

NCCHC Standards:

What's New-- Prison, Jail, and Mental Health

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Presentation Goals

- Describe why the changes were made to NCCHC's standards for health services in jails & prisons
- Identify the 2003 health service standards that are being revised in 2008
- Interpret the 2008 standards for applications at a jail or prison
- Introduce the 2008 Mental Health Standards and Accreditation Program



30 Years of Evolving – Continuums of Concern

- Reviews of all aspects of incarceration (that relate peripherally to health care) vs focus on health care directly (clinical practice issues)
- Written P&P (that if followed = compliance) vs actual outcome (in the end, did the care take place?)
- Quantity (did it happen?) vs Quality (how did it happen?)
- NCCHC is the expert in health care with continuing concentration on clinical outcomes



CAUTION ---

- Today's presentation is an INTRODUCTION and
- a global view of the changes . . .
- there will be time for in-depth understanding and implementation on-site during the upcoming transition period.



Transitioning Outline

- Review of Handout...



NO CHANGE in BASIC ASSUMPTIONS: NCCCHC *Standards* . . .

- require that treatment provided is based on nationally accepted clinical guidelines, although standards are not clinical guidelines directing clinicians how to treat illnesses;
- require that clinicians practice within their scope of training, and are supplemental to discipline-specific directives; and,
- are voluntary, although contracts, court decrees or other requirements may oblige a facility to be in compliance or seek accreditation.



OVERVIEW -- Executive Summary of Changes Handout



Section I – Global Changes

- FORMAT
 - Standard
 - Compliance Indicators
 - Definitions
 - Discussion with Intent
 - Optional Recommendations
- Jail and Prison Distinctions
 - P&P Indicator
- Classification



Section II C --

- A WORD about the “deletions”



Section II B –
for example –
F-01, H-04 and I-05

- What do these '08 standards have in common?



Focusing standards
on patient care
to address patient
classifications:



Questions about initial assessments?
See E-04*, E-05, E-06

Questions regarding inmates not active with health services (periodic assessments, acute, episodic care)? See E-12

Questions regarding care for patients with chronic diseases (including mental illnesses)?
See G-01

Questions about special needs patients (those with disabilities, frail, adolescent, elderly, etc.)?
See G-02



Same Concepts – Different Packaging --

A-10

- Procedure in the Event of an Inmate Death
- 1. All deaths are reviewed within 30 days.
- 2. A death review consists of:
 - a. an *administrative review*,
 - b. a *clinical mortality review*, and
 - c. a *psychological autopsy* if death is by suicide.
- 3. Treating staff are informed of the clinical mortality review and administrative review findings.
- 4. Corrective action(s) identified through the mortality review process are implemented and monitored through the facility's CQI program, for systemic issues; and patient safety program, for staff-related issues.



Same Message – Explicit Language

- G-05 Suicide Prevention Program
- The facility identifies suicidal inmates 1. A suicide prevention program includes the following outcomes:
- a. facility staff identify suicidal inmates and immediately initiate precautions;
 - b. suicidal inmates are evaluated promptly by the designated clinician who directs the intervention and assures follow-up as needed;
 - c. actively suicidal inmates are placed on constant observation;
 - d. monitoring takes place on an irregular schedule with a frequency of no more than 15 minutes between checks; and
 - e. suicidal inmates in *isolated housing* are placed on constant observation.



2. Key components of a suicide prevention program include the following elements:

- a. Training
- b. Identification.
- c. Referral.
- d. Evaluation.
- e. Treatment.
- f. Housing and Monitoring.
- g. Communication.
- h. Intervention.
- i. Notification.
- j. Review.
- k. Debriefing.



Recent research also points out that adolescent suicides in correctional settings have different “high-risk” periods than do the adults.

5 Treatment. Treatment strategies and services to address the underlying reasons for the inmate’s suicide ideology (e.g., depression, auditory commands) are to be considered. The strategies include treatment needs when the patient is at beighten risk to suicide as well as follow up treatment interventions and monitoring strategies to reduce the likelihood of relapse.



Returning to Our Roots

● Standard E-02

- Receiving screening is performed on all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met.



Medical Clearance

● Compliance Indicators

- 1. Persons who are unconscious, semiconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are:
 - a. referred immediately for care and *medical clearance* into the facility; and
 - b. if they are referred to a community hospital and are returned, their admission to the facility is predicated upon written medical clearance from the hospital.
- 2. Immediate health needs are identified and addressed, and potentially infectious inmates are isolated.



Receiving Screening

- 3. “At all jails a *receiving screening* takes place for all inmates *as soon as possible* by qualified health care professionals or health-trained correctional officers.”
- Prison: “In prisons with an ADP of 500 or less, a *receiving screening* takes place for all inmates *as soon as possible* by qualified health care professionals or health-trained correctional officers. In prisons with an ADP of more than 500, a *receiving screening* takes place for all inmates *as soon as possible* by qualified health care professionals.”



Another Return to Basics

P-A-06 CQI Program

Standard

- *A continuous quality improvement (CQI) program monitors and improves upon health care delivered in the facility.*



The *ESSENCE* of CQI

- a facility problem is identified;
- a study is completed;
- a plan is developed and implemented;
- results are monitored and tracked; and
- improvement is demonstrated or the problem is re-studied.



Clinical Chart Review

While the distinction between the basic CQI (facilities with ADP of 500 or less) and the comprehensive CQI programs remains, and the involvement of the physician is essential, clinical chart reviews are no longer part of the requirements.

Clinical chart review is found as a requirement in standards E-12 Continuity of Care During Incarceration, G-01 Chronic Disease Services, and G-02 Special needs Patients.



New Option

E-04 Health Assessment Standard

- Inmates receive initial *health assessments*.

Note: There are two options for implementing and demonstrating compliance with this standard. The first involves performing assessments on 100% of inmates (this is referred to as Full Population Assessment option). The second involves performing assessments on only those who are determined to be at high risk for significant health problems (this is referred to as the Individual Assessment When Clinically Indicated option). Facilities may choose either option.



Option 1

- Full Population Assessment
- [Compliance Indicators (1-3)]
- Standard requirements as they are in 2003



Option 2: Individual Assessment When Clinically Indicated

[Compliance Indicators (4-6)]

4. Inmates identified with *clinically significant findings* as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission to the facility. To qualify for this option, an institution:
- a. Has 24 hour, 7 day on-site health staff coverage, and
 - b. Allows only licensed health care personnel to conduct the comprehensive receiving screening on all inmates.
 - c. Includes in its comprehensive screening all elements of the receiving screening standard plus:
 - i. further inquiry into past history and symptoms of chronic diseases;
 - ii. fingerstick on individuals with diabetes;
 - iii. vital signs to include blood pressure; and
 - iv. further inquiry on medication & dosages where possible.



5. Individual health assessments include at a minimum:

- a. a review of receiving screening results;
- b. a qualified health care professional collecting additional data to complete the medical, dental, and mental health histories taken at receiving screening and subsequent encounters;
- c. a qualified health care professional recording of vital signs (including height and weight);
- d. a physical examination (as indicated by the patient's gender, age, and risk factors) performed by a physician, physician assistant, nurse practitioner, or other practitioner as permitted by law. The responsible physician documents his or her review of other clinicians' findings when they are significant;
- e. Laboratory and/or diagnostic tests for communicable diseases, such as tuberculin skin test, unless there is documentation from the health department that the prevalence rate does not warrant it;
- f. Laboratory and/or diagnostic tests for disease, such as peak flow for asthmatics;
- g. Immunizations when appropriate;
- h. Pap tests (prisons)



6. All assessment data (i.e., history and physical, TB screen, and laboratory) are reviewed by the treating clinician. Specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.



NEW OPTIONS: C-03 Professional Development

(former C-03 Continuing Education for Qualified Health Care Professionals)

3. Compliance can be demonstrated through one of the following options:

- a. In states where at least 12 hours of continuing education is required annually to maintain a clinical license to practice, a current license suffices.
- b. When the health staff is a Certified Correctional Health Professional (CCHP), valid certification suffices.
- c. A list of completed courses, dates, and number of hours per course are on file.



The “New Kids” on the Block

- Are they really new???
- B-01 Patient Safety
- B-02 Staff Safety



B-02 Patient Safety

Standard (New to 2008)

- The responsible health authority (RHA) promotes patient safety by instituting systems to prevent *adverse* and “*near miss*” clinical events.



B-03 Staff Safety

Standard (New to 2008)

- Health staff work in a safe environment.



Section A

- GOVERNANCE
- AND
- ADMINISTRATION
- Other Section A standards' changes:



P-A-10 Procedure in the Event of an Inmate Death

Standard

All deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.



Compliance Indicator #2

- A death review consists of
 - a. an *administrative review*,
 - b. a *clinical mortality review*, and
 - c. a *psychological autopsy* if death is by suicide.



Section B

SAFETY



Section C

• PERSONNEL AND TRAINING



Section D

● HEALTH CARE SERVICES AND SUPPORT



P-D-02 Medication Services

Standard

- Medication services are clinically appropriate and provided in a timely, safe, and sufficient manner.



Section E

INMATE CARE AND TREATMENT



P-E-12 Continuity of Care During Incarceration

Standard

- Inmates receive diagnostic tests and other health services ordered by clinicians.



Care for All (CI # 1- 5) includes TP for acute illness

1. Ordered diagnostic tests or specialty consultations are completed in a timely manner . . .
2. When an inmate returns from an emergency room visit . . .
3. When an inmate returns from hospitalization, the physician sees the patient . . .
4. Diagnostic and treatment results are used by clinicians . . .
5. Individual treatment plans are used to guide treatment for episodes of illness . . .



Periodic Health Assessment (CI #6) and Clinical Chart Review (CI # 7)

6. The responsible physician determines the frequency and content of periodic health assessments on the basis of protocols promulgated by nationally recognized professional organizations.
7. Chart reviews by a physician are of sufficient number and frequency to assure that clinically appropriate care is ordered and implemented by attending health staff.



Section F

HEALTH PROMOTION



Section G

SPECIAL NEEDS AND SERVICES



P-G-01 Chronic Disease Services

Standard

- Patients with chronic diseases are identified and enrolled in a chronic disease program in order to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function.



P-G-02 Patients With Special Health Needs

Standard

- A proactive program exists that provides care for *special needs patients* who require close medical supervision or multidisciplinary care.



Section H

HEALTH RECORDS



Section I

MEDICAL-LEGAL ISSUES



2008 NCCHC 2008

Standards for

- *Mental Health Services in Correctional Facilities*



Distinct Accreditation – Mental Health Services

- 1. When mental health services are under a separate authority than health services at the facility, and
- 2. The facility health services cannot or will not pursue health services accreditation.
- 3. Not a replacement for health services accreditation, but another option, as the OTP accreditation is another option.
- 4. Policies and procedures will parallel the health service and OTP accreditation programs in implementation and program operation.



Separate Mental Health Standards . . .

- Supplement the health services standards, making explicit what is required in health service standards for mental health services regardless of whether there is one or separate authorities
- Replaces the current “Correctional Mental Health Care, Standards and Guidelines for Delivering Services”



Now that I have your attention



ANY QUESTIONS?


