are: (a) referred immediately for stabilization, care and medical clearance into the facility and (b) if they are referred to a community hospital and then

[14] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-02 (E), Receiving Screening, p. 60

[15] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-02 (E), Receiving Screening for Mental Health Needs, p. 52

returned, their admission to the facility is predicated on written medical clearance from the hospital.[16]

21. The initial health screening shall consist of the following:

    a. oral inquiry into current and past illnesses (including history and symptoms of chronic, acute and infectious disorders, medications (including psychotropic medications), health problems, special health requirements (e.g., dietary needs) and conditions (including, for females, pregnancy, time of last menstrual period, contraceptive medications, vaginal discharges), past and current mental illness, including hospitalization and suicidal ideation; dental problems, allergies, alcohol or medication abuse or illegal drug use (including type, amount and time of last use) and drug withdrawal symptoms;[17]

    b. complete examination of vital signs, including weight;

    c. observation for clinical abnormalities (e.g., behavior, appearance, injuries, state of consciousness, breathing, skin, deformities, and psychotic behavior);

    d. utilization of a scientifically accepted test for tuberculosis, with timely follow-ups;

    e. rapid blood glucose tests on patients with diabetes;[18] and Peak Expiratory Flow Rate on patients with asthma.

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[16] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-02 (E), Receiving Screening, p. 60

[17] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-02 (E), Receiving Screening, p. 60

[18] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-04 (E), Initial Health Assessment, Individual Assessment When Clinically Indicated, p. 65

f. prescribed medications and dosages are reviewed and appropriately maintained according to the medications schedule the inmate was following before admission.[19] Alternative treatments options shall be considered;[20,21]

g. history and details of any suicidal behavior;

h. current mental status; and

i. documentation of the disposition of the inmate (e.g., referral to physician, to general population or to a mental health interdisciplinary team) in the inmate's health record.

j. screening for sexually transmitted diseases and HIV infection based on the prevalence of these diseases in the inmate population.

22. Information about the availability of, and access to, health services including mental health is communicated orally and in writing to inmates on their arrival at the facility in a form and language they understand.[22] The RHA shall establish and maintain written protocols to guide admissions personnel in educating new admissions about the health care system. Special procedures ensure that inmates who have difficulty communicating (e.g., foreign speaking, developmentally

[19] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-02 (E), Receiving Screening, p. 61

[20] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-02 (E), Medications Services, p. 49

[21] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-02 (E), Medication Services, p. 43

[22] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-01 (E), Information on Health Services, p. 59

disabled, illiterate, mentally ill, visually impaired, deaf) are informed of how to access health services. [23,24]

23. Initial health receiving screening shall be performed in a physical location (proximate to the correctional booking area) that is suitable in size and space to allow for the orderly and sufficiently private interviewing and examination of the new admissions. The RHA and AOC shall jointly coordinate the selection and designation of the medical intake screening area.

24. If not performed at the time of admission as part of the initial health receiving screening (see. paragraph 21, supra,) a full health assessment shall be performed for each inmate within seven (7) days following his admission.[25] This assessment shall be performed by a licensed physician or by another qualified licensed health care provider as permitted by law. As directed by written policies and procedures, the health assessment shall include a review of the inmate screening results, expansion of the initial medical history, a physical examination as indicated by the patient's age, gender, and risk factors, laboratory and diagnostic tests to detect communicable diseases based on their prevalence in the inmate population (including syphilis, gonorrhea, and HIV infection) and other conditions, genital examinations, and initiation of required treatment and immunizations. In addition, for females there shall be further inquired on their menstrual cycle and unusual vaginal bleeding, breast masses and nipple discharge, vaginal discharge and

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[23] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-01 (E), Information on Health Services, p. 59

[24] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-01 (E), Information on Mental Health Services, p. 51.

[25] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-04 (E), Initial Health Assessment, p. 64.

other obstetrical and gynecological conditions, testing for pregnancy, a Papanicolaou (PAP) smear for cancer, evaluation of vaginal discharges and a breast and pelvic examination. An initial problem list along with a diagnostic and therapeutic plan for each problem shall be completed.[26]

25. Within seven (7) days of admission, all inmates not referred for immediate mental health assessment shall receive a mental health assessment by one or more qualified mental health professionals to determine the need for treatment and the level of care required by the inmate for the purpose of his or her mental health classification. The initial mental health assessment includes a structured interview with inquires into[27]:

    a. A history of :

        i. psychiatric hospitalization, psychotropic medication, and ambulatory treatment,

        ii. suicidal behavior,

        iii. violent behavior,

        iv. victimization,

        v. special education placement,

        vi. cerebral trauma or seizures, and

        vii. sex offenses.

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[26] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-04 (E), Initial Health Assessment, p. 65

[27] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-04 (E), Mental Health Assessment and Evaluation, p. 55.

b. The current status of:

i. mental health symptoms and psychotropic medications,

ii. suicidal ideation,

iii. drug or alcohol use,

iv. mental status exam,

v. emotional response to incarceration; and

vi. a screening for intellectual functioning (inquiry into history of developmental and educational difficulties and, when indicated a referral for application of standardized psychological intelligence tools as appropriate).

26. Inmates with a positive assessment for mental health problems are referred to qualified mental health professionals for further evaluation and to decide the level of care needed. The health record contains results of the evaluation with documentation of referral or initiation of treatment when indicated.[28]

27. No inmate shall be transferred from an intake facility until his intake health screening, including initial history and full health assessment, are completed, unless the transfer is to another intake facility.

28. Health assessments are not required for all inmates readmitted to the correctional system when the last health assessment was performed within twelve (12) months and when the inmate's new receiving screening shows no change in health status. When appropriate,

[28] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-04 (E), Mental Health Assessment and Evaluation, p. 55.

histories, physical examinations, and tests, especially for communicable diseases, are updated on readmitted inmates.[29]

C. PRIMARY CARE/SICK CALL — (ALL FACILITIES)

29. The RHA shall establish and maintain policies and procedures relating to a standardized system for the daily handling of non-emergency oral or written requests for medical, mental or dental care by inmates. All inmates shall have the opportunity daily to request health care services. Their requests are documented, reviewed, and triaged within 24 hours for immediacy of need and the intervention required according to the urgency of the problem.[30]

30. Written guidelines shall direct the actions and decisions of the health care professionals assigned to triage and handle sick call requests.

31. Sick call clinics frequency and staffing shall be provided taking into account: (1) the inmate population as well as institution size, (2) evaluation sessions of an appropriate length or reasonable time, and 3) to assure that inmates are seen in a timely manner based on the triaged assessment of their request.

32. In order to assure the compliance with nonemergency health care request system, trained licensed health care personnel shall walk through each housing unit on a daily basis for the purpose of receiving verbal or written requests for medical, mental or dental care and triaging of complaints. Exceptions to this rule are in those institutions

[29] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-04 (E), Initial Health Assessment, p. 67

[30] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-07 (E), Nonemergency Health Care Request and Services, p. 71

where inmates are allowed free and unimpeded access to the medical areas.

33. Dispositions of the nonemergency health care requests resulting from any written or verbal requests shall be documented and maintained for quarterly review by the Continuous Quality Improvement Committee.

34. All housing units shall be visited by a physician at least once monthly for the purpose of enhanced triage and review of complaints. Inmates shall be allowed to speak directly to the physician, and appropriate documentation of all inmate contacts shall be made by the physician.

D. PRIMARY CARE/OTHER AMBULATORY CARE CLINICS — (ALL FACILITIES)

35. Health care professionals staffed ambulatory care clinics shall be scheduled and documented as required by this paragraph:

    a. Ambulatory care clinics staffed by licensed health care professionals shall be scheduled with sufficient frequency to assure that inmates are seen in a timely fashion according to treatment priorities and established clinical protocols. The frequency and duration of ambulatory care clinics is sufficient to meet the health needs of the inmate population and based according to the institution size.[31] Inmates who request to see a health care professional shall be scheduled as soon as necessary, as indicated by the gravity of the complaint. Access to these clinics shall be determined exclusively by health care

[31] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-07 (E), Nonemergency Health Care Request and Services, p. 73

staff. Correctional officers and inmates shall not control or limit the access of inmates to medical, mental or dental services.

b. A uniform appointment system shall be established in all facilities and shall be utilized to schedule initial and follow-up clinical visits.

c. All appearances at an ambulatory care clinic shall be documented in the health record. Complete vital signs shall be recorded at each physician visit, though such shall not be required for mental or dental evaluations unless clinically indicated.

d. Outreach shall be performed to inquire reasons for inmates' no show and the data is to be kept in the health record. The RHA shall establish and maintain policies and procedures regarding inmate refusal of treatment or health evaluations.[32]

e. AOC shall provide correctional officers to transport inmates to the ambulatory clinics or any other medical area within the institutions.[33]

36. Patient with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.[34] A chronic disease program shall be incorporated in the ambulatory clinics of all correctional facilities and shall maintain

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[32] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-I-05 (I), Informed Consent and Right to Refuse, p. 129

[33] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 17

[34] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-01 (E), Chronic Disease Services, p.91

a list of chronic care patients. Chronic illnesses are listed on the master problem list[35].

37. The RHA establishes and annually approves clinical protocols consistent with national clinical practice guidelines for the management of chronic diseases. Documentation in the health record confirms that clinicians are following chronic disease protocols. [36,37]

38. Inmates with chronic illnesses are initially to be seen by a physician in the ambulatory clinic at least once a month. Once deemed stable by the physician these inmates may be seen at less frequent intervals according to the level of chronicity or severity of their clinical condition but no less than every three months. Those with chronic mental illnesses shall be seen by a psychiatrist in the same frequency set above. [38]

39. Ambulatory care clinics staffing should be provided taking into account (1) the percentage of inmates with chronic conditions; and (2) evaluation sessions at an appropriate length or reasonable time.

40. All inmates in need of mental health services shall be evaluated to determine the appropriate level of care required. Inmates shall be admitted to the necessary unit of service for the management of the mental health condition. Inmate's mental health needs are addressed

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[35] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-01 (E), Chronic Disease Services, p.91

[36] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-01 (E), Chronic Disease Services

[37] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-05 (E), Policies and Procedures, p. 8.

[38] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-01 (E), Basic Mental Health Services, p. 75.

by a range of mental health services of differing levels and focus, including residential components when indicated. [39]

41. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.[40]

42. Ambulatory treatment is provided for inmates whose mental health condition does not require a more intensive level of treatment.

43. A sufficient number of mental health staff shall be available to provide adequate and timely treatment and follow-up in the on-site ambulatory services[41].

44. The RHA shall provide pneumococcal, influenza and other appropriate vaccines, *Pneumocystis jiroveci*, *Mycobacterium avium complex,* toxoplasmosis, tuberculosis, and other prophylaxis medication, and Highly Active Antiretroviral Therapy (HAART) to all inmates who qualify for these protocols.[42]

45. Pregnant inmates shall receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care. Specific therapeutic guidelines shall be established and maintained defining the delivery of prenatal care (medical examinations, prenatal laboratory work-up and diagnostic tests, including offering HIV testing

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[39] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-01 (E), Basic Mental Health Services, p. 75

[40] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-01 (E), Basic Mental Health Services, p. 75.

[41] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-07 (I), Mental Health Staffing, p. 36

[42] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 28

and prophylaxis when indicated[43], frequency of prenatal visits, provision of prenatal diet, levels of activity, special housing and counseling), post partum care and, for the short-term incarcerated female, the continuation of contraceptive medications. Specific therapeutic guidelines also shall be developed defining the process to access and/or initiate elective abortion. A list of specialized obstetrical services is maintained. A list is kept of all pregnancies and their outcomes.[44] All guidelines, shall comport with the laws of the Commonwealth of Puerto Rico and the United States, whenever applicable.

E. SECONDARY CARE – INFIRMARY CARE (INTAKE FACILITIES)

46. The RHA shall establish and maintain written policies and procedures that define the scope for the provision of licensed physician care and skilled nursing or infirmary care in each of the designated intake facilities. The scope for the provision of the infirmary services shall include the following components:

    a. sites and number of beds, as determined by the inmate population special needs;

    b. a level of nursing care provided in each infirmary sufficient to provide twenty-four (24) hour nurse staffing and to allow nursing notes on each shift for every patient;

    c. daily supervision by a registered nurse;

[43] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-07 (E), Care of the Pregnant Inmate, p.105

[44] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-07 (E), Care of the Pregnant Inmate, p.105

d. access to physician staffing twenty-four (24) hour per day coverage through emergency services;

e. daily physician rounds, with no less than weekly (or whenever there has been a change in therapy, diagnosis, or status) progress notes for each patient. Monitoring of vital signs at least daily or as ordered by the physician. Weight shall be monitored upon admission and as ordered by the physician;

f. detailed admission criteria;

g. admission and discharge only by a physician's order;

h. housing of all patients within sight or hearing of health care personnel at all times;

i. provision of handicapped toilets and bathing facilities, anti-slip surface and safety bars;

j. a policy stating that infirmaries are not hospitals and shall not substitute for needed hospitalization; and

k. a complete inpatient health record is kept for each patient.

47. The manual of nursing care procedures is consistent with the state's nurse practice act and licensing requirements.[45]

48. Infirmaries shall be established in at least all intake facilities in accordance with this MMHCP. If the demonstrated demand for this level of care is infrequent at a particular intake facility, the requirement may be met by expeditiously transferring patients to a convalescent unit in another facility.

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[45] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-03 (E), Infirmary Care, p. 96

49. The RHA shall establish and maintain written policies and procedures containing guidelines for the use of intravenous fluids therapy in correctional facilities. Intravenous fluid therapy or intravenous medication therapy shall be given only in infirmaries, or in emergency care areas under constant, direct observation and supervision of qualified health care professionals.

F. REFERRALS (SPECIALTY CLINICS)

50. The RHA shall establish and maintain written policies and procedures that outline in detail a standardized system of referring inmates for specialty care. The policies shall guide referrals to specialty clinics on-site, in any centralized correctional health facilities, contracted health care providers or in designated secondary and tertiary care medical facilities.

51. The RHA and AOC shall jointly develop policies and procedures to assure inmates' right to be referred to other entities (such as "Fondo del Seguro del Estado", "Administración de Compensaciones por Accidentes de Automóviles", and Veterans Administration), according to the Commonwealth Laws of Puerto Rico, when these services are applicable to the inmate's health needs.[46]

52. The RHA shall establish and maintain detailed written agreements with designated hospitals or specialists for the delivery of both on-site and off-site specialty care that outline the terms of care to be provided. The agreements require that the offsite facilities or health professionals give the inmate a summary specifying the pertinent findings, diagnosis,

[46] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 14

treatment given and any follow-up instructions. This information is to accompany the inmate upon their return to the facility. [47,48]

53. Inmates who leave an institution for the purpose of receiving medical care shall be accompanied by a medical consultation sheet to be completed by the consulting physician and to be returned for review by the institutional physician and placement in the inmate's health record. A physician shall evaluate each inmate after an off-site consultation upon return to the facility, and any progress notes reflecting the physician's evaluation and follow-up shall be included in the inmate's health record.[49] Upon implementation of an electronic health information system, the referral consultation and consultant's report may be transmitted electronically.

54. AOC shall provide sufficient correctional officers and vehicles available to transport inmates[50] safely and in a timely manner for medical, mental health, and dental clinic appointments both inside and outside the facility. [51,52] When commitment or transfer to an inpatient psychiatric setting is clinically indicated, required procedures are followed, including the maintenance of suicide and injury prevention precautions en route, and the transfer occurs in a timely manner. Until

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[47] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-05 (I), Hospital and Specialty Care, p. 54

[48] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 15

[49] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 18

[50] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 16

[51] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-10 (I), Patient Escort, p. 77

[52] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-08 (I), Patient Escort, p. 62

such transfer can be accomplished, the inmate is safely housed and adequately monitored.[53]

55. Whenever possible, all off-site appointments shall be scheduled by reasonable and reliable forms of communication (such as telephonically or electronically). A uniform appointment and calendar system shall be instituted in all facilities. The established system shall include the date of the appointment, the name and health record number of the inmate being referred, the specialty clinic, the date the referral was requested, the outcome, the return of a completed consultation form, and the date of any return visit scheduled by the consulting physician.

56. The specialty clinic referral system shall be monitored regularly and monthly statistics shall be sent to the RHA's designated office. These statistics shall be delivered to the Medical Compliance Office (or equivalent designee) of the AOC. Continuous Quality Improvement audits of the specialty of clinic referral system and the clinical quality of consultations shall be performed regularly.

G. MEDICAL DORMITORIES (CHRONIC CARE)

57. The RHA shall establish and maintain policies and procedures pertaining to use of medical dormitories. These facilities shall provide the following:

    a. nursing staff to provide sufficient twenty-four (24) hour nursing coverage for the chronic care unit and adequate coverage for other medical activities within the facility, taking into account its size and functions,

[53] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-01 (E), Basic Mental Health Services, p. 75.

b. a physician on duty 24 hours per day at the facility,

c. at least one weekly progress note by internal medicine or family medicine physician and visits as clinically warranted, and referral to other specialists as needed,

d. AOC shall provide sufficient correctional officers for all medical dormitories to ensure that inmates have immediate access to correctional officers in the event of a health care emergency,[54]

e. capability of providing special diets,

f. appropriate emergency medical equipment to care for this at-risk population,

g. sites and number of beds, are determined by the inmate population special needs,

h. detailed admission criteria,

i. admission and discharge only by a physician's order, and

j. availability of handicapped toilets and bathing facilities, anti-slip surface and safety bars as required[55].

58. The RHA shall establish and maintain specific written policies that detail those illnesses, diseases and conditions that warrant housing in these medical dormitories. The following illnesses or conditions may be included, but are not exclusive:

a. terminal stages of illnesses such as: Cancer, Acquired Immunodeficiency Syndrome (AIDS),

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[54] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 39

[55] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 45

b. end stage or decompensated chronic diseases such as: Diabetes Mellitus, Cardiovascular, Renal, Pulmonary Neurological, Hematologic, and or Hepatic disease,

c. high risk pregnancy,

d. physical disability with mobility impairments,

e. skin lesions requiring frequent dressing changes such as: ulcers, burns;

f. Alzheimer disease, Dementia,

g. other diseases as determined by the RHA,

h. complicated or high risk medication or treatment regimens such: warfarin treatment, active chemotherapy course, hemodialysis, etc.

59. The RHA shall establish and maintain general and disease-specific therapeutic and clinical guidelines that standardize the care of patients with chronic illnesses or conditions requiring special medical, rehabilitative, or diagnostic services.

H. INTERMEDIATE TREATMENT (PSYCHOSOCIAL UNITS)

60. Sufficient psychosocial units (PSU) must be available to provide intermediate mental health treatment to chronic mentally ill inmates who do not require hospitalization, but whose mental health condition requires separation from the general population of an institution.

61. Each PSU provides long-term mental health rehabilitative treatment services, including psychological, social, educational, and vocational services, as well as transitional and convalescent care for inmates returning from the PCH, who still require supervision.

I. RESIDENTIAL UNITS FOR THE TREATMENT OF ADDICTIVE BEHAVIOR (UNIDAD RESIDENCIAL PARA EL TRATAMIENTO DE LOS TRASTORNOS ADICTIVOS, "URTA")

62. The AOC shall ensure the availability of sufficient Residential Units for the Treatment of Addictive Behavior to provide substance abuse treatment to inmates who require a more structured and supervised environment.

63. Each "URTA" provides long-term rehabilitative substance abuse treatment, including psychological, social, educational, and vocational services.

64. Inmates admitted to this unit may receive medication assisted rehabilitative treatment as determined by RHA.

J. TERTIARY CARE

65. The tertiary care hospitals to be utilized for elective, urgent, and emergency care shall be specifically noted for each facility. The RHA shall ensure there is a written agreement for each hospital used for the inmate medical health care that outlines the terms of the care to be provided[56], including delivery for the pregnant inmate[57]. The agreements shall require that the offsite facilities or health professionals give the inmate a summary of the treatment given and any follow-up measures required.[58] Current guidelines and processes

[56] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-05 (I), Hospital and Specialty Care, p. 54

[57] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-07 (E), Care of the Pregnant Inmate, p.105

[58] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-05 (I), Hospital and Specialty Care, p. 54

for hospitalization of inmates shall be detailed in written policies and procedures. The responsibilities of the medical and correctional staff shall be clearly delineated. Upon the inmates' return from hospitalization or an emergency room visit of a tertiary care hospital, the AOC shall ensure that correctional officers must bring the inmates to the correctional facility emergency room. The RHA should ensure that health staff evaluates these inmates including those returning from PCH. The physician in the Correctional Facility's Emergency Room sees the patient, reviews the discharge orders, determines the need for special housing, and issues follow up orders as clinically indicated, prior to releasing the inmate to his housing unit.[59,60] If the physician is not on site, designated health staff contacts the physician on call to review ER findings and obtain orders as appropriate.

66. Inpatient psychiatric hospitalizations should be provided to patients who need these services. The Government of Puerto Rico shall provide to the RHA a facility which will operate as a maximum security hospital for the treatment of inmates requiring crisis intervention and acute care hospitalization.

67. The PCH shall be licensed as required by the Commonwealth of PR. [61]

68. The PCH offers observation, diagnosis, rapid and accessible treatment to inmates under acute mental health symptoms, mental crisis or emotional distress 24 hours a day, 7 days a week, by an interdisciplinary team, in accordance with applicable law. Nursing services are available 24 hours a day, under the direct supervision of a

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[59] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-12 (E), Continuity of Care During Incarceration, p. 79

[60] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 20

[61] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-05 (I), Inpatient Psychiatric Care, p. 46.

psychiatrist who provides active treatment. The AOC shall provide, upon adequate notification by the mental health professionals, appropriate security coverage to permit appropriate recreation and other therapeutic activities. The continuity of care must be assured through individualized treatment, discharge planning and appropriate coordination of services. When disposition of discharge is completed, inmates shall be referred to the appropriate level of care according to the presented needs.

69. The RHA shall establish and maintain policies and procedures concerning the discharge planning process for each hospitalized inmate to assure continuity of care at the appropriate level of service.[62]

70. The RHA shall ensure that the isolation/observation rooms available at the PCH, are properly fitted and adequate to function according to federal and state updated protocols to prevent injuries to the inmate. The room shall be equipped with adequate lighting to permit continuous observation. In addition, the rooms shall be properly fitted to allow the use of restraints for agitated and aggressive patients.[63]

71. The Department of Health shall provide a facility for the treatment of forensic patients, including those that are members of the *Morales Feliciano* class.

72. All inmates discharged from the Psychiatric Forensic Hospital and admitted into the correctional system shall be immediately evaluated at the PCH to determine the level of care required for the mental health condition.

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[62] Recommendations Related To Report 188 Of The Court Monitor To Be Implemented As Ordered By The Court December 28, 1992, Order #1.

[63] Orders Related To Report 224 Of The Court Monitor To Be Implemented As Ordered By The Court March 29, 1993, Order #11.

K. EMERGENCY CARE

73. Each facility shall have access to at least one emergency room. Inmates shall have 24-hour access to emergency medical, mental and dental care. The RHA shall establish and maintain policies and procedures that include the arrangements for emergency evacuation of inmate from a facility, use of ambulances, use of designated hospital emergency rooms or other appropriate health care facilities, and security procedures providing for the immediate transfer of inmates.

74. Emergency Medical Services Ambulances shall be provided by AOC and shall be available at each correctional facility, in quantities according to the size of the facility and its distance from the nearest designated hospital emergency department. AOC shall be responsible for maintenance of these ambulances, and shall ensure that they are in good working order, certified and in compliance with the established governmental regulations. Policies and procedures shall be develop jointly with AOC to assure proper use and availability of functioning equipment and supplies. AOC shall provide sufficient correctional staffing to transport the patients and drive the ambulances, who shall have current certifications as required by governmental regulations.

75. All facilities shall have on duty twenty-four (24) hours per day health trained and currently qualified staff that is capable of responding to emergencies. The RHA shall ensure there is at least one health care professional trained and certified in advance cardiac life support at each intake facility on each shift.[64] In the absence of health care professionals, there shall always be available sufficient numbers of health trained correctional officers who can initiate basic emergency medical care including cardio-pulmonary resuscitation.

[64] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 22

76. Inmates in any institution requiring acute psychiatric care or emergency treatment are referred immediately to the emergency room for stabilization. Mental health emergencies are appropriately managed[65] and upon stabilization, inmates are referred to the PCH.[66]

77. The availability of emergency equipment shall be standardized throughout the correctional system. All facilities shall have at least the following emergency equipment: oxygen tank and oxygen delivery systems, oxygen saturation measurement devices, peak expiratory flow rate meters, finger stick blood glucose testing equipment, manual resuscitator bag, long back board and neck stabilizers, splints, dressings, slings, one-way valve CPR masks, stretchers, wheel chair, intravenous fluid and administration setups, disposable gloves, and face masks. Also, all facilities shall have crash carts with emergency medications, suction machines, paddle defibrillators or automated external defibrillators, and intubation equipment. In the absence of health care professionals, first aid kit, stretchers, and other appropriate emergency equipment shall be readily available to health trained correctional staff, who shall initiate basic emergency care pending the procurement of professional medical assistance. Emergency drugs, supplies, and medical equipment shall be regularly maintained.[67] The RHA shall ensure that pharmaceuticals, medical supplies, and mobile emergency equipment are available at all correctional facilities and

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[65] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-06 (E), Emergency Services, p. 59.

[66] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-05 (I), Inpatient Psychiatric Care, p. 46.

[67] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-08 (E), Emergency Services, p. 73

checked regularly.[68] The designated individual responsible for the evaluation shall verify that any identified deficiencies are corrected.[69] The choice of basic emergency equipment depends on the size of the institution, its distance from the nearest emergency department, and the level of staff training.[70]

78. First aid kits shall be readily available in designated areas of each institution. The contents, number, location, procedures for use, monthly inspection, and restocking of the kits shall be approved by the RHA. Monthly inspections shall be documented. The first aid kits shall be situated for use by the correctional staff pending the procurement of professional medical assistance.

79. Disaster drills shall be conducted at least annually. The RHA shall establish and maintain written policies and procedures that outline the health staff's response to an institutional disaster and ensure that all health staff is prepared to implement the health aspects of the facility's emergency response plan.[71] The medical care components of the disaster plan shall be tailored to each individual facility.

80. Disaster drills shall be fully documented, critiqued, results shared with all health staff, and reports of drills shall be submitted to the Continuous Quality Improvement Committee. The medical disaster plan for each facility shall be signed by the Health Administrator, the Clinical Services Director, and the Superintendent.

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[68] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-03 (I), Clinic Space, Equipment, and Supplies , p. 51

[69] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 21

[70] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-08 (E) Emergency Services, Discussion, p. 74

[71] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-07 (E), Emergency Response Plan, p. 12

L. SEGREGATED INMATE

81. Correctional staff will be responsible for notifying the Clinical Services Director or his designee at the correctional institutions when an inmate is placed in a segregated area. Upon notification that an inmate is placed in segregation, qualified health staff must review the inmate's health record to determine if whether existing medical, dental or mental health needs allow for removal to an appropriate level of health treatment as clinically indicated. Such review is documented in the health record.[72,73]

82. All inmates admitted to segregation area of a correctional institution for punitive, administrative, protective or other segregation, must receive a mental health screening examination within the first business day of their arrival. As a result of the evaluation, appropriately identified inmates must be treated at the institution or be removed to an appropriate level of mental health treatment as clinically indicated.

M. PREVENTIVE ROUNDS

83. Appropriate mental health professionals shall conduct periodic tours of all housing units, including daily tours in high risk areas such as housing areas for new admissions and maximum security.

84. The mental health of segregated inmates shall be monitored regularly. Monitoring of a segregated inmate will be performed at least weekly

[72] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-07 (E), Segregated Inmates, p. 60.

[73] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-09 (E), Segregated Inmates, p.75

with the frequency based on the degree of isolation as detailed in the NCCHC Standards for "Segregated Inmates".[74, 75]

85. Coordinating closely with correctional officers, a mental health professional shall make the rounds in all segregation areas for the purpose of assessing and triaging cases of emotional disturbance, and who shall be responsible for making appropriate referrals to the corresponding level of mental health services care and documenting any and all significant mental health findings.[76, 77]

N. PHYSICAL THERAPY

86. Basic physical therapy services shall be available for no less than twenty (20) hours per week at a facility to be designated by the RHA. Physical therapy services, as ordered by a physician, shall be provided by an appropriately trained and licensed physical therapist and other appropriately trained and licensed health care professional. As needed, additional off-site physical therapy services shall be arranged by the medical staff.

O. PHYSICAL EXAMINATIONS

87. Guided by written protocols, routine health maintenance evaluations and examinations shall be performed no less than annually for all

[74] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-07 (E), Segregated Inmates, p. 60.

[75] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-09 (E), Segregated Inmates, p.75

[76] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-E-07 (E), Segregated Inmates, p. 60.

[77] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-09 (E), Segregated Inmates, p.75

sentenced inmates; however the RHA is responsible for determining the frequency and content of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations.[78] In determining the specific exams and tests to be performed, the protocol for annual evaluations shall take into account the inmate's age, gender, and risk factors. A standard form shall be established and maintained for the purpose of conducting these physical examinations, and shall include the following:

a. oral inquiry into the status of current medical, mental and dental health,

b. complete vital signs, including weight,

c. as indicated by the inmate's gender, age and risk appropriate hands-on physical examination,

d. vaccination update as indicated by nationally recognized professional and public health organizations and by protocols of the RHA,

e. indicated laboratory and screening tests,

f. health education (e.g., AIDS, cancer, smoking, cholesterol),

g. examination and testing for tuberculosis, HIV, and sexually transmitted diseases,

h. genital examination for all males, and

i. in the case of females, pelvic and breast examination and a Pap smear.

[78] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-12 (E), Continuity of Care During Incarceration, p. 79

IV. TRAINING AND STAFFING

A. TRAINING

88. In order to ensure that minimally adequate constitutional medical treatment is afforded to inmates, all health care professionals who provide services to inmates are appropriately credentialed according to the licensure, certification, and registration requirements[79] of the Commonwealth laws of Puerto Rico. Health care professionals do not perform tasks beyond those permitted by their credentials[80].

89. A health related training program including the components set forth in this paragraph shall be developed and implemented.

    a. AOC shall be responsible for implementing and maintaining a health related training program for correctional officers who work with inmates, and this will be done in collaboration with the RHA. Such training should be given at least every 2 years.[81] The RHA must review and approve the content of this training program which shall include at least the following areas[82]:

        1. administration of first aid;

        2. basic cardio-pulmonary resuscitation (CPR);

[79] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-01 (E), Credentialing, p. 33

[80] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-01 (E), Credentialing, p. 33

[81] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

[82] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

3. recognition of the need for emergency care and intervention in life-threatening emergency situations;

4. recognizing acute manifestations of certain chronic illnesses, intoxication and withdrawal, and adverse reactions to medications;

5. recognizing alcohol or drug problems in inmates; [83]

6. recognizing signs and symptoms of mental illness; [84]

7. appropriate clinical referral and disposition procedures; including the appropriate procedure for referral of inmates with mental health complaints or suicidal behaviors to mental health staff; [85]

8. intake screening, including indications for immediate referral of an inmate for medical or mental evaluation and suicide prevention;

9. communication skills for managing inmates with mental disorders; [86]

10. procedures for suicide prevention and intervention;[87] and

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[83] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-05 (E), Substance Abuse Services, p. 84

[84] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-04 (E), Mental Health Training for Correctional Officers, p. 32.

[85] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-04 (E), Mental Health Training for Correctional Officers, p. 32.

[86] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-04 (E), Mental Health Training for Correctional Officers, p. 32.

[87] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-04 (E), Mental Health Training for Correctional Officers, p. 32.

11. precautions and procedures with respect to infectious and communicable diseases.[88]

b. The training program also shall address specialized training needs for correctional officers' employed in PSU's and in high-risk areas of the institution such as admissions, segregation units, protective custody units, and disciplinary units.[89] Correctional Officers who have completed the specialized mental health training shall be assigned to a mental health care unit post for a minimum of six months.[90]

c. The RHA and AOC shall jointly develop and implement a policy and procedure for the removal of a correctional officer from a post within the health care unit for inappropriate behavior.[91] This policy and procedure must include a provision for the immediate removal of correctional officers who jeopardize the well being and or health of an inmate.

d. Health related training will be provided to all correctional officers who work with inmates. All new correctional officer trainees shall receive health related training. While it is expected that 100% of the correctional officers who work with inmates are trained in all of these areas, compliance with this MMHCP requires that at least 75% of them present on each shift are current in their

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[88] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

[89] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-02 (E), Mental Health Programs and Residential Units, p. 76.

[90] Recommendations related to Report 188 of the Court Monitor to be implemented as ordered by the Court December 28, 1992, order #3.

[91] Recommendations related to Report 188 of the Court Monitor to be implemented as ordered by the Court December 28, 1992, order #4.

health related training[92]. Documentation of completion of health related training program shall be appropriately maintained.[93]

e. The health related training program shall be an integral, ongoing component of the training and re-training of all correctional officers. The retraining interval, not to exceed two (2) years, and shall be governed by written policy and procedures.[94]

90. Initial orientation and ongoing in-service training shall be provided for all primary health care professionals. Health services employees and their supervisor are responsible for participating in continuing education.[95] All staff, including part-time staff, shall be mandated to participate. There shall be a minimum of 12 hours of annual continuing education for employees who work full time, however 6 hours of in-service training related to the correctional setting are required. Required hours of continuing education for part-time employees are prorated based on full time equivalency. The RHA shall maintain appropriate documentation that is readily accessible both at the central offices and in the local facility, as well as each individual's personnel files, concerning the particulars of the continuing education taken by each health services employee.

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[92] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

[93] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

[94] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-04 (E), Health Training for Correctional Officers, p. 37

[95] [95] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-03 (E) Professional Development, Discussion, p. 36

91. All qualified health care professional (physicians, nurses, dentists, etc.) whom have clinical encounters with inmates shall be required to have documentation of current CPR certification in their personnel file.

92. Correctional or qualified health care professionals with basic training and current qualification in first aid and basic life support shall be posted continuously within voice or visual contact of all inmates in housing or service units.

93. The AOC, in consultation with the RHA shall develop a security training program for health staff and support personnel who work within the correctional facilities.[96]

B. STAFFING

94. Each correctional facility shall have a designated Clinical Services Director responsible for all aspects of the facility's health care system, who has final clinical judgment regarding the care of inmates in the facility including detoxification services, and a Health Administrator to manage and coordinate the administrative aspects of the health care delivery system. In the intake facilities the Clinical Services Director shall be board eligible or certified in a primary medical care field (internal medicine, family practice or emergency medicine) to the extent that this can be accomplished through reasonable and good faith efforts, or a licensed General Physician with broad clinical and administrative experience in the correctional setting. The Health Administrator at each of the intake facilities shall have experience in health care administration.

[96] Stipulation Regarding Security, Security Training for Medical Staff Security 8, p. 5

95. A minimum staffing plan consistent with this MMHCP shall be achieved and maintained. AOC shall hire the minimum required staff according, to the staffing guidelines recommended and approved by the RHA to ensure that medical services can be provided in a safe, prompt and efficient manner. The following guidelines shall be supplemental to other guidelines that are set forth in this MMHCP;

    a. Facilities with intake health screening, infirmary care and medical dormitories shall have 24 hours per day nursing and physician coverage 7 days per week (but see, paragraph 19(b), supra).

    b. Facilities not included in paragraph 94(a), supra, with populations of 300 or more inmates shall have 24 hour per day nursing coverage 7 days per week, and 7 day per week physician coverage, and an acceptable alternative plan which ensures reasonable and timely access to a physician in the off hours.

    c. Facilities with populations of less than 300 shall have 16 hour per day nurse staffing on weekdays and no less than an 8 hour per day nurse staffing on weekends and holidays, and 5 day per week physician coverage, and an acceptable alternative plan which ensures reasonable and timely access to a physician in the off hours.

    d. Facilities with populations of less than 100, the RHA shall provide an acceptable alternative plan which ensures reasonable and timely access to health care professionals.

    e. In addition to the coverage requirements set forth in subparagraphs (a) through (d) of this paragraph 94, the minimum staffing plan with the exact number of nurses,

physicians, support staff, secretarial and clerical personnel required to provide inmates with adequate and timely evaluations and treatment consistent with contemporary standards of care shall be determined with due consideration of the total population, location, physical plant and the medical needs of a facility's inmate population. This staffing plan shall be revised and adjusted as necessary.

f. A sufficient number of health staff (including mental health staff) of varying types shall be available to provide adequate and timely evaluation, treatment, and follow-up consistent with contemporary standards of care to meet the diverse needs of the inmate population.[97] The adequacy and effectiveness of the staffing plan are assessed by the facilities ability to meet health needs of the inmate population.[98]

g. AOC shall provide sufficient correctional officers to support the delivery of health care services in a safe and professional manner.

96. The RHA shall submit its health staffing plan needs to the AOC as needed to ensure minimum levels of care throughout the correctional facilities and submit to the Court a report outlining the extent of their compliance with the staffing plan. In the event that the RHA reports staffing deficiencies that impact its ability to deliver minimum levels of care to the correctional population, the RHA shall inform the Court of the type and number of staff required to complete the minimum level of

[97] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-07 (I), Mental Health Staffing, p. 36

[98] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-07 (E), Staffing, p. 37

staff required, what efforts defendants are making to recruit staff, and the proposed date by which each unit will be sufficiently staffed.[99]

97. Systemwide and institutional clinical and administrative meetings shall be scheduled regularly. These meetings may include all health care professionals groups or may be divided into separate sessions for clinical, administrative, pharmacy, information management staff and other staff. [100, 101]

98. The AOC shall establish and maintain a compensation plan for health care professionals whose services are required to achieve the purposes and objectives of this MMHCP, according to the RHA's recommendations. This compensation shall be sufficient to allow recruitment and retention of qualified professional staff including specialists.

99. The RHA shall endeavor to establish affiliations with the medical, dental, and nursing schools and residency training programs in the Commonwealth of Puerto Rico and elsewhere. The relationship established may include allowing appropriately trained and licensed residents to provide evening staffing of select correctional facilities or to provide staffing of primary care or specialty clinics. It also may include contracting for the delivery of primary and secondary care in a facility and arranging clinical rotations for students.

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[99] Orders related to Report 224 of the Court Monitor to be implemented as ordered by the Court March 29, 1993, order #23 &#24.

[100] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-04 (E), Administrative Meetings and Reports, p. 7

[101] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-04 (E), Administrative Meetings and Reports, p. 6

100. The RHA and AOC shall ensure that health staff works in a safe environment. [102,103]

101. No inmate shall be employed in the medical and dental care delivery system except for assignments that essentially are janitorial in nature. Inmates employed in cleaning the health services unit are appropriately trained and supervised regarding their work assignments.[104]

102. No inmate shall be employed in the mental health delivery system except for assignments that essentially are janitorial in nature. The RHA however, may request approval from the AOC to allow inmates who have been appropriately screened and cleared by the AOC to be assigned to a supportive and rehabilitative role following proper training and under careful supervision.[105]

V. OTHER SPECIAL CONSIDERATIONS

A. TREATMENT PLAN

103. Individual treatment plans shall be prepared for all inmates who receive any level of mental health or substance abuse treatment. In addition, all requests for psychiatric consultation must be documented.

[102] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-B-03 (I), Staff Safety, p. 27

[103] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-B-03 (I), Staff Safety, p. 23

[104] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-C-06 (E), Inmate Workers, p. 39

[105] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-06 (E), Inmate Workers, p. 34

104. Mental health services shall be provided according to individual treatment plans,[106] which will direct the services needed for the inmate, and will contain the treatment goals and objectives.

105. Relevant psychological testing materials, supplies, and reference resources are available to support the mental health evaluations completed on site and are stored in a secure area.[107] Psychological tests will be offered to inmates for the purpose of permitting more sophisticated mental health screening, and to contribute to the evaluation, diagnosis, and treatment processes. Psychological tests will be performed for diagnostic and therapeutic purposes only.

B. SUICIDE PREVENTION PROGRAM

106. The RHA shall establish and maintain an appropriate suicide prevention program to identify and intervene with suicidal inmates throughout each of the AOC's facilities.

107. The key components of the suicide prevention program must include the following elements: training, identification, referral, evaluation, treatment, housing and monitoring, communication, intervention, notification, review and debriefing. The RHA approves the facilities' suicide prevention plans; training curriculum for staff, including development of intake screening for suicide potential and referral protocols; and training for staff conducting the suicide screening at intake.[108, 109]

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[106] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-03 (E), Treatment Plans, p. 79.

[107] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-03 (I), Clinic Space, Equipment, and Supplies, p. 45.

[108] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-G-04 (E), Suicide Prevention Program, p. 81.

C. VOLUNTARY AND INVOLUNTARY TRANSFER AND TREATMENT

108. Informed Consent for all treatment and hospitalization shall be obtained from inmates in accordance with contemporary legal requirements.[110] Appropriate procedures shall be followed and consent forms shall be read to an inmate who voluntarily submits to treatment before he signs the form. In the event the RHA needs to treat an inmate involuntarily, the RHA shall also fully document its procedures according to applicable law. All transfers to any hospital shall be in compliance with applicable law.

D. MEDICAL LEGAL ISSUES

109. Clinically ordered restraint and clinically ordered seclusion are available for inmates exhibiting behavior dangerous to self or others as a result of medical and mental illness.[111] Except for monitoring their health status, the health services staff does not participate in the restraint of inmates ordered by custody staff. [112]

110. The RHA shall be responsible for securing sufficient and appropriate restraining devices for the PCH, and for all emergency and acute health care units. [113]

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[109] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-05 (E), Suicidal Prevention Program, p. 100

[110] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-I-04 (I), Informed Consent and Refusal of Mental Health Care, p. 101.

[111] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-I-01 (E), Restraint and Seclusion, p. 97.

[112] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-I-01 (E), Restraint and Seclusion, p. 123

[113] Orders related to Report 224 of the Court Monitor to be implemented as ordered by the Court March 29, 1993, order #8.

111. Health staff is prohibited from participating in the collection of forensic information or forensic screening of inmates except when complying with state laws or as court-ordered. [114,115]

112. Behavioral, biomedical, or other research using inmates as participants must be consistent with established ethical, medical, legal, and regulatory standards for human research.[116,117]

E. SPACE AND EQUIPMENT

113. The RHA and the AOC shall produce a written joint evaluation of the health care space and equipment in each of the correctional institutions at least annually. The evaluation shall detail the type of medical equipment (e.g. emergency, diagnostic and transport) available, the location of space and equipment in the institution, the size and adequacy of clinical, administrative and storage space (noting the number of examination rooms, offices, nursing stations, etc.), the condition and state of condition areas and the equipment, and the availability of hand washing and toilet facilities.

114. AOC and the RHA shall jointly review the planned capital improvement program for the health care services areas on an annual basis. In the event of new construction or any major rehabilitation of an existing facility, AOC will incorporate the RHA as an advisor in the planning of

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[114] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-I-03 (I), Forensic Information, p. 100.

[115] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-I-03 (I), Forensic Information, p.126

[116] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-I-05 (I), Research, p. 104.

[117] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-I-06 (I), Medical and Other Research, p.131

said facility so as to allow design input of the health care areas and the overall design that may impact the provision of medical services.

115. The AOC and RHA shall jointly provide sufficient clinic space and non-medical equipment and supplies in all facilities for the delivery of adequate medical, dental and mental health care in accordance with this MMHCP. [118,119]

116. The AOC and RHA shall jointly provide adequate facilities for which healthcare services can be offered, and will be responsible for the adequate and continuous maintenance and refurbishing of these facilities, as well as the office and medical equipment required for the scope and level of care rendered. The RHA shall identify present and future space needs for the provision of health care services and submit it to AOC, so that AOC may consider incorporating these recommendations in their capital improvement program.

117. Health services are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of services.[120,121]

118. The AOC and RHA shall identify the non-living areas within the institutions dedicated for mental health purposes to include, at a minimum, sufficient space for private and group counseling sessions, program space, and staff offices. Individual therapies and assessments

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[118] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-03 (I), Clinic Space, Equipment, and Supplies, p. 44.

[119] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-03 (E), Clinical Space, Equipment, and Supplies p. 51-52

[120] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-09 (I), Privacy of Care, p. 15.

[121] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-09 (I), Privacy of Care, p. 15

as well as group therapies are provided in an area with private interview space.[122]

119. AOC shall provide telephone and connectivity to the RHA's health information technology in the medical areas of all facilities, to improve the efficiency and effectiveness of the health care system through the functionality of the electronic medical record, and enable uniform electronic exchange of certain health information, to facilitate medical transfers, the arrangement of consultations and diagnostic testing, and the coordination of the emergency medical responses.

120. Each institutional medical area shall have timely access to current and comprehensive, text or electronic medical references, which at a minimum include the following: pharmaceutical and therapeutics, general medicine, family medicine, general surgery, emergency medicine, dermatology, medical dictionary and, in the facility housing female inmates, obstetrical-gynecology.

121. The AOC shall provide all inmates with clean mattresses and pillows, sheets and pillow cases, personal hygiene supplies, and hot water for bathing and the sanitation of eating utensils.[123] In addition, the RHA will notify the AOC of identified needs in these aspects for the appropriate corrective action by the AOC and to ensure appropriate infection control measures.

F. PHARMACY

122. Pharmaceutical services in all correctional facilities shall be directed and supervised, according to written policies and procedures, by a

[122] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-D-03 (I), Clinic Space, Equipment, and Supplies, p. 44.

[123] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 43

systemwide Director of Pharmaceutical Services. The Director of Pharmaceutical Services or his designee shall inspect and monitor the pharmaceutical services provided in each facility. A sufficient number of qualified and licensed pharmacists and pharmacy technicians shall be hired according to the needs, health care services rendered and the population of the correctional facilities. Intake facilities will be adequately staffed with at least 1 chief pharmacist and any and all additional pharmacists as required to serve the needs of the inmate population in a reasonable and timely manner, and in accordance with the minimum staffing requirements set forth by the RHA. All other facilities shall similarly be staffed with appropriate levels of pharmacists and pharmaceutical personnel as required to provide reasonable and timely service to inmates.

123. A written formulary of all medication used in AOC facilities shall be established by the RHA.

124. In order to insure that minimally adequate constitutional medical care is afforded to inmates, pharmaceutical services throughout the correctional system shall comply with all applicable Commonwealth of PR and federal laws and regulations regarding prescribing, dispensing, administering, and procuring pharmaceuticals.[124] Pharmacy services are clinically appropriate and provided in a timely, safe, and sufficient manner.[125] The RHA shall ensure that health staff maintains a medication profile on every patient to protect against duplication of medications and adverse drug interaction.[126]

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[124] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-01 (E), Pharmaceutical Operations, p. 47

[125] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-02 (E), Medications Services, p. 49

[126] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 24

125. The RHA shall automate pharmaceutical services to expedite the prescribe-dispense-refill process and to reduce the possibility of prescription error.[127]

126. Only pharmacists and, under the direct supervision of a pharmacist, pharmacy technicians, pharmacy technicians trainees, or pharmacy interns may dispense prescribed medications. Licensed physicians and dentist may prescribe and administer medications. Only specialized, general and associate nurses, (collectively referred to as professional nurses), a dentist, or physician may administer medications. Professional nurses will be responsible for the medication maintained at the nurses' station. In Ambulatory Care Services, licensed practical nurses under the direction of a professional nurse may administer medications in the inmates' residential units. These medications must have been dispensed by a license pharmacist or, under the direct supervision of a pharmacist by a pharmacy technician, pharmacy technician trainee, or a pharmacy intern as per the written orders of a licensed physician or dentist. The RHA shall implement appropriate procedures to ensure that this policy is followed. No correctional officer or inmate may be involved in the delivery or administration of any prescribed medication. [128]

127. The controlled substances, psychotropic, anti-tuberculosis and other medications as determined by the RHA shall be dispensed in dose- by-dose quantities.[129]

128. The RHA shall establish and maintain a manual of policies and procedures aimed at ensuring that psychotropic medications, including

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[127] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 26

[128] Court Order of July 9, 1993 for the Carlos Morales Feliciano Case

[129] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 27

hypnotics and sedatives, are accounted for, that such medications are: ordered by a qualified physician, dispensed only by qualified professionals, that appropriate professional caution is used with respect to the use of sedative hypnotics in the correctional population, and that medications are prescribed only when clinically indicated.

129. Health staff that administers and/or delivers prescription medications to inmates are permitted by state law to do so and are trained as needed in matters of security, accountability, common side effects and documentation of administrations of medicines.[130] Personnel who administer psychotropic medication are appropriately trained.[131]

130. The RHA shall establish and maintain a mechanism that ensures that the unit doses medications are administered to the inmate.

131. The RHA may develop a self-medication program for bulk medications where appropriate and applicable. Psychotropic, anti-tuberculosis, and other medications as determined by the RHA, are to be administered by nursing personnel (including licensed practical nurses under the direction of a registered nurse) via direct observed treatment (DOT), and the patient will be observed to assure these medications are consumed.

132. Medications are prescribed only when clinically indicated. Written documentation of each medication prescribed or the written prescription itself shall be maintained in a section for prescribed medication in the inmate's health record in accordance to all applicable Commonwealth and federal laws. Documentation of the medication

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[130] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P- C-05 (E), Medication Administration Training, p. 38.

[131] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-C-05 (E), Medication Administration Training, p. 33.

administration (given, refused, out-to-court, no show, etc.), including administration of injectables such as insulin, shall be noted in the health record. No inmate shall be deprived of a prescribed diet or of medication as a punitive or disciplinary measure.

133. The RHA shall establish and maintain a system by which the pharmacy notifies the health care professionals of the impending expiration of a prescribed medication. The medication shall be prescribed according to the inmate's health condition and at no time will a prescription be renewed for more than three (3) months without a physician's reevaluation at the ambulatory clinics.

134. All routine medical supplies and pharmaceuticals shall be filled and delivered to the ordering facility on a timely fashion. Emergency requests shall be expeditiously filled and delivered to the ordering facility. Written policies and procedures shall be in place to allow individual correctional facilities to procure from alternative sources (e.g., private pharmacies or local hospitals) medications for which there is an emergency shortage and unusual medications or supplies not readily available. When an alternate source cannot be procured, alternative treatment options shall be considered. Limited pharmaceutical supplies shall be maintained at each facility, and these supplies shall be inspected on a regular basis.

135. The RHA or designee, shall maintain an adequate perpetual inventory and storage procedures for needles, syringes, and controlled medications that comply with the Control of Medical Items procedures and Pharmaceutical Services procedures in the existing Security Plan. The RHA will be responsible for overseeing compliance with said

procedures in the medical areas and pharmacies at all AOC facilities.[132]

G. LABORATORY AND RADIOLOGY SERVICES

136. Laboratory and radiology services shall be provided pursuant to the following provisions.

a. The RHA shall establish and maintain policies and procedures for obtaining needed laboratory and radiological diagnostic services for inmates under the custody of the AOC. The system shall provide for the timely completion of ordered tests and for timely return of test results to the health care provider. These diagnostic services may be provided by reference laboratories, hospital radiology and laboratory departments, public health agencies, or correctional facilities.[133] In the event that the diagnostic services were to be contracted with any public and/or private laboratory and radiology centers, the RHA shall develop a written agreement with the entity contracted to provide these services, including the adequate terms of transportation on a timely fashion. These policies also apply for on-site diagnostic services.

b. Each and every correctional facility shall have a fully implemented system to provide laboratory services that includes: pickup of specimens at Intake Facilities from Monday thru Saturday, and all other facilities from Monday thru Friday, a turnaround time of no more than 48 hours for routine laboratory

[132] Stipulations Regarding Security, Stipulation 3, Medical Security, p. 1

[133] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-04 (I), Diagnostic Services, p. 53

tests, the development of a “panic” value protocol in which results falling outside established norms are immediately communicated to the facility's health staff, and the prompt review and signing of all laboratory results by the facility's physician prior to their placement in the health record. Whenever “stat” laboratory services are required, inmates may be transported to the nearest emergency room in the community for these services, if they are not available at the Institution.

c. The RHA shall ensure that a physician reviews all completed laboratory results and this review is documented in the health record. A physician should follow-up any abnormal laboratory results within 48 hours.[134]

d. The RHA may choose to establish on-site laboratories or to contract with private or public laboratories. If on-site laboratories are created, a written laboratory manual of policies and procedures shall be developed. All on-site laboratories shall comply with the applicable federal and state laws.

e. Every facility shall have equipment and/or testing capability, together with written protocols for testing, as follows:

   1. multiple-test dipstick urinalysis,

   2. finger-stick blood glucose,

   3. peak-flow meter (hand held or other),

   4. stool blood-testing material,

[134] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 32

5. pregnancy tests in any facility housing female inmates, [135]

6. oxygen saturation measurement devices, and

7. microscope and supplies required to evaluate vaginal discharges (at facilities housing females).

f. On-site, non-contrast radiology services shall be available at all intake facilities. All x-ray studies done on-site in a correctional facility, excluding routine tests ordered in ambulatory clinics shall be reviewed preliminarily and documented by a physician prior to being sent out for interpretation by a radiologist. The turnaround time for the return of the radiologist's report shall be no more than five (5) days.

g. The RHA shall ensure that a physician reviews all completed x-ray reports and should follow-up any abnormal x-ray results within 48 hours.[136]

h. Written policies outlining the procedures for obtaining contrast x-ray studies, ultrasound testing, and other special radiological studies shall be established and maintained, and shall be reviewed on an annual basis.

i. The RHA shall regularly maintain and inspect its radiological units within the correctional facilities and ensure the same are in compliance with local and federal laws.

j. The RHA shall provide radiological safety systems in all medical x-ray areas.[137]

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[135] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-D-04 (I), Diagnostic Services, p. 53

[136] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 32

k. All radiological procedures shall be performed by licensed radiology technologists or other trained medical personnel as permitted by the laws of Puerto Rico.

H. HEALTH RECORDS

137. A Registered Health Information Administrator shall be responsible for the supervision of Health Information Management Services for the entire correctional system. This professional shall coordinate and develop all policies and procedures concerning the management, storage, conservation and use of the health records in electronic and/or paper forms. Each facility shall have at least one (1) full time Health Information Administrator, responsible to coordinate and supervise all Health Information Management staff at the designated facility. Correctional institutions with an inmate population of 200 or less may delegate this function to a full time Health Record-Clerk, under the supervision of the Health Information Administrator, according to the needs and complexity of services available at the facility. For every 500 inmates the correctional facility shall have at least two (2) Health Information Management professionals (Health Information Technician/Clerk), depending upon the volume, complexity and decentralization of the health services offered at the different organizational structures within the correctional system.

138. Health Information Management Services, health records system, health chart and all clinical forms must be standardized throughout all the correctional system, and shall be maintained and used in accordance with established laws and applicable regulations as well as with the following provisions set forth below.

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[137] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 31

a. Each sentenced inmate and pre-trial detainee shall have a permanent health record, in electronic and/or paper form, to be initiated upon admission into the correctional system to facilitate continuity of care. [138] This record shall reflect the inmate's initial contacts with health care professionals including intake health screening and health assessment forms and all the information related to the medical, mental, and dental services provided. Health Information Management personnel shall retrieve and grant access to health records developed during prior periods of incarceration for inmates returning to the system.

b. Correctional institutions will use a hybrid system based on both electronic and paper forms, until such time full use of the RHA's electronic record is in place, along with appropriate procedures to address the integration of health information in electronic and paper forms.[139] The system shall assure the management, compilation and conservation of the socio-demographic and health information of the inmate.

c. At a minimum, the health record shall include the following information:[140]

    1. identifying information (e.g., inmate name, identification number, date of birth, sex),

[138] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-04 (I), Management of Health Records, p. 118

[139] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-01 (E), Health Record Format and Contents, p. 115

[140] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-01 (E), Health Record Format and Contents, p. 115

2. a problem list containing medical, dental and mental health diagnosis and treatments as well as known allergies,
3. receiving screening and health assessment forms,
4. progress notes (medical, dental and psychiatric) of all significant finding, diagnosis, treatments and dispositions,
5. laboratory results, x-ray results, and diagnostic studies,
6. clinician orders including prescribed medication, Medication Administration Record, and copies of prescriptions until medical electronic record is fully implemented,
7. flow sheets,
8. consent, refusal and release of information forms,
9. results of specialty consultations and off site referrals,
10. discharge summaries of hospitalizations and other inpatient stays,
11. special needs treatment plan, if applicable,
12. immunization records, if applicable,
13. place, date, and time of each clinical encounter, and
14. signature and title of each documenter.

d. Each health record shall contain treatment orders.

e. A format and documentation method in the health record must be established, according to the requirements of each health discipline, which shall be approved by the RHA.

f. All laboratory results, x-ray results and consultations shall be reviewed by a physician and this review documented in manual or electronic form prior to being filed in the appropriate health record.

g. Until full use of the electronic record is in place, whenever an inmate is transferred from one institution to another, his or her complete health record in paper form shall accompany the inmate, including results of intake health screening, health assessments, tuberculosis test, sexually transmitted disease testing, and prescriptions. The health record in paper form shall be transported in a sealed envelope[141] or pouch as determined by the RHA.

h. Health records filed in the electronic system shall be accessible and available to all the authorized health staff. If there is a need for any previous health record in paper form, the same shall be timely provided to the authorized health staff. The confidentiality of inmates' written or electronic health record, as well as orally conveyed health information, shall be maintained. [142, 143]

139. All health records shall be maintained in a secure and confidential manner, and access to such records shall be limited to health staff, as appropriate. Appropriately qualified medical staff of the AOC may have assisted access to review the health records, as determined and approved by RHA. The review will be subject to applicable federal and

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[141] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-02 (I), Confidentiality of Health Records, p. 116

[142] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-02 (E), Confidentiality of Health Records, p. 116

[143] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-H-02 (E), Confidentiality of Clinical Records and Information, p. 91.

state laws to the extent that it is necessary for the AOC to assure adequate provision of health care to inmates.

140. The RHA shall establish and maintain written policies and procedures governing the communication of health information, including mental health, to appropriate correctional and/or parole board staff, including communications regarding inmates' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.[144,145]

141. Qualified health care professionals have access to information in the inmate's custody record when the RHA determines that such information may be relevant to the inmate's health and course of treatment.[146]

I. INMATE TRANSFERS

142. The AOC and RHA shall establish and maintain a written agreement that ensures correctional staff notifies health staff of an inmate's impending transfer. This agreement shall include the following: timely notification so that health staff can prepare the inmate's health record for transfer,[147] provisions to assure that the inmates continue to receive appropriate health care according to their special needs taking into account considerations for housing assignment, and the necessary medications to be transported with the inmate.

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[144] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-A-08 (E), Communication on Patients' Health Needs p. 14.

[145] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-08 (E), Communication on Patients' Mental Health Needs p. 14.

[146] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-H-03 (I), Access to Custody Information, p. 117

[147] Recommendations Related to Report 224 to be Implemented as Ordered by the Court,Dec. 28, 1992, Order 2.

143. AOC shall develop a system to notify health staff of all transfers into the institution so that health staff can review the inmate's health record and perform any required physical examinations if necessary within 24 hours.[148]

144. The RHA shall establish and maintain a system by which qualified health care professionals perform a transfer screening on all intrasystem transfers. Qualified health care professionals review each transferred inmate's health record within 12 hours of arrival to ensure continuity of care. Inmates transferred from an intake facility that do not have initial medical, dental, or mental health assessments are to be evaluated at the receiving facility in a timely manner.[149,150]

J. MEDICAL DIETS

145. Medical diets as ordered by qualified health care professionals shall be provided by the AOC to enhance inmates' health, and are modified when necessary to meet specific requirements related to health conditions.[151] At minimum, low sodium, low cholesterol/fat, prenatal, diabetic (varied caloric levels); dental soft, broken jaw, weight reduction (controlled calories) and other special diets shall be prepared separately or in combinations as prescribed by a physician or dentist. Orders for medical diets include the type of diet, the duration for which

[148] Recommendations Related to Report 224 to be Implemented as Ordered by the Court,Dec. 28, 1992, Order 3.

[149] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-03 (E), Transfer Screening, p. 63.

[150] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 4.

[151] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-F-02 (I), Medical Diets, p. 86

it is provided, and special instructions, if any.[152] Orders for medical diets will be renewed every 12 months unless written for a shorter duration. No less than every six (6) months, AOC's managerial registered dietician shall review a sample of the regular and therapeutic diets for nutritional adequacy and whenever a substantial change in the menus is made. Reviews shall take place in a documented site visit, and the written report of findings shall include the date, signature and title of the dietitian.

146. The RHA shall establish and perform periodic monitoring activities to evaluate the components that impact the preparation and nutritional adequacy of the therapeutic diets. Findings shall be submitted to AOC for the development and implementation of corrective actions.

147. When inmates refuse prescribed diets, follow-up nutritional counseling is provided[153] and shall be documented in the health record.

K. FOOD SERVICE WORKERS

148. The AOC shall establish and maintain written policies and procedures requiring that all food service workers involved in the preparation or distribution of food are free from diarrhea, skin infections, and other illnesses that are transmissible by food or utensils. On a daily basis, all food service workers shall be monitored for health and cleanliness by AOC's non-inmate coordinator of food services. This monitoring will be documented and made available to the health staff as requested. All food service workers shall wear disposable gloves when they are

[152] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-F-02 (I), Medical Diets, p. 86

[153] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-F-02 (I), Medical Diets, p. 86

involved in any preparation or distribution of food that requires food to be touched.

149. Workers who prepare medical diets are trained in preparing the diets, including appropriate substitutions and portions. [154]

L. DENTAL CARE

150. Dental care shall be provided in accordance with the following provisions of this paragraph.

    a. The RHA shall establish and maintain policies and procedures for obtaining emergency and non-urgent dental care by a dentist licensed in the Commonwealth of Puerto Rico. All inmates shall receive dental screening by trained health care professionals at the time of or within seven (7) days of admission, and all sentenced inmates shall receive a dental examination by a licensed dentist within thirty (30) days of sentencing. In case of a readmitted inmate who has received a dental examination in the correctional system within the past year, a new exam is not required except as determined by the supervising dentist.[155]

    b. At a minimum, the dental care provided to inmates shall include fillings, extractions, relief of pain and infection, minor repair and adjustment of dentures, basic hygiene and cleaning, pulpotomies and root canals. Full and partial dentures shall be provided to sentenced inmates. Written policies shall describe conditions for which endodontic, periodontic, prosthetic and

[154] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-F-02 (I), Medical Diets, p. 86

[155] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-06 (E), Oral Care, p. 71

prophylactic services will be provided. Among factors to be considered before instituting a major or lengthy course of treatment are the potential effect on the inmate's health and the expected length of the stay in the correctional system. The RHA shall enter into written agreements with dental and oral surgical providers to render necessary services that cannot be provided in the correctional facilities.

c. A licensed dentist shall be employed as Dental Director to supervise all dental care provided in the correctional system.

d. The Dental Director also may be assigned to provide primary dental care in the correctional institutions.

e. The RHA shall employ sufficient dental professionals to fill the complement of dental staff.[156]

f. A continuing evaluation of the dental staff, facilities and equipment necessary to provide adequate dental care to all inmates in the correctional system shall be maintained by the RHA.

g. All deficiencies in dental care services noted in that evaluation shall be corrected in a timely fashion by the responsible party.

h. Contemporary infection control procedures shall be followed.[157]

M. PROSTHETIC DEVICES AND OTHER AIDS TO IMPAIRMENT

[156] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 30.

[157] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-E-06 (E), Oral Care, p. 70

151. Medical and dental orthoses or prostheses and other aids to impairment shall be supplied in a timely manner when the health of the inmate would otherwise be adversely affected, as determined by the responsible physician or dentist.[158] However, where the uses of specific aids to impairment are contradicted for security concerns, alternatives may be considered that will adequately and safely meet the health needs of the inmate.[159] The RHA shall establish and maintain policies and procedures concerning the guidelines and system for obtaining such devices. The arrangement for payment of costs for said devices shall be delineated in the written agreement between the AOC and the RHA.

N. INFECTION CONTROL PROGRAM[160]

152. There shall be an effective infection control program. All aspects of the infection control program are addressed by written policy and defined procedures. The RHA shall establish and maintain a written exposure control plan that is reviewed and updated annually.

153. The RHA ensures that:

    a. appropriate medical, dental, and laboratory equipment and instruments are decontaminated,

[158] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-10 (I), Aid to Impairment, p. 108

[159] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", 2008, P-G-10 (I), Aid to Impairment, p. 108

[160] National Commission on Correctional Health Care*, "Standards for Health Services in Prisons"*, 2008, P-B-01 (E), Infection Control Program, p. 23-25

b. surveillance to detect inmates with serious infectious and communicable disease is effective (e.g., skin infections),

c. immunizations to prevent disease are provided when appropriate,

d. infected patients receive medically indicated care, and

e. if appropriate, inmates with contagious diseases are medically isolated.

154. The facility completes and files all reports as required by local, state, and federal laws and regulations.

O. HIV INFECTION

155. An intensive program encompassing all aspects of Human Immunodeficiency Virus (HIV) infection (education, prevention, screening and treatment) shall be established and maintained by the RHA. In addition, training and educational programs related to HIV shall be provided for inmates, correctional staff, and health staff.

a. Inmates with AIDS or advanced HIV infection shall be assigned to institutions housing inmates with other chronic illnesses, diseases, or conditions (See, paragraph 58 supra). Inmates with significant debilitation (whether due to HIV infection or other illnesses) whose condition warrants extensive nursing care but not hospitalization shall be evaluated for admission to the medical dormitory or infirmary, available throughout the correctional system. Referral for specialty consultation, hospitalization, or admission in these medical areas shall be expeditiously arranged as the patient's clinical condition dictates.

b. Under no circumstances are inmates to be segregated from other inmates in any institution solely because of their HIV infection.

c. Inmates with documented or suspected HIV infection shall be evaluated as required based on the severity of the disease as well as the potential toxicities of prescribed therapy. Many HIV infected inmates on HAART will need to be seen on a monthly basis or more frequently as clinical guidelines indicate. Inmates with evidence of stable treatment regimens under excellent control, with no toxicities, complications, or co-morbidities, and with minimal risk of deterioration may be seen at intervals of more than one but not greater than three months. Those patients not on anti-retroviral treatment will be seen not less than every three months or more frequently as indicated by their clinical and laboratory status.

d. Frequently updated clinical, diagnostic and therapeutic guidelines concerning HIV infection and its complicated presentations shall be disseminated to all health care professionals in the correctional system. These guidelines shall minimally include the components set forth below:

    1. All HIV positive inmates shall be referred for counseling about AIDS and its prevention.

    2. HIV positive inmates must have a documented HIV antibody result (Elisa and Western Blot) in their record, and ongoing CD4 lymphocyte assessment, HIV RNA viral load testing, and chest x-rays screening done as established by the guidelines concerning HIV care as promulgated by the Department of Health and Human Services (DHHS), CDC, and National Institutes of Health.

Other recommendations established by the DHHS, CDC, and National Institutes of Health, such as resistance studies, renal, liver, and hematologic testing, shall be followed.

3. A Tuberculin Skin Test (TST) of >5mm will be considered reactive in all HIV positive patients. Screening for tuberculosis using TST or other approved screening modalities will be done as directed by CDC guidelines and the protocols of the RHA.

4. Any further recommendations emanating from the Center for Disease Control and Prevention (CDC) will be implemented.

e. A protocol relating to the medical treatment of inmates with HIV infection and setting forth the therapeutic modalities to be used for treatment of these inmates shall be established and maintained by the RHA.

f. A structured and updated comprehensive educational program shall be maintained to instruct all inmates, correctional and health staff about HIV infection and its prevention.

g. A system shall be maintained and promulgated for the initial and ongoing HIV testing of inmates. All laws and regulations concerning pre-test and post-test counseling shall be adhered.

h. The RHA shall educate inmates concerning the use of preventive materials and measures needed to prevent the dissemination of HIV infection among inmates in the correctional facilities of PR.

VI. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

156. The RHA shall establish and maintain a continuous quality improvement (CQI) program for the purpose of monitoring and improving health care including mental health services, delivery throughout the AOC facilities.[161,162] The CQI program shall establish policies and procedures for its reviews and operations that include the following:

    a. The establishment of a multidisciplinary quality improvement committee that meets periodically, but no less than quarterly. The establishment of CQI coordinators, available at each facility, who are responsible for ensuring that directives of the CQI committee are carried out. The establishment of a Director of the CQI program that coordinates, implements, and evaluates the quality improvement activities under the guidance of and in conjunction with the CQI committee.

    b. At least monthly reviews of health records at each of the facilities shall be included. All results of CQI program audits and review shall be forwarded to the Central CQI Committee. At a minimum, the Central CQI Committee shall review inmate mortalities, staff performance, adequacy of documentation with regard to health records, utilization review, the clinical care and laboratory outcomes of select chronic and acute illnesses (AIDS, diabetes, hypertension, etc.), specialty services and the specialty referral system, infirmary care, emergency care, and disaster drills.

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[161] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", P-A-06 (E), Continuous Quality Improvement Program, p. 10

[162] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-A-06 (E), Continuous Quality Improvement Program, p. 10

c. The quality improvement committee and program will initiate systemwide and local improvements to correct deficiencies identified through its reviews, and monitoring of the quality, processes and outcomes of the care provided in the correctional system.

157. The program also shall contain a component establishing a risk management system based on critical incident reporting at the PCH and at all institutions. [163,164]

158. The RHA shall conduct a quality of care study throughout the system to evaluate the appropriateness, utilization, and safety of medication practices.[165]

159. All deaths, including those who commit suicide, are reviewed to determine the appropriateness of health care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.[166,167]

VII. HEALTH EDUCATION AND PROMOTION PROGRAM

160. The RHA shall establish and maintain a Public Health Education and Health Promotion Program for the entire correctional system. These

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[163] National Commission on Correctional Health Care, "Standards for Mental Health Services in Correctional Facilities", 2008, MH-B-02 (I), Patient Safety, p. 22.

[164] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", Appendix B-Continuous Quality Improvement, p. 144

[165] Orders related to Report 224 of the Court Monitor to be implemented as ordered by the Court March 29, 1993, order #19 &20.

[166] National Commission on Correctional Health Care, *"Standards for Mental Health Services in Correctional Facilities"*, 2008, MH-A-10 (I), Procedure in the Event of an Inmate Death, p. 16.

[167] National Commission on Correctional Health Care, "Standards for Health Services in Prisons", P-A-10 (I), Procedure in the Event of an Inmate Death, p. 16

activities will be programmed both for health care professionals and inmates and aimed at educating and promoting health throughout the correctional facilities.

161. The RHA shall ensure a sufficient number of health educators and the appropriate and sufficient educational equipment is provided[168] for both group and one-on-one sessions.

VIII. MODIFICATION OF MMHCP

162. The RHA may modify provisions of the MMHCP provided the modification satisfies the intent of the provision for which the modification is being sought and appropriate notice is given to all parties in the Morales Feliciano litigation for as long as the MMHCP remains under the jurisdiction of the Court. If the parties agree to said modification, they shall so inform the Court. If the parties are not in agreement with said modification, the RHA shall so notify the Court for its review and disposition. If either party to the Morales Feliciano lawsuit wishes to modify a provision of the MMHCP, it shall timely submit its recommendations in writing to the RHA and opposing counsel for review. If there is agreement by all involved to the modification proposed, the RHA and the parties shall so inform the Court. In the absence of agreement between all the parties, the RHA shall also submit the proposal to the Court for review and disposition.

[168] Recommendations Related to Report 224 to be Implemented as Ordered by the Court, Dec. 28, 1992, Order 42

DEFINITIONS

1. **ACCESS TO CARE** means that in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered.

2. **AIDS** abbreviation for Acquired Immune Deficiency Syndrome (AIDS) which is an infectious disease caused by the human immunodeficiency virus (HIV). AIDS is the advanced form of infection with the HIV virus, which may not cause recognizable disease for a long period after the initial exposure (latency). At present, all forms of AIDS therapy are focused on improving the quality and length of life for AIDS patients by slowing or halting the replication of the virus and treating or preventing infections and cancers that take advantage of a person's weakened immune system.

3. **AIDS TO IMPAIRMENT** include, but are not limited to, eyeglasses, hearing aids, canes, crutches, and wheelchairs.

4. **AMBULATORY CLINICS** is a site where patients receive health services on an outpatient basis (including diagnosis, observation, treatment, rehabilitation or any form of clinical care), either as a first-time visit, or as a follow-up to some form of previous evaluation or therapy.

5. **CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)** is a federal agency of the U.S. government that provides facilities and services for the investigation, identification, prevention, and control of disease. It is concerned with all of the epidemiologic aspects and the laboratory diagnosis of disease. Immunization programs, quarantine regulations and programs, laboratory standards, and community surveillance for disease are among the activities of the CDC, which is located in Atlanta.

6. **CENTRAL CQI COMMITTEE** is a group integrated by the Principal Executive Officer, Corporate Vice- President, Corporate Director of the Continuous Quality Improvement program, Corporate Clinical Services Director, Corporate Operations Director, Corporate Human Resources Director, Corporate Nursing Director, and the AOC Compliance Medical Officer. This committee will review the results and effectiveness of the quality improvement program concerning the health care services provided, including but not limited to: inmate mortalities, staff performance, adequacy of documentation with regard to health records, utilization review, the care of select chronic and acute illnesses, specialty services and the specialty referral system, infirmary care, emergency care, and disaster drills.

7. **CHRONIC CARE** health care provided to patients over a long period of time; health care services provided to patients with long term health conditions or illnesses. Care usually

includes initial assessment, treatment, and periodic monitoring to evaluate the patient's condition.

8. **CHRONIC DISEASE** is an illness or condition that affects an individual's well-being for an extended interval, usually at least 6 months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. Examples of chronic disease include diabetes, hypertension, asthma, HIV, seizures, and mental health diagnosis.

9. **CHRONIC DISEASE PROGRAM (CLINICS)** incorporates a treatment plan and regular clinic visits. The clinician monitors the patient's progress during clinic visits and, when necessary, changes the treatment. The program also includes patient education for symptom management.

10. **CLINICAL ENCOUNTERS** are interactions between patients and health care professionals that involve a treatment and/or an exchange of confidential information.

11. **CLINICALLY ORDERED RESTRAINT** immobilization or direct control through mechanic methods or physical force of the limbs, head or body of the inmate. It is used when the inmate exhibits an extremely aggressive, combative, and impulsive behavior, that represents imminent danger to self or others, and other less restrictive interventions has not been effective to establish the necessary control. This intervention must be ordered by a qualified professional (a psychiatrist or a physician).

12. **CLINICALLY ORDERED SECLUSION** is a therapeutic measure initiated by medical or mental health staff constituted by the involuntary closure of an inmate with a mental health disorder in a room designed to safely limit a patient's mobility, isolated from others, from which is physically impeded of getting out, for a period of time, and requires of specific procedures and care.

13. **CLINICAL PRACTICE GUIDELINES** according to the national Academy Sciences' Institute of Medicine are systematically developed, science-based statements designed to assist practitioner and patient with decisions about appropriate health care for specific clinical circumstances. Clinical practice guidelines are used to assist clinical decisions making, assess and assure the quality of care, educate individuals and groups about clinical disease, guide the allocation of health care resources, and reduce the risk of legal liability for negligent care.

14. **CLINICAL PRACTICE GUIDELINES-NATIONAL** are those presented by national professional organizations and accepted by experts in the respective medical field.

15. **CLINICAL SERVICES DIRECTOR** is a physician, who will be the health authority for all health care delivered in the correctional facility, and who has final clinical judgment regarding the care of inmates in the facility including detoxification services. The Clinical Services Director at each of the intake facilities shall be board eligible or certified in a primary medical care field (internal medicine, family practice or emergency medicine) to the extent that this can be accomplished through reasonable and good faith efforts, or a General Physician with broad clinical and administrative experience in the correctional setting.

16. **CLINICIAN'S CLINICS** see Ambulatory Clinics.

17. **COMMUNICABLE** capable of being transmitted from one individual to another; contagious.

18. **COMMUNICABLE DISEASES** include those diseases that are transmitted sexually, through the respiratory system, or by infected blood (e.g., syphilis, gonorrhea, chlamydia, HIV, tuberculosis, hepatitis).

19. **COMPREHENSIVE MANAGEMENT CONTRACT FOR THE PROVISION OF HEALTH CARE SERVICES TO THE CORRECTIONAL POPULATION UNDER THE CUSTODY OF THE ADMINISTRATION OF CORRECTIONS (CMA):** is the written agreement clarifying the authority of the Responsible Health Authority and the mutual responsibilities for the delivery of health care by the Administration of Corrections and Correctional Health Services Corporation. This agreement has been developed jointly and signed by the Administrator of Corrections and Chief Executive Officer of CHSC and has been submitted to the Federal Court for the District of Puerto Rico.

20. **CONTINUOUS QUALITY IMPROVEMENT PROGRAM (CQI)** includes a multidisciplinary quality improvement committee, monitoring of the areas specified in the compliance indicators including mental health services, delivered in the facilities, for the entire correctional health care system, and an annual review of the effectiveness of the CQI program itself. In addition, the program includes two process quality improvement studies and two outcomes quality improvement studies, and both studies identify areas in need of improvement and effect remedial actions or strategies.

21. **CORRECTIONAL HEALTH SERVICES CORPORATION (CHSC)** is a not-for-profit corporation created to design, manages, direct the operations, supervise and organize the correctional health care delivery system. CHSC provides all inmates under the custody of the Administration of Corrections of Puerto Rico, high quality health care services in compliance with this MMHCP, the Court's orders and the applicable laws, regulations and in accordance with the existing community standards of the medical care industry and through the use of a cost-efficient, integrated health care delivery model. This integrated model of health care delivery embraces the need to create and enhance

awareness as well as to educate the correctional population in preventive care aimed at improving quality of life and promoting healthier lifestyles.

22. **CORPORATE CLINICAL SERVICES DIRECTOR** is a physician certified in a primary medical care field (internal medicine, family practice or emergency medicine) designated and employed by CHSC, who will be the health authority for all health care delivered in the correctional system.

23. **CRITIQUES** of emergency or disaster drills or actual events document activities including response time, names and titles of health staff, and the roles and responses of all participants. The critique contains observations of appropriate and inappropriate staff response to the drill.

24. **CUSTODY STAFF- CORRECTIONAL OFFICERS** are persons employed by the AOC charged with the responsibility of the supervision, safety, security, care, custody and control of all the inmates in the correctional facilities. They maintain security and inmate accountability to prevent disturbances, assaults, and escapes. They maintain order within the institution and enforce rules and regulations.

25. **DAILY** means 7 days a week including holidays.

26. **DENTAL BASIC HYGIENE** instruction and preventive oral education are given by dentists, dental hygienists, or dentally trained personnel, and consist of measures to assist the patient in caring for his or her own oral health, including information on plaque control, and the proper brushing and flossing of teeth.

27. **DENTAL CARE** includes instruction in oral hygiene, examination, and treatment of dental problems. Instruction in oral hygiene minimally includes information on plaque control and the proper brushing of teeth.

28. **DENTAL EXAMINATION** by a dentist includes taking or reviewing the patient's oral history, an extra oral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral c**a**vity with a mouth mirror, explorer, and adequate illumination.

29. **DENTAL SCREENING** includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

30. **DETOXIFICATION** is the treatment and observation process of individuals who are undergoing withdrawal from alcohol or other drugs in the appropriate level of care according to inmates needs, following specific and established protocols. The protocols are approved by the RHA, are current, and consistent with nationally accepted guidelines.

It is done only under physician supervision in accordance with local, state, and federal laws.

31. **DEVELOPMENTAL DISABLED** include those with limited intellectual ability who may need habilitation planning, assistance in accepting the limitations of their conditions, and special attention to their physical safety in the corrections environment.

32. **DIAGNOSTIC SERVICES** include biomedical or imaging services and results that are used to make clinical judgments. These diagnostic services may be provided by reference laboratories, hospital radiology and laboratory departments, public health agencies, or correctional facilities.

33. **DISABILITY** is an incapacity or lack of the ability to function normally. It may be either physical or mental, or both. As defined by the Federal Government, inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last or has lasted for a continuous period of not less than twelve months.

34. **DISCHARGE PLANNING** refers to the process of coordinating for necessary follow-up health services, before the inmate's discharge from any level of mental health or substance abuse treatment, and medical units as medical dormitories and infirmaries. In addition provides sufficient medications and arranging for necessary follow-up health services before the inmate's release to the community.

35. **EMERGENCY HEALTH CARE** (medical, mental health and dental) is care for an acute illness or an unexpected health need that cannot be deferred until the next scheduled sick call or clinic.

36. **EMERGENCY MEDICAL SERVICES AMBULANCES** are motor vehicles, public or private, specially designed, constructed or modified, and equipped to be used in the transportations of sick, injured, or physically disabled persons.

37. **EMERGENCY RESPONSE PLAN** is the plan developed to respond to manmade or natural, internal or external, disasters. It includes, at least, health aspects of an emergency plan, among other items, include the triaging process, outlining where care can be provided, and laying out a backup plan.

38. **EMOTIONAL DISTURBANCE** any mental disorder not caused by detectable organic abnormalities of the brain and in which a major disturbance of emotions is predominant.

39. **EXPOSURE CONTROL PLAN** describes staff actions to be taken to eliminate or minimize exposures to pathogens.

40. **FACILITY** is an establishment consisting of a complex of buildings or institutions where inmates are confined that may include different levels of health services and must have at least one emergency room. It is also known as a correctional complex. For the purpose of the correctional system of Puerto Rico, the Psychiatric Correctional Hospital and Guerrero are also considered as a correctional facility.

41. **FORENSIC** is defined as pertaining to or applied in legal proceedings.

42. **FORENSIC INFORMATION** is a physical or psychological data collected from an inmate that may be used against him or her in disciplinary or legal proceedings.

43. **FORENSIC PATIENTS** are persons accused of a crime, whose judicial procedures are awaiting upon mental health evaluations to determine if they are able to undergo the criminal procedure against them and to collaborate in their defense.

44. **FORMULARY** is a written list of prescription and nonprescription medications that are ordinarily available to authorized prescribers, including consultants, working for the facility.

45. **GRIEVANCE** consists of a mechanism that addresses inmates' complaints about health services, filed with the appropriate body. It provides protection of the patient's right to question or complain about the health care system.

46. **HAART** abbreviation for Highly Active Antiretroviral Therapy which is the aggressive use of extremely potent antiretroviral agents in the treatment of HIV infection.

47. **HEALTH ADMINISTRATOR** is a person who by virtue of education, experience, or certification is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for inmates.

48. **HEALTH ASSESSMENT** is the process whereby and individual's health status is evaluated, including questioning the patient about symptoms. The extent of the health assessment is defined by the responsible physician but should include at least the steps noted in paragraphs 24 and 25 of this MMHCP.

49. **HEALTH CARE** is the sum of all actions, preventive and therapeutic, taken for the physical and mental well-being of a population. Health care includes medical, dental, mental health, nutrition, and other ancillary services, as well as maintaining clean and safe environmental conditions.

50. **HEALTH CARE PROFESSIONAL** see Qualified Health Care Professionals

51. **HEALTH EDUCATION** is an educational program directed to the inmates that attempts to improve, maintain, and safeguard the health care of the correctional population. Public health activities that promote health and provide information and training about hazards in the environment that would decrease exposure, illness, or disease.

52. **HEALTH INFORMATION ADMINISTRATOR** is an expert in managing patient health information and medical records, administering computer information systems, collecting and analyzing patient data, and using classification systems and medical terminologies. Possesses comprehensive knowledge of medical, administrative, ethical and legal requirements and standards related to healthcare delivery and the privacy of protected patient information. Is responsible to coordinate and supervise all Health Information Management staff at the designated Correctional Facility.

53. **HEALTH RECORD** is a collection of documents that provides an account of the date and time in which a patient visited or sought treatment and received care or a referral for care from a health care facility. The record is confidential and is usually held by the Responsible Health Authority, and the information in it is released only to the patient or with the patient's written permission. It contains the initial assessment of the patient's health status, the health history, laboratory and radiologic reports of tests performed, notes by health care professionals regarding the daily condition of the patient, and notes by consultants, as well as order sheets, medication sheets, admission records, discharge summaries, and other pertinent data. A problem-oriented medical record also contains a master problem list. The patient record is often a collection of papers held in a folder, but it may be computerized.

54. **HEALTH STAFF** includes all qualified health care professionals as well as administrative and support staff (e.g., health record administrators, laboratory technicians, nursing and medical assistants, clerical workers).

55. **IMMUNIZATION** a process or procedure that protects the body against an infectious disease. A vaccination is a type of immunization.

56. **INFECTION CONTROL** refers to policies and procedures used to minimize the risk of spreading infections, especially in health care facilities. The procedures and protocols are designed to prevent or limit cross-contamination in the health care delivery environment. Practices are defined by the American Dental Association and the Centers for Disease Control and Prevention as including sterilizing instruments, disinfecting equipment, and properly disposing of hazardous waste. The purpose of infection control is to reduce the occurrence of infectious diseases.

57. **INFECTION CONTROL PROGRAM** a multidisciplinary program that includes a group of activities to ensure that recommended practices for the prevention of healthcare-associated infections are implemented and followed by health care workers making the

healthcare setting safe from infection for patients and healthcare personnel. The following five components are essential for an infection control program: 1) surveillance: monitoring patients and healthcare personnel for acquisition of infection and/or colonization; 2) investigation: identification and analysis of infection problems or undesirable trends; 3) prevention: implementation of measures to prevent transmission of infectious agents and to reduce risks for device- and procedure-related infections; 4) control: evaluation and management of outbreaks; and 5) reporting: provision of information to external agencies as required by state and federal law and regulation.

58. **INFIRMARY** is a medical area in the facility accommodating patients for a period of 24 hours or more, expressly set up and operated for the purpose of caring for patients who need skilled nursing care but do not need hospitalization or placement in a licensed nursing facility, and whose care cannot be managed safely in an outpatient setting. It is not the area itself but the scope of care provided that makes the bed an infirmary bed.

59. **INFIRMARY CARE** is defined as care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention.

60. **INFORMED CONSENT** is the agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about nature, consequences, and risks of the proposed treatment, examination, or procedure; the alternatives to it; and the prognosis if the proposed action is not undertaken.

61. **INITIAL HEALTH SCREENING** is a process of structured inquiry and observation of all inmates being admitted, designed to obtain immediate treatment for inmates who are in need of emergency health care, identify and meet ongoing current health needs, and isolate those with communicable diseases; also referred as receiving screening.

62. **INITIAL ORIENTATION** is provided on the first day of employment, includes information necessary for the health staff member (e.g., full-time, part-time, consultant, per diem) to function safely in the institution.

63. **INSTITUTION** is an establishment consisting of a building where inmates are confined. Adjacent institutions shall be considered a single facility for purposes of this MMHCP.

64. **INTAKE FACILITY** is a facility in which there is an institution that functions as a reception center, through which all inmates admitted to the correctional system are received. These intake facilities must have at least an Infirmary unit.

65. **INTELLECTUAL FUNTIONING SCREENING** includes inquiry into history of developmental and educational difficulties and, when indicated, referral for application of standardized psychological intelligence tools as appropriate.

66. **INTERMEDIATE TREATMENT** is a housing unit that offers continuous mental health services according to the intensity required for those inmates with present severe mental health conditions that need major therapeutic structure in order to be integrated to the correctional population.

67. **INTRASYSTEM TRANSFERS** are inmates being transfer from one facility or institution to another.

68. **INMATE** any individual, whether in pretrial, unsentenced, or sentenced status, who is confined in a correctional institution.

69. **(MASS) DISASTER DRILL** is a simulated emergency involving multiple casualties that require triage by health staff. It frequently involves a natural disaster (e.g., tornado, flood, earthquake), an internal disaster (e.g., riot, arson, kitchen explosion), or external disaster (e.g., mass arrests, bomb threat, power outage).

70. **MEDICAL AREAS** refers to an examination or treatment setting appropriately supplied and equipped to address the patient's health care needs.

71. **MEDICAL CLEARANCE** is a clinical assessment of physical and mental status before an individual is admitted into the facility. Correctional officers quickly inspect individuals to determine who may be too ill to wait for routine screening or be admitted. Those identified to get immediate medical clearance are pulled from the group prior to admission. The medical clearance may come from on-site health staff or may require sending the individual to the local hospital emergency room. The medical clearance is to be documented in writing.

72. **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 calorie, low sodium, low fat, pureed, soft, liquid, and nutritional supplementation diets. The medical diets addressed in this MMHCP do not include special diets ordered for religious or security reasons.

73. **MEDICAL DORMITORIES** is a long term unit that offers integrated health care services to inmates with serious and complicated health conditions but that do not require infirmary care, designed to meet their special needs and assistance by nursing and medical personnel.

74. **MEDICATION- ADMINISTRATION** is the act in which a single dose of an identified drug is given to a patient.

75. **MEDICATION- DISPENSING** is the placing of one or more doses of a prescribed medication into containers that are correctly labeled to indicate the name of the patient, the contents of the container, and all other vital information.

76. **MEDICATION- PROCURING** is the act of ordering medications for the facility.

77. **MENTAL HEALTH CARE LAW OF PUERTO RICO, OCTOBER 2, 2000, LAW 408** is a law created by the Commonwealth of Puerto Rico in order to establish the needs of prevention, treatment, recovery and rehabilitation in mental health; to create " Bills of Rights" for adults and minors who receive mental health services; to uniform the procedures related to these rights; and to establish the basic principles of the levels of care in the offering of mental health services.

78. **MENTAL HEALTH SERVICES** include the use of a variety of psychosocial and pharmacological therapies, either individual or group, including biological, psychological, and social, to alleviate symptoms, attain appropriate functioning, and prevent relapse.

79. **MENTAL HEALTH STAFF** include qualified health care professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services.

80. **MENTAL HEALTH CARE PROFESSIONAL** see Qualified Mental Health Professionals.

81. **MENTAL STATUS** is the degree of competence shown by a person in intellectual, emotional, psychological, and personality functioning as measured by psychological testing with reference to a statistical norm. Assessment of level of patient awareness or consciousness.

82. **MENTAL STATUS EXAM** is a diagnostic procedure for determining the mental status of a person. The trained interviewer poses certain questions in a carefully standardized manner and evaluates the verbal responses and behavioral reactions. It is an assessment of a patient's level of cognitive (knowledge-related) ability, appearance, emotional mood, and speech and thought patterns at the time of evaluation. It is one part of a full neurologic (nervous system) examination and includes the examiner's observations about the patient's attitude and cooperativeness as well as the patient's answers to specific questions.

83. **MENTALLY UNSTABLE** lacking control of one's emotions; marked by unpredictable behavior**.**

84. **MULTIDISCIPLINARY QUALITY IMPROVEMENT COMMITTEE** is a group of health staff from various disciplines (e.g., medicine, nursing, mental health, dentistry, health records,

pharmacy, laboratory) that designs quality improvement monitoring activities, discusses the results, and implements corrective action.

85. **OUTCOME QUALITY IMPROVEMENT STUDIES** examine whether expected outcomes of patient care were achieved.

86. **OUTREACH** in the correctional system, implies a systematic attempt to reach inmates directly, in the housing units, to provide or retrieve information regarding health services concerning their individual health needs.

87. **PAPANICOLAOU (PAP) SMEAR** is a screening test, especially for cervical cancer, in which a smear of cells exfoliated or scraped from the cervix or vagina is treated with Papanicolaou stain and examined under a microscope for pathological changes. Also called Papanicolaou smear, Papanicolaou test, Pap test.

88. **PATIENT** a recipient of a health care service; a health care recipient who is ill or hospitalized; a client in a health care service**.**

89. **PHYSICAL DISABILITY** can refer to mobility impairments (e.g., amputations, paraplegia) or to other disabilities that limit a person's daily functioning (e.g., visual impairments, hearing impairments, speech impairments).

90. **PHYSICAL EXAMINATION** is an objective, hands-on evaluation of an individual. It involves the inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical signs of disease.

91. **POLICY** is a course or line of action adopted and pursued by an agency that guides and determines present and future decisions and actions. Policies indicate the general course or direction of an organization within which the activities of the personnel must operate. They are statements of guiding principles that should be followed in directing activities toward the attainment of objectives. Their attainment may lead to compliance with standards and compliance with the overall goals of the agency or system.

92. **PREVENTIVE ROUNDS** the health professional's monitoring of a segregated inmate, including daily tours in high risk areas such as housing areas for new admissions, and maximum security, to check and ensure that each segregated inmate has the opportunity to request care for medical, dental, or mental health problems. In addition, by visiting with each inmate during these checks, health staff is able to ascertain the inmate's general medical and mental health status.

93. **PRIMARY CARE** basic or general health care traditionally provided by physicians trained in: family practice, pediatrics, internal medicine, and occasionally gynecology with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment.

94. **PROCEDURE** is the detailed and sequential actions that must be executed to ensure that a policy is fully implemented. It is the method of performing an operation or a manner of proceeding on a course of action. It defers from a policy in that it directs action in a particular situation to perform a specific task within the guidelines of policy.

95. **PROCESS QUALITY IMPROVEMENT STUDIES** examine the effectiveness of the health care delivery process.

96. **PROTHESIS/PROSTHETIC DEVICES** are artificial devices to replace missing body parts such as limbs, teeth, eyes, or heart valves.

97. **PSYCHIATRIC CORRECCTIONAL HOSPITAL** a hospital which offers observation, diagnosis, and rapid and accessible treatment to inmates under acute mental health symptoms, mental crisis or emotional distress 24 hours a day, 7 days a week, by an interdisciplinary team, according to the Mental Health Care Law, 408, of Puerto Rico.

98. **PSYCHOSOCIAL UNIT** see Intermediate Treatment.

99. **QUALIFIED HEALTH CARE PROFESSIONALS** include physicians, nurses, dentists, mental health professionals, and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.

100. **QUALIFIED MENTAL HEALTH PROFESSIONALS** include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

101. **RECEIVING SCREENING** see Initial Health Screening.

102. **REGISTERED HEALTH INFORMATION ADMINISTRATOR (RHIA)** is a graduate of a bachelor and master's degrees in health information administration from an accredited program and has a certification from the American Health Information Management Association.

103. **REQUEST** for health care refers to oral or written petitions for medical, dental, or mental health services.

104. **RESIDENTIAL UNITS FOR THE TREATMENT OF ADDICTIVE BEHAVIOR (*Unidad Residencial para el Tratamiento de los Trastornos Adictivos*- "URTA")** provides long-term rehabilitative substance abuse treatment to inmates who require a more structured and supervised environment, including psychological, social, educational, and vocational services.

105. **RESPONSIBLE HEALTH AUTHORITY (RHA)** is the entity responsible for the correctional system health care services, and arranges for all levels of health care and assures quality, accessible and timely health services for inmates. The RHA supervises the clinical aspect of health care, and functions to assure that health services are organized, adequate, and efficient.

106. **RESTRAINT** the forcible confinement or control of subject, as a violently psychotic or irrational person**.**

107. **SECONDARY CARE** is the medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge, skill, or equipment than the primary care physician has.

108. **SEGREGATION** is the confinement of an inmate to an individual cell that is separated from the general population. There are three forms of segregation: 1) administrative segregation, 2) disciplinary detention, and 3) protective custody.

109. **SEGREGATED INMATES** are those isolated from the general population and who receive services and activities apart from other inmates. Facilities may refer to such conditions as administrative segregation, protective custody, disciplinary segregation, or a supermax tier.

110. **SERIOUS MENTAL HEALTH NEEDS** include those patients with basic psychotic disorders or mood disorders (e.g., manic-depressives), self-mutilators, the aggressive mentally ill, those with post-traumatic stress disorders, and suicidal inmates.

111. **SICK CALL** is a term used to describe how inmates request and receive health care attention, when it is not an emergency.

112. **SPECIAL NEEDS** include those patients with health conditions that require regular care. The special needs program serves a broad range of health conditions and problems that require the physician or other designated qualified health care professionals to design a treatment plan tailored to the patient's needs.

113. **SPECIALTY CARE** means specialist-provided health care (e.g., nephrology, surgery, dermatology, urology, ophthalmology, neurology, cardiology and orthopedics).

114. **STAFFING PLAN** lays out the full-time equivalent (FTE) staff coverage required, lists current incumbents and vacancies, and addresses how full coverage will be accomplished if all positions are not filled (e.g., use of agency, temporary, or part-time staff). A staffing plan is a detailed schedule on which classifications of staff are assigned to posts and positions for the health care unit.

115. **TERTIARY CARE** the most specialized health care, administered to patients with complex diseases who may require high-risk pharmacologic regimens, surgical procedures, or high-cost high-tech resources; It is provided in 'tertiary care centers', often university hospitals, as it requires sophisticated technology, multiple specialists and subspecialists, a diagnostic support group, and intensive care facilities.

116. **TRAINING- HEALTH RELATED** education and teaching of correctional officers to recognize when the need to refer an inmate to a qualified health care professional occurs, and to provide emergency care until he or she arrives. It includes at a minimum: administration of first aid, recognizing the need for emergency care and intervention in life-threatening situations (e.g., heart attack), recognizing acute manifestations of certain chronic illnesses (e.g., asthma, seizures), intoxication and withdrawal, and adverse reactions to medications, recognizing signs and symptoms of mental illness, procedures for suicide prevention, procedures for appropriate referral of inmates with health complaints to health staff, precautions and procedures with respect to infectious and communicable diseases, and cardiopulmonary resuscitation.

117. **TREATMENT PLAN** is a series of written statements specifying a patient's particular course of therapy and the roles of qualified health care professionals in carrying it out. The treatment plan is individualized, typically multidisciplinary, and based on an assessment of the patient's needs, and includes a statement of short- and long-term goals as well as the methods by which these goals will be pursued. When clinically indicated, the treatment plan gives patients access to the range of supportive and rehabilitative services (such as physical therapy, individual or group counseling, and self-help groups) that the treating clinician deems appropriate.

118. **TRIAGE** is the screening and classification of inmates' health care concerns to determine the priority of need and the appropriate level of intervention.

119. **VICTIMIZATION** is the abuse of the disenfranchised–eg, those underage, elderly, women, mentally retarded, illegal aliens, or other, by coercing them into illegal activities–eg, drug trade, pornography, prostitution.

120. **VIOLENT BEHAVIOR** is defined as expressive violence initiated as a result of an interpersonal altercation where the goal is to injure the other person or as instrumental violence where the goal is to get something from the person (usually the result of criminal intent).

121. **WITHIN SIGHT OR HEARING-SOUND** means that the patient can gain the professional's attention through visual or auditory signals.

122. **WRITTEN AGREEMENT** means a contract, letter of agreement, or memorandum of understanding between the facility and the hospital, clinic, or specialist for the care and treatment of patients.