

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 1.00

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CHRONIC DISEASES SERVICES

Effective Date: 05/01/10

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) staff shall provide systematic chronic disease management aimed to decrease the frequency and severity of symptoms, prevent disease progression and complication, and foster improved function.

PROCEDURE:

The CMHC Director of Medical Services shall establish and periodically review CMHC's management of chronic diseases, including systematic approaches to identifying, monitoring, and managing inmates.

Staff shall document clinical findings on **Forms HR 420 Chronic Disease Initial Baseline Health Data, HR 421 Chronic Disease Visit Follow-up**, and in the health record as appropriate.

Health assessments for inmates seen for initial Chronic Disease Management visits are to be completed and documented on **Form HR420, Chronic Disease Initial Baseline Health Data** unless a health assessment was completed and documented on **Form HR 002, Physical Exam F or M** within the previous **ninety (90)** days.

Resource guides are included as addenda to this policy:

- Assessment of Diabetes Control
- Graph of Adult Weight Status by Body Mass Index (BMI)
- Assessment of Disease Control: Hypertension
- Epilepsy/Seizure Disorder
- Predicted Average Expiratory Flow Rates: Normal Males and Females

REFERENCES: *Administrative Directive 8.1, Scope of Health Services*. 2007. Connecticut Department of Correction.

Standards for Health Services in Prisons (P-G-01). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

Title: CMHC Director of Medical Services, Johnny Wu MD

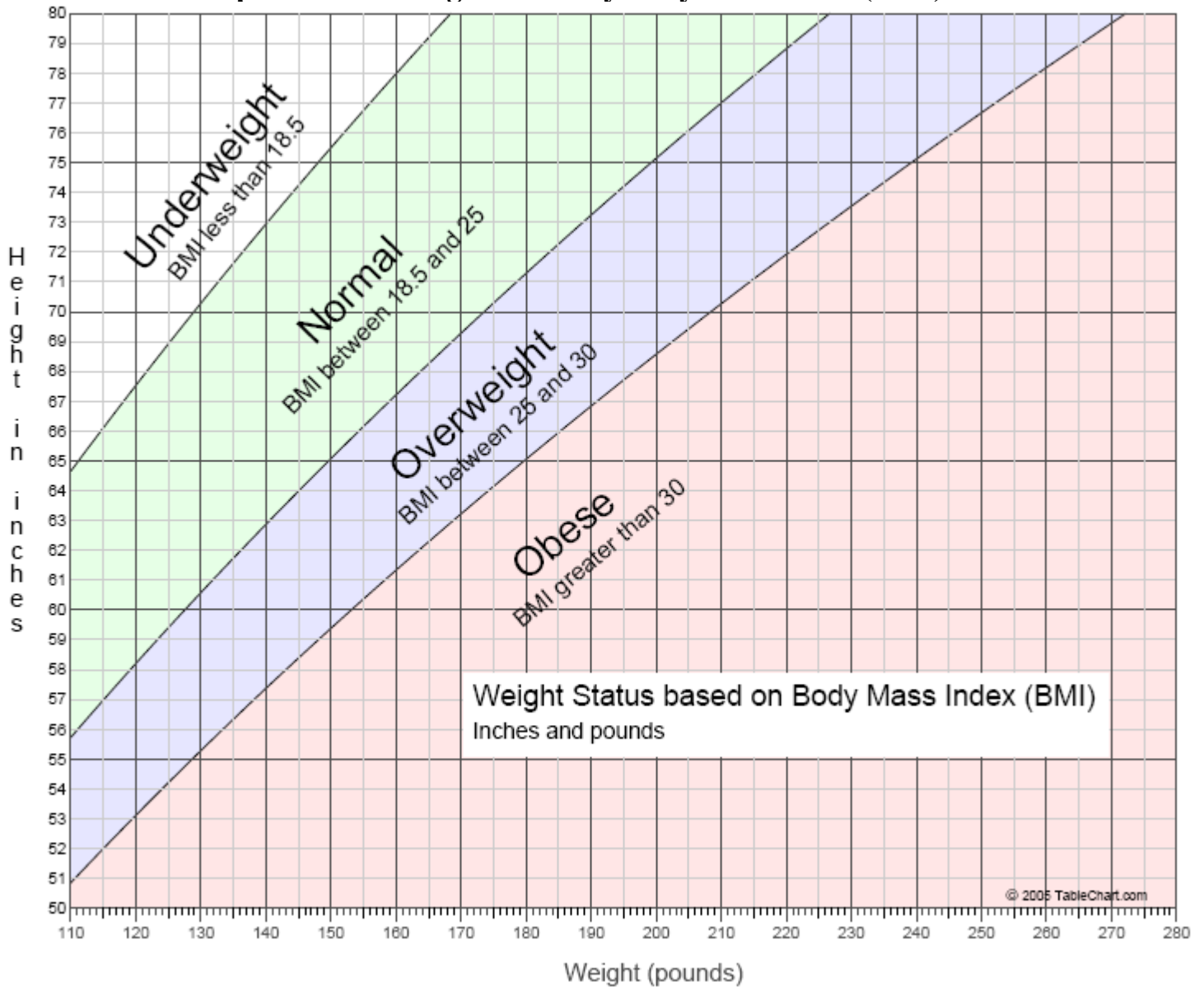
Title: CDOC Director Health Services, Kathleen Maurer MD

Diabetic Care Guidelines

Assessment of Diabetes Control			
	GOOD	FAIR	POOR
Symptoms <i>(include only symptoms reported in the last 30 days)</i>	None of the symptoms listed to the right	Mild polyuria; or nocturia not explained by BPH or insomnia; or 2-7 spells of symptomatic hypoglycemia	Unintentional weight loss; or vaginal moniliasis due to hyperglycemia; or 8 or more spells of symptomatic hypoglycemia
Weight	BMI <27	BMI 27 to 30	BMI >30
Blood Pressure*	<130/80	130-150/80-95	>150/>95
Average Preprandial Glucose	65-120	50-64 or 121-140	<50 or >140
Hgb A1c	<7	7-9	>9
LDL-C*	<100	100-130	>130
* Goal parameters are lower for patients with diabetes			
Status of Disease Control : I = Improved S = Same W = Worse			

Recommended Frequency of Diabetic Visits and Testing							
Frequency of Visits	<table border="0" style="width: 100%;"> <tr> <td style="width: 70%;">Diet alone or on oral agents alone and HgbA1c <8:</td> <td style="width: 30%;">Every 6 months</td> </tr> <tr> <td>On insulin and/or HgbA1c ≥ 8:</td> <td>Every 3 months</td> </tr> <tr> <td colspan="2">More often if unstable</td> </tr> </table>	Diet alone or on oral agents alone and HgbA1c <8:	Every 6 months	On insulin and/or HgbA1c ≥ 8:	Every 3 months	More often if unstable	
Diet alone or on oral agents alone and HgbA1c <8:	Every 6 months						
On insulin and/or HgbA1c ≥ 8:	Every 3 months						
More often if unstable							
Hgb A1c Testing	Same criteria as visits, but not more often than every 3 months						
Blood Pressure Measurement	<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Good control:</td> <td style="width: 70%;">Every 6 months</td> </tr> <tr> <td>Fair control</td> <td>Every 3 months</td> </tr> <tr> <td>Poor control</td> <td>Monthly</td> </tr> </table>	Good control:	Every 6 months	Fair control	Every 3 months	Poor control	Monthly
Good control:	Every 6 months						
Fair control	Every 3 months						
Poor control	Monthly						
LDL-C Testing	<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Good control:</td> <td style="width: 70%;">Annually</td> </tr> <tr> <td>Fair control:</td> <td>Every 6 months</td> </tr> <tr> <td>Poor control:</td> <td>Every 3 months</td> </tr> </table>	Good control:	Annually	Fair control:	Every 6 months	Poor control:	Every 3 months
Good control:	Annually						
Fair control:	Every 6 months						
Poor control:	Every 3 months						
Creatinine Testing	Annually; more often if over 2						
Urinary Protein (dipstick) Testing	Annually (may substitute urine micro albumin or 24 hr protein)						
24 hr. protein and creatinine clearance Testing	At discretion of prescriber						
Undilated retina exam by non-specialist	At discretion of prescriber						
Dilated retinal exam	Annually or as recommended by eye specialist						
Foot Examination	At each visit (see frequency of visits)						

Graph of Adult Weight Status by Body Mass Index (BMI)



HbA1c & Glucose Correlations

HbA1c	Average Blood Glucose	Average Plasma Glucose
6%	120 mg/dL	135 mg/dL
7%	150 mg/dL	170 mg/dL
8%	180 mg/dL	205 mg/dL
9%	210 mg/dL	240 mg/dL
10%	240 mg/dL	275 mg/dL
11%	270 mg/dL	310 mg/dL
12%	300 mg/dL	345 mg/dL
13%	330 mg/dL	380 mg/dL
14%	360 mg/dL	415 mg/dL

In general, venous plasma glucose is approximately 15% higher than venous whole blood glucose. Laboratory glucose determinations are usually performed on plasma. Older glucose meters typically reported whole blood glucose concentrations. Newer meters are almost all “plasma standardized” — i.e., while they still obviously measure the glucose concentration in whole (capillary) blood, an internal correction is made, and the meter actually reports calculated plasma glucose.

http://www.med.yale.edu/intmed/endocrin/resources/docs/yale_diab_bklt08.pdf

Hypertension Care Guidelines

Assessment of Disease Control			
	GOOD	FAIR	POOR
Blood Pressure: Non-diabetic	BP<140/90	140-160 / 90-105	>160 / >105
Blood Pressure: Diabetic	<130/80	130-150/80-95	>150/>95
Frequency of Follow-up			
Blood Pressure (Inmates on a stable medication regimen)	GOOD	FAIR	POOR
	Every 6 months	Every 3 months	Monthly
<i>Inmates may also be scheduled for measurement and documentation of BP between formal visits. Follow-up interval after a change in regimen is at discretion of providers.</i>			
Status of Disease Control : I = Improved S = Same W = Worse			

Dyslipidemia Care Guidelines

Assessment of Disease Control			
	GOOD	FAIR	POOR
LDL-C			
Nondiabetic:	LDL-C at goal	LDL-C 130-159 mg/dL	LDL-C >160 mg/dL
Diabetic:	<100	100-130	>130
Frequency of Follow-up			
LDL-C	GOOD	FAIR	POOR
	Annually	Every 6 months	Every 3 months
<i>When drug treatment is initiated, monitoring for efficacy and side effects should be more frequent</i>			
Status of Disease Control : I = Improved S = Same W = Worse			

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Seizure Disorder Care Guidelines

Assessment of Disease Control			
	GOOD	FAIR	POOR
Seizure activity in prior 6 months	1	2 to 3	≥ 4
Frequency of Follow-up	Every 6 months	Every 3 months	Every 2 months or sooner
<i>Inmates may also be scheduled for evaluation between formal visits. Follow-up interval after a change in regimen is at discretion of providers.</i>			
Status of Disease Control : I = Improved S = Same W = Worse			

Asthma/COPD Care Guidelines

Assessment of Disease Control			
	GOOD	FAIR	POOR
Beta-agonist MDI canisters used within the last 6 months	< 1	1	> 1
Oral steroid medication to treat asthma	None within the last 6 months	At least once within the last 6 months	More than 2 weeks consecutively at anytime over the past year
Respiratory acute sick call visits or need for acute respiratory treatments or emergency department evaluation and treatment	None	≤ 2 per week	> 2 per week
Night-time awakening(s) with asthma symptoms	None	≤ 2 per week	> 2 per week
<u>Peak flow measurement</u> : Percent of personal best or predicted peak flow measurement	80 to 100 %	50 to 79%	$\leq 49\%$
Frequency of Follow-up	Every 6 months	Every 3 months	Every 1 to 2 months
<i>Inmates may also be scheduled for evaluation between formal visits. Follow-up interval after a change in regimen is at discretion of providers.</i>			
Status of Disease Control : I = Improved S = Same W = Worse			

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Predicted Average Expiratory Flow Rates: Normal Males

Predicted Average Peak Expiratory Flow for Normal Males (L/min)[†]

Age	Height				
	60"	65"	70"	75"	80"
20	554	602	649	693	740
25	543	590	636	679	725
30	532	577	622	664	710
35	521	565	609	651	695
40	509	552	596	636	680
45	498	540	583	622	665
50	486	527	569	607	649
55	475	515	556	593	634
60	463	502	542	578	618
65	452	490	529	564	603
70	440	477	515	550	587

[†]Redrawn from Leiner, GC, et al, Am Rev Respir Dis 1963; 88:644.

These values represent average normal values within 100 L/min. Predicted values for African American and Hispanic minorities are approximately 10 percent lower.

Predicted Average Expiratory Flow Rates: Normal Females

Predicted Average Peak Expiratory Flow for Normal Females (L/min)[†]

Age	Height				
	55"	60"	65"	70"	75"
20	390	423	460	496	529
25	385	418	454	490	523
30	380	413	448	483	516
35	375	408	442	476	509
40	370	402	436	470	502
45	365	397	430	464	495
50	360	391	424	457	488
55	355	386	418	451	482
60	350	380	412	445	475
65	345	375	406	439	468
70	340	369	400	432	461

[†]Redrawn from Leiner, GC, et al, Am Rev Respir Dis 1963; 88:644.

These values represent average normal values within 80 L/min. Predicted values for African American and Hispanic minorities are approximately 10 percent lower.

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DIABETES MANAGEMENT

Effective Date: 02/01/99

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) will ensure that all inmates in Connecticut Department of Correction (**CDOC**) facilities diagnosed with Diabetes are provided care consistent with NCCHC Guideline for Disease Management in Correction Settings: Diabetes.

Each appropriate CDOC facility will provide chronic care management of diabetic inmate care.

PROCEDURE:

When CMHC staff has determined from **Form HR 001, Intake Health Screening** or by new diagnosis that an inmate has diabetes, an immediate referral will be made to the CMHC prescriber assigned to the facility for the purpose of determining initial therapy.

When the CMHC prescriber is not available for any reason, the on-call physician will be contacted immediately for treatment orders in accordance with the provisions contained herein.

In addition, CMHC staff will implement the following *minimum* procedures:

History and Physical Exam

A health assessment, consisting of a health history and either a focused physical exam or a comprehensive physical exam will be performed following admission. **Forms HR 420, Chronic Disease Initial Baseline Health Data** will be used for documentation unless **Form HR 002, Physical Exam M/F** was completed within the last 3 months.

The history will focus on relevant information known at the time of the visit.

- The inmate's Type of diabetes and medication: Type I if taking insulin, Type II if taking an oral hypoglycemic agent, the name and dosage
- A review of current non-diabetic medications, including dosage, time and frequency

DIABETES MANAGEMENT

- History of known chronic complications such as infections, vision problems, circulatory problems, etc.
- Dates and results of last dilated retinal examination
- Hospitalizations(reasons and approximate dates)

Clinical Management of Inmates with Diabetes

1. The following initial clinical activities will be completed or scheduled:
 - Blood Pressure
 - Electrolytes and creatinine
 - Hemoglobin A1C and CBC
 - Lipid Profile
 - Urine protein
 - Foot exam by a medical prescriber yearly in addition to exams by nursing at each chronic care encounter
 - Dilated retinal exam by an optometrist or ophthalmologist
 - If documentation is available from the community within the past year, the dilated retinal exam may be deferred

If the inmate has been transferred from another CDOC facility, those values are to be reviewed during the initial Diabetic Chronic Care visit.

2. Insulin orders for the inmate may be obtained from the on-call physician only for the period until seen by the facility prescriber for diabetic management utilizing **Form HR 925I Physician's Orders Regular Sliding Scale (RISS)** when applicable.
3. A physician/APRN/PA whose scope of practice includes management of diabetes will see inmates with Insulin-Dependent Diabetes Mellitus (**IDDM**) within 2 weeks of admission to a CDOC facility. This provision includes inmates transferred within CDOC facilities as well.
4. While incarcerated, the IDDM inmate will be seen at regular intervals in Diabetic Chronic Care Clinic, as determined by the treating prescriber.

At a minimum:

- Type I Diabetes: Q 3 months
 - Type II Diabetes: Q 3 months if on insulin
 - Type II Diabetes: Q 6 months if *not* on insulin
5. Patient education will be provided to inmates to help them learn how to manage their diabetes.

DIABETES MANAGEMENT**Type I Diabetes: Insulin Dependent Inmates**

1. Insulin dosages will be adjusted to regulate the blood glucose levels and overall determination of adequacy of control will be based on hemoglobin A1C levels. All insulin doses and blood sugar results are to be documented on the MAR (Medication Administration Record). In addition to the MAR, they also may be documented on Form HR 402, Diabetic Flow Sheet if used at the facility (Note: documentation on Form HR 402 does not replace documentation on the MAR).
2. Nursing staff will notify the on-site prescriber - or if not available, the on-call physician - of unexpected changes in blood glucose. The on-site prescriber or on-call physician will address the unexpected changes in blood glucose. When the situation is addressed by the on-call physician, nursing staff will schedule the inmate to be seen by the on-site prescriber for evaluation within the next week.
3. Nursing staff will obtain **monthly** weights which are to be documented on **Form HR 421 Chronic Disease Visit Follow-up as appropriate**. In addition, weights may also be documented on **Form HR 402, Diabetic Flow Sheet** if used at the facility. (Note: documentation on Form HR 402 does not replace documentation on Form HR 420) and/or the MAR .

Type II Diabetes: Inmates on Oral Hypoglycemic Agents

1. The inmate will be seen by an on-site physician, APRN, or PA within **4** weeks of admission.
2. Inmates will have blood glucose levels completed at intervals based on the control of their level of control determined largely from their Hemoglobin A1c levels.
3. Nursing staff will obtain **monthly** weights which are to be documented on **Form HR 420, Chronic Disease Visit Follow-up**. In addition, weights may also be documented on **Form HR 402, Diabetic Flow Sheet** if used at the facility. (Note: documentation on Form HR 402 does not replace documentation on Form HR 420).
4. The inmate must be seen promptly if there is significant deterioration in blood sugar management or if the inmate develops a complicating illness.

Type II Diabetes: Inmates on No Diabetes Medication

Nursing staff will obtain **monthly** weights which are to be documented on **Form HR 420, Chronic Disease Visit Follow-up**. In addition, weights may also be documented on **Form HR 402, Diabetic Flow Sheet** if used at the facility. (Note: documentation on Form HR 402 does not replace documentation on Form HR 420).

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Quality Assurance for All Inmates with Diabetes

- Serum hemoglobin A1c will be performed based on disease status (see Policy G 1.00 Chronic Diseases Services, resource materials)
- Urine protein will be measured at least once per year
- A dilated retinal exam by an optometrist or ophthalmologist will be performed at least once per year
- An exam of the feet, focused on determining integrity of the skin and assessment of sensation, will be conducted at least once per year by a medical prescriber and documented on Forms **HR 420 Chronic Disease Initial Baseline Health Data or HR 421 Chronic Disease Visit Follow -up.**
- Blood Pressure will be taken 2x/year or more often if > 130/85
- Lipid profile will be performed at least annually

All results will be documented in the inmate health record.

(See Policies E 4.01 Health Assessment, G 1.00 Chronic Disease Services)

REFERENCES: *Administrative Directive 8.1, Scope of Health Services.* 2007. Connecticut Department of Correction.
 NCCHC Guideline for Disease Management in Correctional Settings: Diabetes. May 2011.
 Standards for Health Services in Prisons (P-G-01). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD	_____
Title: CMHC Director of Medical Services, Johnny Wu MD	_____
Title: CDOC Director Health Services, Kathleen Maurer MD	_____

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HYPERTENSION: DIAGNOSIS AND MANAGEMENT

Effective Date: 08/15/11

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) staff shall provide appropriate medical treatment, based upon currently accepted standards of practice, for Connecticut Department of Correction (**CDOC**) inmates who are diagnosed with hypertension.

PROCEDURE:

Introduction

Hypertension is a very common chronic condition. As many as 65,000,000 Americans are estimated to be hypertensive with blood pressures $\geq 140/90$. Chronically elevated blood pressure has been linked to increased risk of stroke, chronic renal failure and coronary artery disease, including myocardial infarction. Elevated blood pressure is a major risk factor leading to renal failure in patients with diabetes. Although elevated blood pressure has been recognized since the first sphygmomanometers were used in the late 19th century, the consequences of hypertension and their responsiveness to therapy was not defined until the late 1960's. It is now generally accepted that control of hypertension reduces risk of stroke, renal failure and cardiovascular events.

Diagnosis of hypertension

Of primary importance in determining if a patient should be treated for hypertension is determining that hypertension is indeed present. Although several societies provide guidelines and targets for treatment of hypertension, there is little mention made of the initial diagnosis. In our view, this first step is problematic in a correctional setting, particularly at intake. Mention is commonly made of elevation of blood pressure by stress, alcohol use and illicit drug, particularly cocaine, use. For none of those causes of hypertension is chronic antihypertensive therapy indicated or thought beneficial. Hypertension that is chronic is the type known to be harmful; treatment, to be beneficial, must be chronic. Emergent treatment of hypertension has no beneficial effect and may cause harm.

For inmates who have been incarcerated for weeks to months before they are noted to have a blood pressure reading $>140/90$ (either or both numbers), the most practical option is to simply repeat the measurement at another time, e.g. one month later, after advising the inmate to minimize consumption of salty soups. If the reading is once again elevated, the inmate should be referred to a prescriber, who can determine subsequent treatment and follow up. For the large majority of patients and blood pressure, this is not an emergent or urgent step. Follow-up in the next several weeks is reasonable. (See the section on Hypertensive emergencies for exceptions.)

For inmates who have recently been incarcerated -e.g. intake screening, the interpretation of an elevated blood pressure requires even more caution, since some or many of the factors that can transiently increase blood pressure are likely to be present. A practical approach would be to repeat the readings in 1-2 weeks and, if those readings are also elevated, again 2 weeks later. If all of the readings are elevated, the patient should be advised to avoid the salty soups available through commissary and referred to a prescriber within the next several weeks. This approach adheres very well to the current JNC guidelines, which recommend "lifestyle modifications" as the

first step in controlling elevated blood pressure.

Hypertensive emergencies

Although the vast majority of elevated blood pressure readings suggest a need for management of a chronic condition, occasional patients may need more urgent management. These patients are considered to represent "hypertensive emergencies". Before the most recent guidelines from the JNC, two groups of hypertensive crises were recognized -emergencies and urgencies. The urgency listing, with its slightly lower pressure readings, was dropped because *"Unfortunately, the term 'urgency' has led to overly aggressive management of many patients with severe, uncomplicated hypertension. Aggressive dosing with intravenous drugs or even oral agents, to rapidly lower BP is not without risk. Oral loading doses of antihypertensive agents can lead to cumulative effects causing hypotension, sometimes following discharge from the ER."* So, the only levels of blood pressure that are currently considered to warrant immediate treatment are those **>180/120** "complicated by evidence of impending or progressive target organ dysfunction.". "Emergencies" are those with organ dysfunction. If an inmate is found to have a blood pressure in that range, the nurse should let the patient relax and repeat the blood pressure reading in a short time (e.g. 10-15 minutes). **If the reading remains >180/120, a prescriber should be contacted immediately (the on-call physician, if necessary).** Whether or how the patient should be further evaluated is a decision the nurse is not expected to make. If the reading remains >160/110, the patient should be evaluated within 24h, by a prescriber.

If a prescriber is contacted, it is important that the nurse be able to discuss the patient's status, particularly:

mental status -alert, cooperative vs. obtunded or combative

pulse

respiratory rate and ease of breathing

chest pain or focal neurologic deficit

edema

dipstick urinalysis, particularly protein and glucose

illicit drug and alcohol use prior to incarceration for new intakes and, of course, the blood pressure readings.

Patients with hypertensive emergencies must be transferred to the inpatient unit or referred to an ED for evaluation -again, at the discretion of a prescriber.

Appropriateness of diagnosis of hypertension

Medical follow-up, done properly, requires that the prescriber reassess the clinical status of the patient at each visit. One key element in that process is questioning the accuracy of the diagnoses for which the patient is being seen. This is particularly relevant when the patient is being treated for hypertension. It is important to review the blood pressure readings since the time of initial diagnosis of hypertension. Obviously, poor control of the blood pressure requires adjustment of the antihypertensive drug regimen or, in refractory cases, referral of the patient to a specialist. But, if, upon review, the only elevated readings were those taken in a time of stress (e.g., intake), with all subsequent readings being normal in a patient who was not diagnosed as being hypertensive before incarceration, it is reasonable to question the diagnosis of hypertension. Even if the patient is truly hypertensive, no harm can result from an interruption of treatment, monitoring the blood pressure, e.g. at weekly intervals, and reassessing the need for drug therapy after 4-6 weeks. If the patient is not found to have elevated blood pressure in the follow-up, we have done him/her a service by discontinuing unnecessary medications, which could cause unpleasant or dangerous side effects.

HYPERTENSION: DIAGNOSIS AND MANAGEMENT

The initial approach is graphically illustrated in Appendix A.

Classification and approach to treatment

These are clearly outlined in the JNC7 guidelines, which are copied here.

Table 1. Classification and management of blood pressure for adults*

BP CLASSIFICATION	SBP* MMHG	DBP* MMHG	LIFESTYLE MODIFICATION	INITIAL DRUG THERAPY	
				WITHOUT COMPELLING INDICATION	WITH COMPELLING INDICATIONS (SEE TABLE 8)
NORMAL	<120	and <80	Encourage		
PREHYPERTENSION	120–139	or 80–89	Yes	No antihypertensive drug indicated.	Drug(s) for compelling indications.‡
STAGE 1 HYPERTENSION	140–159	or 90–99	Yes	Thiazide-type diuretics for most. May consider ACEI, ARB, BB, CCB, or combination.	Drug(s) for the compelling indications.‡ Other antihypertensive drugs (diuretics, ACEI, ARB, BB, CCB) as needed.
STAGE 2 HYPERTENSION	≥160	or ≥100	Yes	Two-drug combination for most† (usually thiazide-type diuretic and ACEI or ARB or BB or CCB).	

DBP, diastolic blood pressure; SBP, systolic blood pressure.

Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; BB, beta-blocker; CCB, calcium channel blocker.

* Treatment determined by highest BP category.

† Initial combined therapy should be used cautiously in those at risk for orthostatic hypotension.

‡ Treat patients with chronic kidney disease or diabetes to BP goal of <130/80 mmHg.

Table 5. Lifestyle modifications to manage hypertension**

MODIFICATION	RECOMMENDATION	APPROXIMATE SBP REDUCTION (RANGE)
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m ²).	5–20 mmHg/10 kg weight loss ^{23,24}
Adopt DASH eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat.	8–14 mmHg ^{25,26}
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).	2–8 mmHg ^{27,28}
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week).	4–9 mmHg ^{29,30}
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men and to no more than 1 drink per day in women and lighter weight persons.	2–4 mmHg ³¹

DASH, Dietary Approaches to Stop Hypertension.

* For overall cardiovascular risk reduction, stop smoking.

† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.

Table 8. Clinical trial and guideline basis for compelling indications for individual drug classes

COMPELLING INDICATION*	RECOMMENDED DRUGS†						CLINICAL TRIAL BASIS‡
	DIURETIC	BB	ACEI	ARB	CCB	ALDO ANT	
Heart failure	•	•	•	•		•	ACC/AHA Heart Failure Guideline, ⁴⁰ MERIT-HF, ⁴¹ COPERNICUS, ⁴² CIBIS, ⁴³ SOLVD, ⁴⁴ AIRE, ⁴⁵ TRACE, ⁴⁶ ValHEFT, ⁴⁷ RALES ⁴⁸
Postmyocardial infarction		•	•			•	ACC/AHA Post-MI Guideline, ⁴⁹ BHAT, ⁵⁰ SAVE, ⁵¹ Capricorn, ⁵² EPHEBUS ⁵³
High coronary disease risk	•	•	•			•	ALLHAT, ³³ HOPE, ³⁴ ANBP2, ³⁶ LIFE, ³² CONVINCENCE ³¹
Diabetes	•	•	•	•	•		NKF-ADA Guideline, ^{21,22} UKPDS, ⁵⁴ ALLHAT ³³
Chronic kidney disease			•	•			NKF Guideline, ²² Captopril Trial, ⁵⁵ RENAAL, ⁵⁶ IDNT, ⁵⁷ REIN, ⁵⁸ AASK ⁵⁹
Recurrent stroke prevention	•		•				PROGRESS ³⁵

* Compelling indications for antihypertensive drugs are based on benefits from outcome studies or existing clinical guidelines; the compelling indication is managed in parallel with the BP.

† Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; Aldo ANT, aldosterone antagonist; BB, beta-blocker; CCB, calcium channel blocker.

‡ Conditions for which clinical trials demonstrate benefit of specific classes of antihypertensive drugs.

Goals of treatment

Obviously, when we are treating a condition, our goal is to return abnormal parameters to “normal”, without causing unpleasant or dangerous side effects. What is considered the “normal” goal in treating hypertension? As in the decision to treat, the target varies depending on comorbid conditions. According to the guidelines,

“Treating SBP and DBP to targets that are <140/90 mmHg is associated with a decrease in CVD complications. In patients with hypertension and diabetes or renal disease, the BP goal is <130/80 mmHg.”

The target is set lower in patients with diabetes mellitus or renal insufficiency because data show that the lower targets are associated with more favorable outcomes.

If control of blood pressure is not achieved after adjustment of dosage and mix of thiazides, ACE inhibitors and beta-blockers, other agents may be needed to optimize control. While usual publications provide a long list of agents, we will restrict the list to medications currently on the CMHC formulary.

Initial contact

(see attached [Hypertension Decision Tree](#))

If patient on intake claims treatment for hypertension in community, verification of medications with pharmacy or through outside medical records should be considered. Most hypertension patients are Medical level 2 and can be at any facility. Hypertension per se is not ordinarily a reason to increase the medical level. Remember that, for newly diagnosed at intake hypertension, the initial management will usually consist of counseling about lifestyle issues (see Table 5 above) and monitoring.

Initial BP	recheck BP
≤ 130/90	not recommended
≤ 160/100	1-2 weeks
> 160/100 and < 180/120	1-3 days
≥ 180/120	1-2 hours

If the BP shows no sign of decreasing through 4 consecutive readings and the patient has no confounding issues that are active (e.g. drug or alcohol withdrawal), the patient should be seen in prescriber sick call within a week of the last reading.

Suggested follow-up

Type of patient	Interval	Tests which may be appropriate at the visit
Initial visit	-----	BP, EKG, Chem7, lipid profile, UA
Follow-up visits		
HBP -at target, normal creatinine	6-12 mo	BP, Cr, K+(if on diuretic), dipstick UA
HBP -at target, Cr >2, stable	3-6 mo	BP, Cr, K+(if on diuretic), dipstick UA
HBP -at target, Cr >2, unstable or stability not yet determined	1-3 mo	BP, Cr, K+(if on diuretic), dipstick UA
HBP - not at target	1-3 mo	BP -Cr, K+(if on diuretic), dipstick UA q 3 mo
HBP - not at target despite multiple meds	give medications DOT to assess adherence; if adherence validated, consider URC request to Hypertension specialist	

HYPERTENSION: DIAGNOSIS AND MANAGEMENT

Antihypertensive medications currently on CMHC's formulary

Generic Name	Brand name	Status*
Thiazides		
Chlorthalidone	Thalitone, Hygroton	F
Hydrochlorothiazide	Esidrix	F/C
Triamterene/HCTZ	Maxzide 75/50	F
Triamterene/HCTZ	Dyazide 37.5/25	F
ACE inhibitors and antagonists		
Enalapril	Vasotec	F
Lisinopril	Prinivil	F/C
Losartan	Cozaar	F
Beta blocker		
Atenolol	Tenormin	F/C
Carvedilol	Coreg	F
Labetalol	Normodyne	F/C
Metoprolol	Lopressor	F/C
Propranolol	Inderal	F
Calcium-channel blockers		
Amlodipine	Norvasc	F
Diltiazem	Cardizem	F
Nifedipine	Procardia	F/C
Nifedipine CC	Adalat CC	F
Verapamil SR	Calan SR	F
Other Agents		
Acetazolamide	Diamox	F
Clonidine	Catapres	F/C
Hydralazine	Apresoline	F
Methyldopa	Aldomet	F/C
Minoxidil	Minoxidil	F
Prazosin	Minipress	F
Terazosin	Hytrin	F
Other diuretics		
Furosemide	Lasix	F/C
Metolazone	Zaroxilin	F

* F = formulary F/C = formulary and contingency

Choice of antihypertensive medications

Since treatment of hypertension has no evident immediate benefit to the patient and must be continued for years for the real benefits to be seen, the treatment must be as convenient, easy to remember and as free of annoying side-effects as possible. With the diversity of antihypertensive medications available today, those treatment conditions can usually be met. The following suggestions are based on agents available in the current CMHC formulary.

HYPERTENSION: DIAGNOSIS AND MANAGEMENT

Initial Treatment

Uncomplicated HBP	HBP in patients with Diabetes or renal insufficiency (see JNC table 8 above)
Thiazide Diuretic – hydrochlorothiazide 25mg po QD or chlorthalidone 25 mg po QD or ACE inhibitor – lisinopril 10mg po QD	ACE inhibitor – lisinopril 10mg po QD

If target BP is not reached after 1-2 months of treatment

Uncomplicated HBP	HBP in patients with Diabetes or renal insufficiency
If ACEI was initial Rx – add Thiazide Diuretic – hydrochlorothiazide 25mg po QD or chlorthalidone 25 mg po QD or increase dose of ACE inhibitor – lisinopril -up to 40mg po QD ----- If thiazide was initial Rx add ACE inhibitor – lisinopril 10mg po QD	Increase dose of ACE inhibitor – lisinopril -up to 40mg po QD or Add beta-blocker atenolol 25-100mg po QD or metoprolol 50-100mg po QD or in patients with DM and good renal function, add thiazide diuretic – hydrochlorothiazide 25mg po QD or chlorthalidone 25 mg po QD

REFERENCES:

The Seventh Report of the Joint National Commission on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health National Heart, Lung, and Blood
Institute National High Blood Pressure Education Program NIH
Publication No. 03-5233 December, 2003

Download at: www.nhlbi.nih.gov/guidelines/hypertension/express.pdf

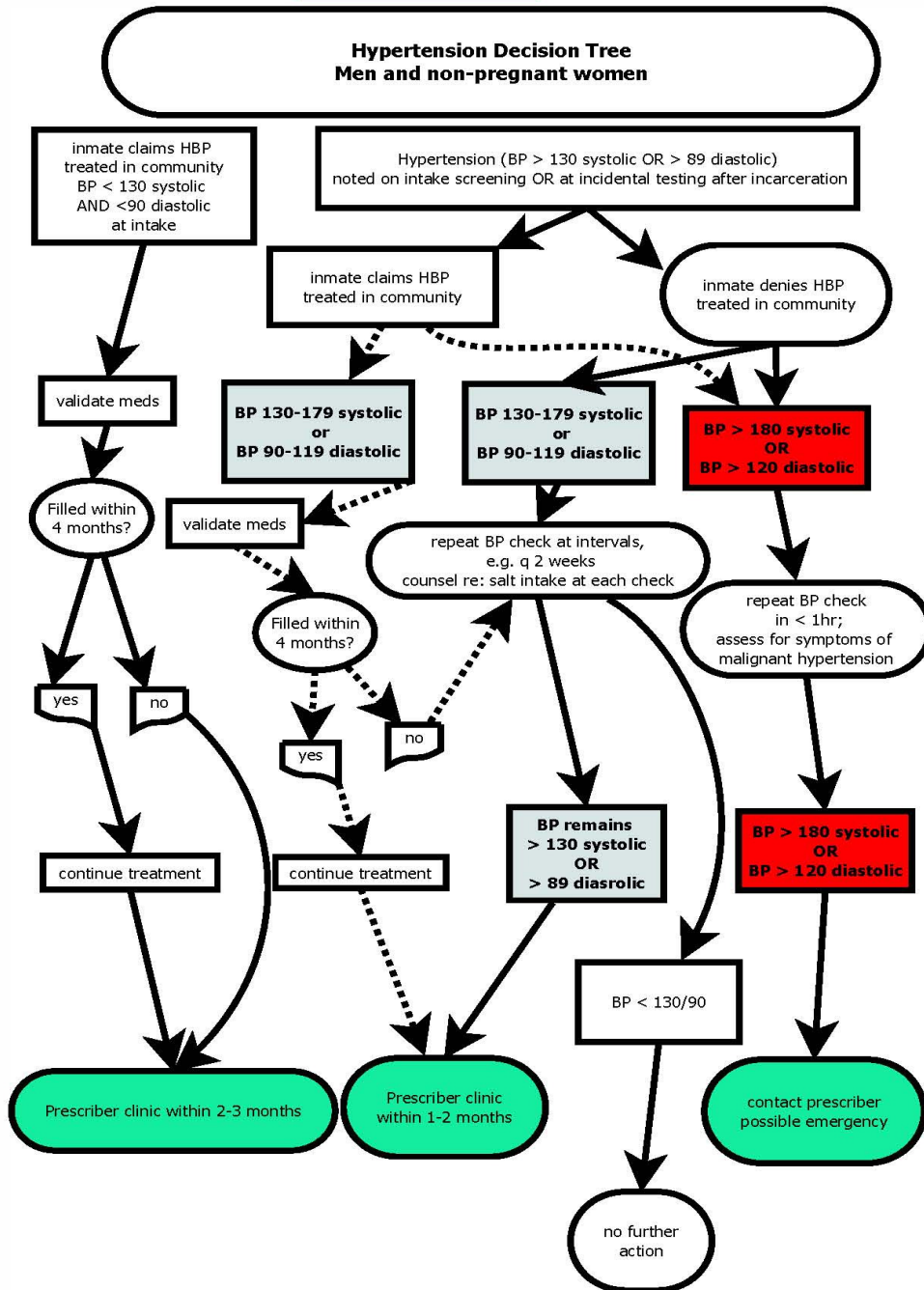
NCCHC Guideline for Disease Management in Correctional Settings -Hypertension.
November, 2009.

For latest version go to: www.ncchc.org/resources

Approved: UCHC – CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Director of Medical Services, Mark Buchanan MD _____	
Title: CDOC Director Health Services, Kathleen Maurer MD _____	

HYPERTENSION: DIAGNOSIS AND MANAGEMENT

Appendix A



**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 1.03

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HEMODIALYSIS

Effective Date 11/01/01

POLICY: All inmates in Connecticut Department of Correction (**CDOC**) facilities requiring hemodialysis shall be afforded care equivalent to the standard of care afforded hemodialysis patients in the community. Hemodialysis shall be offered in a secured dialysis unit via a contracted provider, within the medical wing of the MacDougall-Walker Correctional Institution (CI). Hemodialysis shall also be offered to female inmates and selected male inmates at designated community sites. Whenever possible, male inmates pre-certified to receive hemodialysis at the MacDougall-Walker CI shall be housed at that institution.

PROCEDURE: When a determination has been made from **Form HR 001, Intake Health Assessment** or new diagnosis, that an inmate requires hemodialysis, an immediate referral shall be made to the physician assigned to the facility for the purpose of initiating **Form HR 202, Utilization Review Request** for referral for continuation/initiation of treatment.

When the facility physician, APRN, or PA is not available for any reason, the "on-call" physician shall be contacted immediately for treatment orders in accordance with provisions contained herein.

All hemodialysis services shall be pre-authorized by the CMHC Utilization Management Unit.

Unless otherwise indicated by the nephrologist, inmates requiring hemodialysis shall be scheduled to receive treatments three times per week.

A schedule of all pre-certified hemodialysis appointments shall be distributed weekly by the CMHC Utilization Management unit.

The facility CMHC staff shall obtain a signed **CMHC Form HR 301, Refusal of Health Services** and notify the CMHC Utilization Management Unit and the hemodialysis unit of each instance of inmate refusal of scheduled hemodialysis treatment.

Discharge planning shall be in accordance with CMHC policy and procedures.

HEMODIALYSIS**MacDougall-Walker Secured Hemodialysis Unit**

Inmates assigned to the secured hemodialysis unit shall be pre-certified to receive services by CMHC Utilization Management Unit.

The CMHC Utilization Management Unit shall be notified of any change in anticipated CDOC release date.

The MacDougall-Walker CI infirmary correctional officer shall make scheduled rounds of the secure dialysis unit whenever it is in use.

Inmates receiving hemodialysis shall remain in the secure dialysis unit until the treatment is complete.

The contracted staff shall document all hemodialysis treatments on the **Form HR 201 Health Consultation** noting any pertinent issues pertaining to the delivery of services. **The DCI staff shall fax all completed Consultation forms to the CMHC Utilization Management unit at the end of each day.**

The DCI contracted staff shall maintain all inmate-patient dialysis records.

All requests for health care services beyond the scope of the secure dialysis unit and/or MacDougall-Walker CI health care unit shall require pre-certification via the CMHC Utilization Management Unit review process.

The DCI contracted staff shall receive at least one day of training on safety and security issues within the CDOC and on policies and procedures specific to MacDougall-Walker CI. This training shall be a joint presentation from CDOC custody staff and CMHC health services staff and shall be repeated once per year for each staff person. Records of the training shall be kept in the CMHC Nurse Clinical Instructor's records.

Community Hemodialysis:

Inmates shall be transported to the hemodialysis unit with a UR consultation form and any other appropriate medical information. For emergency purposes, contact the CDOC Director of Clinical Services.

The sending facility's transportation officer(s) shall remain with the inmate throughout the entire dialysis treatment.

Upon completion of the treatment, the facility CMHC staff shall fax a copy of the completed UR consultation form to the CMHC Utilization Management Unit

All requests for health care services beyond the scope of the community dialysis unit shall require pre-certification via the CMHC Utilization Management Unit review process.

REFERENCES: *Standards for Health Services in Prisons. (P-G-01).* 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC – CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

Title: CMHC Director of Medical Services, Johnny Wu MD

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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 1.03a

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PERITONEAL DIALYSIS

Effective Date: 11/01/01

POLICY: All inmates in Connecticut Department of Correction (**CDOC**) facilities requiring peritoneal dialysis shall be afforded care equivalent to the standard of care afforded peritoneal dialysis patients in the community. Peritoneal dialysis shall be offered in CDOC facilities.

PROCEDURE: When a determination has been made from **CMHC Form HR 001, Intake Health Screening** or new diagnosis, that an inmate requires peritoneal dialysis, an immediate referral shall be made to the physician assigned to the facility for the purpose of initiating a utilization review request for referral for continuation/initiation of therapy and/or nephrology consultation.

When the facility staff physician, APRN, PA is not available for any reason, the "on-call" physician shall be contacted immediately for treatment orders in accordance with provisions contained herein.

Initial and community peritoneal dialysis services shall be pre-authorized by the Utilization Management Unit.

Inmates requiring peritoneal dialysis shall be followed by a consulting nephrologist. CMHC facility physicians shall refer the inmates for such specialty care per CMHC Utilization Management procedures.

CMHC staff shall collaborate with appropriate consultants to develop a treatment plan for all inmates receiving peritoneal dialysis per **CMHC Policy G 2.01 Patients with Special Health Needs**.

Discharge planning shall be in accordance with CMHC policy and procedure.

REFERENCES: *Standards for Health Services in Prisons. (P-G-01)*. 2008. National Commission on Correctional Health Care. Chicago, IL.
CMHC Infirmery Manual: Continuous Ambulatory Peritoneal Dialysis (CAPD)

Approved: UCHC – CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Mark Buchanan MD _____

Title: CDOC Director Health Services, Daniel Bannish PsyD _____

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 1.04

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HUMAN IMMUNODEFICIENCY VIRUS

Effective Date: 04/01/00

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall provide humane and medically appropriate diagnosis and treatment to inmates in the Connecticut Department of Correction (**CDOC**) infected with the Human Immunodeficiency Virus (**HIV**).

CMHC shall provide HIV counseling services consistent with standards approved by the Connecticut Department of Public Health, AIDS & Chronic Diseases Section.

CMHC, in collaboration with CDOC, shall offer HIV-related educational programs and materials to both CMHC and CDOC staff and to inmates.

PROCEDURE: **HIV Non-Discrimination**

CMHC and CDOC Staff

Prospective employees shall not be tested for HIV serostatus to determine suitability for employment.

HIV serostatus shall not be considered as an exclusionary criterion for employment.

Restrictions shall not be placed on an employee's status based on a diagnosis of HIV seropositivity, or related conditions, if the employee's health enables the employee to perform required duties.

CMHC/CDOC may modify an employee's duties based on medical recommendations or managerial prerogatives.

Inmates

An inmate shall not be segregated in a CDOC facility solely due to being HIV infected or due to the stage of the inmate's HIV infection.

No housing unit shall be designated specifically and exclusively for the housing of HIV infected inmates.

HUMAN IMMUNODEFICIENCY VIRUS

HIV seropositive status shall not be considered as an exclusionary criterion for a job assignment.

HIV seropositive inmates shall be eligible for consideration to participate in any CDOC inmate program without regard to HIV status. However, an inmate shall be ineligible for the Extended Family Visiting Program if the inmate has tested HIV seropositive and refuses to sign a release authorizing the disclosure of the existence of HIV infection to the inmate's significant other.

Staff Education/Training

The CDOC Director of Training and Staff Development, and the CDOC Director of Health and Addiction Services, or designee, shall approve all staff training relative to HIV/AIDS and blood borne pathogens.

Training shall include efforts designed to enhance the understanding of HIV infection and reduce fear, prejudice and discrimination against HIV positive individuals. Training shall also include information concerning HIV/AIDS confidentiality and disclosure laws, prevention of HIV infection and the management of HIV-seropositive individuals.

All new CMHC and CDOC staff shall receive mandatory HIV/AIDS-related education during the CDOC Pre-Service training at the CDOC Maloney Center for Training and Staff Development. All other staff shall receive mandatory HIV/AIDS-related training annually.

All training shall be documented in the staff member's training record.

Inmate Health Education

The CDOC Director of Health and Addiction Services shall approve all materials and curricula for inmate health education sessions, prior to their use in CDOC facilities.

Inmate health education shall include efforts designed to enhance the understanding of HIV infection and reduce fear, prejudice and discrimination against HIV positive individuals

Each inmate, upon entry to a CDOC facility, shall be offered written information concerning HIV infection and available counseling and testing protocols within the CDOC. Each inmate shall be required to sign a receipt for such information. The receipt shall be filed in the inmate's health record (**HR**).

HUMAN IMMUNODEFICIENCY VIRUS

Inmates shall be offered health education sessions, including the opportunity to receive HIV-related information and ask related questions, as frequently as necessary, but no less than three times a week at CDOC intake facilities and once a week at all other CDOC facilities. Reasonable provisions shall be made for each inmate with cultural or linguistic barriers, educational difficulties, or mental impairments.

HIV-Discharge packets, which include HIV/AIDS-related information and available community resources, shall be made available to each inmate re-entering the community, participating in furlough or participating in the family visiting programs.

HIV Testing With Informed Consent of the Inmate

Qualified CMHC staff shall recommend HIV testing to any inmate who has been identified with high-risk behaviors for HIV infection.

HIV counseling and testing shall be available to inmates without referrals from CMHC staff

The HIV counselor shall obtain the inmate's informed consent prior to voluntary testing which shall consist of an explanation of the test, implications for medical treatment, the medical impact of refusing the test and the confidentiality of the test results. The inmate's verbal informed consent shall be obtained prior to performing the rapid HIV 1/2 antibody test and documented in the SOAP note in the inmate HR.

The HIV counselor shall provide the inmate with a post-test counseling session if not the same day, within five (5) working days of the receipt of the result.

The HIV counselor shall offer each inmate testing positive for HIV an additional post-test counseling session within one week of the initial post-test counseling session.

HIV Testing Without Informed Consent of the Inmate

Involuntary HIV testing shall only be conducted after a reasonable effort has been made to secure the inmate's informed consent.

All involuntary HIV testing shall require the pre-test approval of the CDOC Director of Health Services.

Involuntary HIV testing of an inmate shall be accompanied by pre and post-test counseling, appropriate referrals, and if needed, medical/mental health follow-up.

HUMAN IMMUNODEFICIENCY VIRUS

Involuntary HIV testing may be ordered in the following circumstances:

- When an inmate is unable to consent to HIV testing and no other person is available to authorize HIV testing and the results are needed to provide urgent medical care, treatment of co-infections or to prevent further progression of the disease **and** the CDOC Director of Clinical Services determines the inmate poses a significant risk of HIV transmission to others or has been the cause of significant exposure to another and no reasonable alternative exists;
- When a staff member, in the performance of his/her duties, experiences a clinically significant occupational exposure, in accordance with **Administrative Directive 2.19, Employee Health**, provided **all** of the following criteria are met:
 - The employee is able to document significant exposure during performance of the employee's duties;
 - The employee verbally reports the incident immediately and completes **Form CN 6601, Incident Report** within 48 hours of the exposure, identifying the participants in the exposure, witnesses, time, place, and nature of the event;
 - The employee submits to a baseline HIV test within 72 hours of the exposure incident and the test is negative;
 - The facility physician has approached the inmate and sought voluntary consent and the inmate has refused to consent to testing;
 - The employee has a clinically significant exposure to the blood of an inmate and the inmate, or the inmate's legal guardian, refuses to grant informed consent for an HIV test; and
 - The employee will be able to take meaningful immediate action, if results are known, which could not otherwise be taken;
 - Pursuant to court order when the court finds a clear and imminent danger to the public health or the health of a person and that person has demonstrated a compelling need for the HIV related test result that cannot be accommodated by other means.

Disclosure of Inmate HIV Status

An inmate's HIV status shall remain confidential as part of the inmate HR and disclosed only as follows:

HUMAN IMMUNODEFICIENCY VIRUS

- To the inmate or the inmate's legal guardian unless the minor (18 and under) has requested voluntary testing.
- To any person who secures a signed **Form CN 4401, Authorization for the Release of Information** from the inmate and the signed release is specific for HIV information;
- To CMHC staff responsible for providing care or treatment to the inmate;
- To the Unit Administrator in order to provide necessary health services when the behavior of one or more inmate(s) poses significant risk of transmission to another inmate, or if significant exposure has occurred. Such disclosure shall be made only if the disclosure will enable the inmate to receive appropriate services or is likely to prevent or reduce the risk of transmission of HIV infection, and no reasonable alternative exists that will achieve the same goal and maintain confidentiality of the HIV information.
- To an employee, in cases where such employee, in the course of occupational duties has had a significant exposure incident to HIV infection, and has satisfied the criteria listed in this policy.
- Pursuant to a court order, if the court finds a clear and imminent danger to the public health of a person and that person has demonstrated a compelling need for the test results.

Written permission shall be obtained from the inmate for each individual disclosure of HIV information, in accordance with **CDOC Administrative Directive 4.4, Access to Information**, utilizing **Form CN 4401, Authorization for Release of Information**.

In addition to any penalties provided for by law, a CMHC or CDOC staff member shall be subject to progressive discipline, including suspension or dismissal, for unauthorized disclosures of HIV-related patient information.

Medical/Mental Health Care for HIV Seropositive Inmates

Each HIV seropositive inmate shall have access to health care as provided by CMHC.

Appropriate infirmary level care shall be available to each HIV seropositive inmate having chronic disease or acute illness requiring continuous medical observation.

Current therapies, and/or other treatments that become available in the future, shall be made available to all inmates in accordance with community standards if clinically indicated by the physician.

HUMAN IMMUNODEFICIENCY VIRUS

CMHC staff shall attempt to provide each inmate known to be HIV seropositive upon sentence discharge or release to the community, appropriate arrangements to meet the medical care basic needs and services as required.

Records Maintenance

Each Unit Administrator shall have access to all available inmate HRs in accordance with the law.

Systems established to identify and monitor an inmate's HIV status shall ensure confidentiality.

No external markings, lists, housing card or other visible identifiers shall be used to designate or identify an HIV seropositive inmate.

Community Involvement

Community resources, including trained volunteers, shall be utilized to assist inmates, staff and families with HIV related assistance, such as education, counseling and emotional support.

Volunteers shall be subject to the same standards of security clearance, training and supervision, applicable to CDOC staff and contractors in accordance with **CDOC Administrative Directive 10.4, Volunteer and Recreation Services**, and other participating agencies.

Research

Each request for HIV/AIDS related research shall be subject to review in accordance with **CDOC Administrative Directives 1.7, Research, and 4.4, Access to Information**.

HIV seroprevalence surveys shall be conducted with the pre-approval of the CDOC Commissioner. Information about individual inmates shall not be released without the written consent of the inmate. Information without identifiers, or in aggregate form, may be released.

Research data shall not be released without the permission of the CDOC Director of Health Services and/or the CDOC Commissioner.

REFERENCES: *Administrative Directive 8.11, Human Immunodeficiency Virus.* 2008. Connecticut Department of Correction.

HIV Testing Implementation Guidance for Correctional Settings. January 2009. Centers for Disease Control and Prevention. Atlanta, GA.

Connecticut General Statutes., Sections 5-142(b), 18-81, 19a-581 through 19a-585, 19a-590, 54-131(c) and 54-131(e).

Doe vs. Meachum Consent Judgment. 1990. Connecticut Department of Correction.

Occupational Safety and Health Administration (OSHA) Standards.

Prison Health Care: Guidelines for the Management of an Adequate Delivery. 1991. National Institute of Corrections. U.S. Department of Justice.

Standards for Adult Correctional Institutions 4th Edition, 2003. American Correctional Association.

Standards for Health Services in Prisons (P-G-01). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC – CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

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**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.01

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PATIENTS WITH SPECIAL HEALTH NEEDS

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) staff shall ensure that health care services delivered to special needs inmates in the custody of the Connecticut Department of Correction (**CDOC**) include written individualized treatment plans.

Special needs patients include but are not limited to the following groups:

- Chronically-ill inmates
- Inmates with serious communicable diseases
- Physically disabled inmates who require close medical supervision
- Pregnant inmates
- Frail or elderly inmates who require close medical supervision
- Terminally ill inmates
- Inmates with mental health needs
- Inmates with **developmentally disabilities**
- Inmates with severe visual and/or hearing impairments
- Minors

DEFINITION: A treatment plan is a series of written statements specifying the particular course of therapy and the roles of qualified health care professionals in carrying it out. A physician or other qualified health practitioner develops and reviews the treatment plan as appropriate.

PROCEDURE: The plan shall be individualized, reviewed/signed-off by the inmate. The plan shall be based on an assessment of the inmate needs, short and long-term goals developed, including the methods by which these goals shall be addressed. The plan may include instructions about diet, exercise, adaptation to the correctional environment, medication, the type and frequency of follow-up for medical evaluation, frequency of diagnostic testing and therapeutic regimens, and adjustment of treatment modality.

(See related CMHC policy A 8.01, Communication on Patients' Health Needs)

REFERENCES: *Administrative Directive 8.1, Scope of Health Services Care.* 2007. Connecticut Department of Correction.
Administrative Directive 10.19, Americans with Disabilities Act. 2008. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-02). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC – CMHC	Date:
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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.02

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**LIVING WILL
APPOINTMENT OF HEALTH CARE AGENT**

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) and the Connecticut Department of Correction (**CDOC**) shall permit inmates, in accordance with Connecticut State Statutes, to formally record their decisions on medical treatment which are intended to be followed should they become incompetent.

PROCEDURE: It is the ethical and legal right of each inmate who possesses the capacity to make decisions regarding his or her health care to do so. Further, it is the concomitant ethical and legal right of each inmate to be provided with adequate information about the diagnostic and therapeutic options (including risks, benefits, nature, and purpose of the options) that are reasonably available.

Decisions to forgo life-sustaining treatment should be made between the inmate and the attending physician after as thorough a discussion of therapeutic options as is reasonably possible.

An inmate may not compel a physician to provide any treatment that in the professional judgement of the physician is unlikely to provide the inmate with significant benefits.

Any physician may decline to participate in the limitation or withdrawal of therapy. In exercising this right however, the physician must take appropriate steps to transfer the care of the inmate to another qualified physician who is willing to comply with the inmate's wishes. Such a decision should be made only for reasons of conscience and after serious efforts have been made to dissuade the inmate from the decision to forgo treatment and after adequate notice has been given to the inmate that the physician will have to withdraw from the case.

It is the physician's responsibility to provide the inmate with adequate information and diagnostic options so that the inmate can make an informed consent. This information includes the risks, discomforts, side effects, and financial costs of treatment, the potential benefits of treatment, and the likelihood, if known, that the treatment will realize its intended beneficial effects, and the prognosis of nontreatment.

LIVING WILL/APPOINTMENT OF HEALTH CARE AGENT

The physician should seek to elicit questions from the inmate, should provide truthful and complete answers to such questions, should attempt to ascertain whether or not the inmate understands the information and advice provided and should attempt to enhance understanding when deficient.

Understanding of options by the inmate will often increase over time. Therefore, decision-making should be treated as a process rather than an event. In order to provide adequate time to deal with the inmate before he/she lose his/her capacity to decide, the process of informing inmates should begin at the earliest possible time.

Inmates should be considered, in the first instance, to possess the capacity to make health care decisions. In the case of conscious and alert inmates the ethical and legal presumption of capacity will govern unless countervailing evidence arises to call the presumption into question.

An inmate's authority to make his/her own decisions should be overridden only after a clear demonstration of lack of capacity. Inquiry into an inmate's capacity may be initiated by such conditions as delirium, dementia, depression, mental retardation, psychosis, intoxication, stupor, or coma.

The formal assessment of capacity is a process that ordinarily ought to be performed and documented by the attending physician. "Incapacitated" means being unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and to reach and communicate an informed decision regarding the treatment. A psychiatric consultation may be indicated if psychological factors are thought to be compromising capacity. A consultation is not required if the attending physician is able to assess capacity without it.

When the attending physician has reason to question the inmate's decision-making ability, the physician shall request a psychiatric consultation for the purpose of assessing such ability. The psychiatrist shall document findings and recommendations in the inmate's HR and, if appropriate, have direct verbal conversation with the attending physician. This communication shall be documented in the inmate's HR.

Inmates who lack decision-making capacity have the same substantive ethical and legal rights as do inmates who possess such capacity. The only distinction is that, in the case of inmates lacking decision-making capacity, health decisions must be made on their behalf by a surrogate decision-maker.

Any person eighteen years of age or older may execute a document which shall contain directions as to specific life support systems, which such person

LIVING WILL/APPOINTMENT OF HEALTH CARE AGENT

chooses to have administered. Such documents shall be signed and dated by the maker with at least two witnesses. (Conn. Gen. Stat. Sec. 19a-575)

Any or all of the attesting witnesses to any living will document or any documented appointing a health care agent may, at the request of the declarant, make and sign an affidavit before any officer authorized to administer oaths in or out of this state, stating such facts as they would be required to testify to in court to prove such living will. The affidavit shall be written on the living will document, or if that is impracticable, on some paper attached thereto. The sworn statement of any such witness so taken shall be accepted by the court of probate as if it had been taken before the court. (Conn. Gen. Stat. 19a-578)

A physician or other health care provider who is furnished with a copy of a written living will or appointment of health care agent shall make it a part of the declarant's medical record. A physician or other health care provider shall also record in the patient's medical record any oral communication concerning any aspect of health care, including the withholding or withdrawal of life support systems, made by the inmate directly to the physician or other health care provider or to the inmate's health care agent, legal guardian, conservator, or next of kin.

A living will or appointment of a health care agent becomes operative when the document is furnished to the attending physician and the declarant is determined by the attending physician to be incapacitated. (Conn. Gen. Stat. 19a-579)

A living will or appointment of health care agent may be revoked at any time and in any manner by the declarant, without regard to the declarant's mental or physical condition. The attending physician or other health care provider shall make the revocation part of the declarant's medical record. In the absence of such knowledge of the revocation whether of a living will or an appointment of health care agent, a person is not subject to civil or criminal liability or discipline for unprofessional conduct for carrying out the living will pursuant to the requirement of section 19a-571, 19a-573, and 19a-575 to 19a-580c inclusive. (Conn. Gen. Stat. 19a-579a)

Within a reasonable time prior to withholding or causing the removal of any life support system pursuant to sections 19a-570, 19a-571, 19a-573, and 19a-575 to 19a-580c, inclusive, the attending physician shall make a reasonable effort to notify the individuals' health care agent, next-of-kin and legal guardian or conservator, if available. (Conn. Gen. Stat. 19a-580)

A physician/designee shall approach the inmate regarding the availability of the Living Will. The inmate shall be afforded the opportunity to ask questions and have a copy of Form **HR 312, Living Will** when the discussion takes place.

LIVING WILL/APPOINTMENT OF HEALTH CARE AGENT

The physician/designee shall document each discussion relating to the Living Will in the inmate's Health Record (**HR**) along with any questions asked or opinions expressed by the inmate. The physician/designee shall be responsible for obtaining the inmate's signature on the Living Will form. Two witnesses, either CMHC medical or mental health staff, and/or CDOC custody staff shall witness the signature. No inmate shall serve as a witness to the signing of a Living Will. For the Living Will and the appointment of a health care agent, an *optional* form is provided called a witnesses' affidavit. It is the witnesses' sworn statement that they saw the inmate sign the Living Will or appointment form and that the inmate was of sound mind and signed the Living Will of free choice. In the event that there is a dispute regarding the Living Will or appointment of a health care agent, the witness' affidavit supports its validity. This affidavit requires the use of an attorney or notary public.

The original Living Will form shall be placed in the plastic sleeve of the inmate's HR on the left side, directly above the clinic divider. A copy shall be offered to the inmate and the inmate's family if Form **HR 303 or CN 4401, Release of Information** is signed by the inmate.

Copies of the completed Living Will shall also be sent to the Unit Administrator (Warden). The Living Will sticker shall be affixed on the outside of the inmate's HR jacket(s), above the title CDOC. "Living Will" shall also be placed on the health problem list in the inmate's HR.

A copy of the Living Will shall accompany the inmate upon discharge or transfer to an outside health provider.

- REFERENCES:** *Standards for Health Services in Prisons (P-G-02). 2008.* National Commission on Correctional Health Care. Chicago IL.
Connecticut General Statute 19a-578
Connecticut General Statute 19a-579
Connecticut General Statute 19a-579a
Connecticut General Statute 19a-580

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Mark Buchanan MD _____

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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.03

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BOTTOM BUNK ASSIGNMENT

Effective Date: 12/20/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) staff shall restrict the assignment of bottom bunks to only those inmates in Connecticut Department of Correction (**CDOC**) facilities who have valid medical/mental health conditions.

PROCEDURE: Inmates with the following conditions shall be considered for a bottom bunk pass upon a CMHC prescriber's order:

Seizure Disorder – only those inmates currently receiving or taken off medication(s) for a seizure disorder in the last 90 days.

Neurological Disease – inmate with documented central or peripheral motor deficit involving extremities, including diabetic and HIV neuropathy.

Orthopedics:

- acute fracture or sprain with documented physical findings;
- severe degenerative arthritis documented by x-ray and exam;
- back pain; limited to those inmate with symptomatic disease documented by MRI, CT or myelogram;
- amputees;

Severe/Morbid Obesity – inmates weighing 50% or more above ideal weight for height.

Chronic Debilitating Medical Diseases:

- end-stage HIV syndrome;
- severe COPD;
- coronary artery disease (recent);
- CHF (compromised)
- metastatic cancer
- end-stage renal failure
- ascites
- severe edema
- sleep apnea/CPAP machine

Patients on anticoagulation medication

BOTTOM BUNK ASSIGNMENT

Psychiatric – patients on high doses of psychotropic medications documented by a CMHC psychiatrist.

Surgical – according to a CMHC physician order.

Alcohol/Drug Detoxification – Temporary assignment of bottom bunk while on detox medications.

Aged – inmates over the age of 65.

Pregnancy

Bottom bunk pass orders shall include:

- reason for bottom bunk pass
- duration of the pass
- expiration date of the order (not to exceed one year)

All orders shall be re-evaluated at a minimum, once per year. This information shall be place on form HR 800 Problem List.

CMHC staff at the facility shall maintain a current list of inmates issued bottom bunk passes in the health services unit.

REFERENCES: *Standards for Health Services in Prisons. (P-G-02) 2014.* National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. of MH and Psychiatric Services Robert Berger MD _____

Title: CMHC Director of Medical Services, Johnny Wu MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURE MANUAL
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.04

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HEPATITIS C: MANAGEMENT & TREATMENT

Effective Date: 12/10/02

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) shall create a special board of Infectious Disease (**ID**) experts who shall evaluate all requests for treatment of Hepatitis C infection in inmates in Connecticut Department of Correction (**CDOC**) facilities.

Hepatitis C assessment and treatment management is complex and shall be under the direct supervision of a board-certified or board eligible infectious disease specialist (**IDS**) employed by CMHC with experience in the management of this disease.

Evaluation of candidates for treatment of Hepatitis C, as well as implementation of therapy, shall be performed by the ID specialists (IDS) that currently manage HIV and other infectious diseases within CDOC facilities.

A Hepatitis C Utilization Review Board (**HepCURB**) shall review all requests for treatment. This review board shall be chaired by the CMHC Director of Medical Services, and shall consist of board-certified or eligible specialists in infectious diseases who are conversant with management of hepatitis C and with correctional health care concerns and practice. In general, the HepCURB will follow the specific recommendations of American Association for the Study of Liver disease (AASLD), Infectious Diseases Society of America (IDSA), and the International Antiviral Society-USA (ISA-USA) regarding Hepatitis C management and treatment currently in force at the time of the inmate review.

Although they will not directly provide specific anti-viral drugs for Hepatitis C, CMHC Primary Care Physicians (PCPs) will provide appropriate supportive care to inmates with Hepatitis C, including management of their liver disease and its complications.

PROCEDURE:

1. Hepatitis C Evaluation/Referral by the CMHC Primary-Care Physician (PCP)

When an inmate has been found to have a positive anti-HCV study, and there are clinical indication for treatment, the CMHC PCP shall conduct an initial evaluation using the **Form HR 007A, Initial Evaluation of Hepatitis C Infection by Primary Care Provider**.

Unless the information is already available, the PCP will order appropriate testing of the inmate's HIV status and risk of future infection by Hepatitis A and B, and shall obtain a complete blood count (CBC) and liver function tests (LFTs) to assess hepatic inflammation. (These may be omitted if recent values drawn within the CDOC are available.) Additional

HEPATITIS C: MANAGEMENT & TREATMENT

diagnostic studies to assess the appropriateness of therapy for Hepatitis C infection in an inmate shall only be ordered by the IDS.

The PCP shall inform the inmate of the diagnosis, provide the inmate with the approved CMHC Hepatitis C informational packet, and document the discussion in the inmate's health record on the **Form HR 401, Clinical Record**. For those inmates lacking protective antibodies against Hepatitis A and B, the PCP will offer active immunization.

The PCP shall recommend follow-up in not less than 6 months, either within the CDOC or the community, with clinical re-evaluation and repeat measurement of complete blood count and liver function tests. If the inmate is still incarcerated at the time of repeat testing, the PCP shall discuss the new findings with the inmate, and at that time shall either refer the inmate to the facility IDS for consideration of specific therapy, **or** shall counsel the inmate to continue monitoring of the disease either within the CDOC or in the community. If the inmate is referred to the IDS and has not been tested for HIV infection, the PCP will refer the inmate HIV testing. The follow-up visit shall be documented on **Form HR 007B, Follow-Up Evaluation of Hepatitis C Infection by Primary Care Provider**. This form is also to be used as the referral form if the PCP refers the inmate to the IDS.

The PCP shall withhold any referral to the IDS until court sessions have concluded and the inmate has been sentenced. The PCP shall also withhold any referral to the IDS until 2 CBCs and 2 LFTs, spaced at least 6 months apart and both performed within the CDOC, are available and are consistent with active liver disease.

It is expected that the CMHC PCP will continue to monitor the inmate regarding related health issues, such as the management of hepatic decompensation or intensive fluid retention, should these occur.

The PCP shall remain responsible for continuing care of the inmate, including the inmate's liver disease, regardless of whether anti-viral therapy is given.

2. Hepatitis C Assessment by the On-Site ID Specialist (IDS)

Assessment of Hepatitis C-infected inmates by the IDS shall include the following:

- An inmate history that includes the following: drug and alcohol abuse history; suspected acute hepatitis episodes; hospitalizations related to hepatic disease or decompensation; any previous assessments or treatment for Hepatitis C; neuropsychiatric history including severe depression or suicidal ideation or attempts; past autoimmune disease; known immunosuppression, including HIV infection or solid-organ transplant; current pregnancy; and any history of chronic disease (e.g. diabetes mellitus, cardiomyopathy) that requires special management as well as an assessment of how well this chronic disease is being controlled.
- A comprehensive evaluation of the inmate's hepatic status, including signs of decompensation (ascites, wasting, persistent jaundice, variceal hemorrhage, hepatic encephalopathy); or a history of such decompensation, stigmata of hepatic disease.

HEPATITIS C: MANAGEMENT & TREATMENT

- Review of laboratory tests already performed, as well as review of any available community records.

If following this initial evaluation, the inmate appears to be a reasonable candidate for treatment, the IDS will counsel the inmate about the potential benefits and risks of treatment, and about CMHC's expectations about treatment adherence.

If the inmate wishes to proceed further, the IDS/designee shall ask the inmate to sign **Form HR 307, Consent and Compliance Agreement for Hepatitis C Treatment**, agreeing to comply with recommended treatment, including compliance with transient elastography testing (FibroScan), liver biopsy (if required), drug administration and laboratory testing, and stating an understanding that noncompliance with treatment will mean that therapy will stop and will not be offered again in the future.

This signed document shall be kept in the ID section of the inmate's Health Record (HR); refusal to agree to the terms of the **Form HR 307, Consent and Compliance Agreement for Hepatitis C Treatment** shall make the inmate ineligible for treatment.

If the inmate will not agree to the terms of the Consent and Compliance Agreement, the IDS shall ask the inmate to sign **Form HR 301 Refusal of Health Services** indicating her/his unwillingness to comply with the Agreement, and shall advise that no further evaluation for anti-viral treatment will be done, and shall return the inmate to the care of the PCP.

The IDS shall document the discussion in the inmate's Health Record on the **Form HR 401, Clinical Record**.

If the inmate signs the Consent and Compliance Agreement Form, agreeing to its terms, the IDS shall then use the Patient Safety System (PSS) to order the following laboratory studies using **Hepatitis C Diagnostic Orders**:

- 1) Liver function studies
- 2) CBC with differential
- 3) Chronic Hepatitis Profile (If not already done)
- 4) HAV IgG (If not already done)
- 5) Hepatitis C Genotype
- 6) HCV-RNA (quant. level by PCR)
- 7) Alpha-fetoprotein
- 8) ANA
- 9) TSH and free T4
- 10) Anti-mitochondrial Ab
- 11) Iron studies (Fe/TIBC/Transferrin)
- 12) HIV-Ab (If inmate's HIV Status unknown)
- 13) T4 count and HIV-1 viral load (If patient know to be HIV positive & if recent values not available)
- 14) PT / PTT
- 15) BUN / Creatinine
- 16) RPR

The IDS may omit any of these tests if recent values are available.

HEPATITIS C: MANAGEMENT & TREATMENT

Prior to ordering an HIV-Ab study, standard pre-test counseling will be provided.

The IDS/designee will then assist the inmate in completing Form HR 401D, Initial HCV Functional Status Report, and will place the completed form in the ID section of the inmate HR. In addition, the IDS shall order a mental health evaluation, to assess the psychological risks of therapy:

- For inmates classified Mental Health 3, 4, or 5, a psychiatrist shall make an assessment of the inmate's present psychological status and current stability, advising the IDS regarding the risk of decompensation as a result of anti-Hepatitis C therapy. The psychiatrist shall summarize and document this evaluation on the **Form HR 401, Clinical Record**, the encounter to be identified as "MH Evaluation for HCV Treatment"
- For inmates classified Mental Health 1 or 2, a psychiatrist or psychologist will complete the mental health evaluation and document the findings, as outlined above.
- The IDS may refer a Mental Health 1 or 2 inmate directly to a psychiatrist, bypassing the above step, in selected cases.

If the results of the mental health assessment do not indicate any increased psychological risk, the IDS may then initiate a referral to the Hepatitis C Utilization Review Board.

The IDS/designee shall inform the inmate regarding Hepatitis C issues as the assessment progresses.

Once the laboratory studies are completed and the IDS discussed treatment options with the inmate, if the inmate wishes to pursue treatment, the IDS shall place a request to CMHC UR to schedule transient elastography (FibroScan).

If at any point the IDS believes that treatment is inappropriate, but the inmate insists on therapy despite the advice of the IDS, the IDS does not need to perform the entire evaluation described above, but shall forward the inmate's request to the HepCURB, explaining why he or she does not believe that treatment is appropriate, and including whatever testing has been completed.

3. Referral to the Hepatitis C Utilization Review Board (HepCURB)

Once the above assessment is complete, the IDS shall discuss treatment options with the inmate. If the IDS recommends treatment and the inmate wishes to pursue this, the IDS shall make a formal referral to the HepCURB by entering the request in the UR application.

At the same time, the following documents should be faxed to the Central Office Utilization Review (UR) Unit, utilizing **Form HR 924C, HepCURB Referral Fax Cover Sheet and Checklist**.

- **Form HR 007A, Initial Evaluation of Hepatitis C Infection by Primary Care Provider**

HEPATITIS C: MANAGEMENT & TREATMENT

- **Form HR 007B, Follow-Up Evaluation of Hepatitis C Infection by Primary Care Provider**
- **Form HR 307, Consent and Compliance Agreement for Hepatitis C Treatment**
- **Form HR 401C, IDS Hepatitis C Evaluation**
- **Form HR 401D, Initial HCV Functional Status Report**
- **Form HR 504, Mental Health Screening**
- Psychiatrist's written opinion (if obtained)
- IDS clinical documentation record
- Written report of any prior liver biopsy or transient elastography (FibroScan)

As part of the referral process, the IDS/designee will inquire about any private health insurance. This will be documented in the inmate HR and included on **Form HR 401C, IDS Hepatitis C Evaluation**, including the name of the carrier and the policy number. The decision to treat or not treat shall be made without reference to third-party coverage, but if treatment is approved, the UCHC pharmacy will attempt to recover some or part of its costs through third-party payers.

4. Review by HepCURB

The HepCURB shall review the submitted materials and make a decision regarding further assessment and/or treatment.

Hepatitis C is a chronic disease that requires ongoing infection for a number of years before the development of end-stage liver disease and cirrhosis. The duration of therapy is also substantial (up to 12 months) and complex. The HepCURB will not generally approve Hepatitis C therapy unless there is a reasonable likelihood that the inmate will remain under CDOC supervision for the entire duration of treatment period.

The HepCURB shall first determine if a liver biopsy should be performed prior to making a decision regarding the initiation of specific therapy for Hepatitis C where there is technical limitation of the transient elastography test (FibroScan)

In many circumstances the HepCURB may waive the requirement for a liver biopsy prior to the initiation of Hepatitis C therapy.

If a liver biopsy is judged to be necessary, the HepCURB will notify the IDS through comments and internal messaging within the UR application. The IDS will inform the inmate that this is necessary and document this discussion in the inmate's HR on the **Form HR 401, Clinical Record** located in the ID section of the HR.

CMHC Central Office UR Unit shall schedule an appointment at UCHC for this purpose.

If the liver biopsy is to be performed within the Interventional Radiology Department at John Dempsey Hospital, the inmate shall have a CBC, platelet count, PT, and PTT performed no more than 14 days prior to the date of the biopsy, and the results shall be available to the radiologist.

CMHC Central Office UR Unit shall notify the designated CMHC nurse at the CDOC facility of the timing of this.

HEPATITIS C: MANAGEMENT & TREATMENT

Once the HepCURB has either decided to forego the liver biopsy, or has obtained the pathology report regarding the liver biopsy in question, the HepCURB shall decide on treatment initiation.

To reduce the risk of re-infection following treatment, the HepCURB must have a reasonable expectation that the inmate will not engage in alcohol or drug abuse following release from the CDOC. For this reason, the HepCURB may insist that an inmate participate in the CDOC Addictions Program either before definitive therapy for Hepatitis C is initiated or simultaneous with such therapy.

Prioritization for treatment is based on:

- Advanced hepatic fibrosis/cirrhosis Metavir stage F4
- Liver transplant patients
- HIV co-infection
- Comorbid medical conditions associated with HCV, e.g. cryoglobulinemia and certain types of lymphomas; Hepatitis C related renal disease
- Continuity of care for newly incarcerated inmates who were being treated at the time of incarceration.

Treatment approvals will specify the most optimal therapy available at the time of treatment approval

5. Treatment Selection and Initiation Process

Once the HepCURB approves an inmate for Hepatitis C treatment, it shall notify the appropriate IDS/designee through comments and internal messaging within the UR application. The IDS shall notify the inmate that treatment has been approved, and shall document this discussion on **Form HR 401, Clinical Record**, in the ID Clinic Section of the HR, and obtain the inmate's signature confirming the discussion on the URC computer-generated report. The IDS will also obtain the inmate's signature on **Form 305 Consent for Treatment**.

All treatments shall start on a standardized day of week and month in order to reduce errors by standardizing practice, to minimize side-effects interfering with inmate employment and programming during the week, and to 'batch' viral load testing to allow faster results. All treatment will start on the 3rd Friday of each month.

The URC shall regularly furnish the CMHC Pharmacy Director and the CMHC Operations Administrator for Quality Assurance a list of inmates who have been approved for treatment.

The CMHC Pharmacy Director shall coordinate the various steps in acquiring the medications, including any registration procedures with the pharmaceutical company involved.

Inmates on Hepatitis C therapy will not be allowed to transfer to certain CDOC facilities while receiving Hepatitis C therapy, or may be required to transfer from their current facility to one with greater clinical capability. Halfway houses shall not be considered suitable sites for administering Hepatitis C therapy. Therefore, inmates approved for therapy shall be placed on a "medical hold." The IDS/designee will complete **Form HR 106, Health-Related**

HEPATITIS C: MANAGEMENT & TREATMENT

Transfer Hold, place it in the HR (uppermost left hand-side). The ID nurse will notify the CDOC Counselor Supervisor and request that the patient be kept at the approved facility as long as treatment continues (and if necessary, be moved to that approved facility before the onset of treatment.)

When the medication is available, the IDS/designee will assist the inmate in completing **Form HR 401E, HCV Functional Follow-up Status Report**, and will place the completed form in the ID section of the inmate HR.

6. Patient Management During Hepatitis C Therapy

Side effects may require modification of an inmate's medication dosage or even discontinuation of therapy.

HCV viral load need to be drawn prior to treatment, at 4 weeks in to treatment and at the end of treatment, as well as either 12 or 24 weeks after treatment completion for those with undetectable end of treatment viral loads.

Relevant measurements including lab test and drug dosage will be documented on **Form HR 107, Hepatitis C Treatment Flow Sheet**, located in the ID Section of the HR. Medication administration shall be documented on the inmate's monthly Medication Administration Record (MAR), or on an MAR designed specifically for Hepatitis C medications.

7. Patient Follow-Up upon Completion Of Therapy

The IDS/designee shall also inform the CDOC Counselor Supervisor, who shall notify population management to release the medical hold.

The IDS shall also arrange to have another HCV viral load drawn three (3) months following completion of the therapy. The results of this assay will determine if the inmate has successfully responded to therapy (i.e. whether they can be classified as a long-term responder) or has failed therapy.

The managing IDS shall document these results in the inmate's HR and also convey the results directly to both the inmate and the HepCURB.

8. Treatment Denials

If the HepCURB denies a request for Hepatitis C therapy, the official report generated by the HepCURB will outline the specific reasons why the inmate was denied the therapy. Copies of the HepCURB decision will be sent to the IDS who initiated the request, who will then personally communicate the decision to the inmate involved, and document this notification in the inmate's HR. The inmate must also sign to acknowledge that he/she has been notified.

An IDS who disagrees with the HepCURB decision may file an appeal for reconsideration, and may appear at a scheduled HepCURB meeting to discuss the case in person if so desired.

HEPATITIS C: MANAGEMENT & TREATMENT

If the HepCURB does not authorize treatment for Hepatitis C, the inmate's hepatitis care and monitoring shall again become the responsibility of the PCP, rather than the IDS. The PCP may make another referral to the IDS if a change in the inmate's condition justifies it.

If the HepCURB denies care for patients with advanced hepatitis, such patients shall be continually be monitored by the IDS and PCP

Treatment denial due to release date, such inmate shall be referred to the facility based discharge planner for a timely referral to an appropriate community based health care provider.

9. Protocol for Continuation of Therapy Begun Before Incarceration

As soon as the health services staff becomes aware that a newly admitted inmate has been receiving treatment for Hepatitis C in the community at the time of incarceration, the staff should attempt to have the inmate's medication brought in from home at once. By the morning after admission, the facility ID nurse must contact the patient's pharmacy, ascertaining whether the patient has faithfully been picking up the medication and documenting the date of most recent medication pickup, and the patient's physician, ascertaining whether the patient has been appearing for follow-up visits as ordered, and documenting the date of the most recent follow up. The staff must also inventory whatever medication was brought in by the patient, and ascertain whether and how and for how long the patient's friends or family would be able to continue supplying the medications. The facility staff must put this information into an email addressed to the facility IDS, to the CMHC Director of Medical Services, and the CMHC Pharmacy Director. Any patient who can be shown to have been off the treatment schedule for more than 14 days will be deemed to have been off treatment, and will not be continued on treatment while in DOC unless and until that inmate later meets CMHC criteria for HepC treatment.

The inmate shall be referred promptly to the IDS, who shall review the inmate's history and obtain health records from the outside physician. Such health records shall include the same type of information required when initiation of treatment is contemplated within the CDOC, as well as the dosage, treatment side effects, and results (if any) of Hepatitis C PCR assay done while on treatment.

This information shall be forwarded to the HepCURB for consideration at their next meeting. Until that meeting, the inmate shall generally be continued on the same therapy regimen as given prior to incarceration.

To receive temporary approval for treatment, the IDS should contact the CMHC Director of Medical Services by phone to discuss the case, and should submit a non-formulary exception request form. Until the medication is obtained through the CMHC pharmacy, the inmate's own medication brought from home (if available) may be administered under the direction of the IDS, in compliance with **CMHC Policy D 2.16, Inmate Personal Medication: Identification.**

Readmission:

Revision Dates: 05/30/05, 12.21.10; 02/28/11; 02/01/12; 07/31/13; 06/30/15; 06/30/16

HEPATITIS C: MANAGEMENT & TREATMENT

When an inmate is admitted and identifies completion of previous Hepatitis C treatment, the inmate should be referred to the ID Case Manager for scheduling with the IDS to have an HCV RNA/REFLEXHCV GT drawn to determine if the inmate is reinfected.

REFERENCES: *An Update on Treatment of Genotypy 1 Chronic Hepatitis C Virus Infection: 2011 Practice Guideline by the American Association for the Study of Liver Diseases.* Ghany et al. Hepatology, vol 51, No 4, pp 1433 ff, October 2011

*Recommendations for Testing, Managing, and Treating Hepatitis C.*American Association for the Study of Liver Diseases and the Infectious Diseases Society of America .
<http://www.hcvguidelines.org/node/141> (2015)
 Updated: February 24, 2016. Changes made: April 25, 2016.

Approved: UConn Health	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD	_____
Title: CMHC Director of Medical Services, Johnny Wu MD	_____
Title: CDOC Director Health Services, Kathleen Maurer MD	_____

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.05

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**TRANSFERS OF INMATES WITH
SEVERE MENTAL ILLNESS/INTELLECTUALLY CHALLENGED**

Effective Date: 07/01/02

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that provisions are made for the necessary treatment and transfer of severely mentally ill/intellectually challenged inmates housed in Connecticut Department of Correction (**CDOC**) facilities.

PROCEDURE:

Acute Mental Health Services.

When it has been determined that an inmate has a need for acute mental health intervention, CMHC mental health staff shall ensure provisions are made for his/her necessary treatment.

Transfers

An inmate determined to be gravely disabled, or a danger to self or others, by a CMHC licensed, mental health professional may be transferred to a designated Mental Health facility for continued assessment, evaluation, and treatment.

Transfer to Other State Agencies.

Notification of the transfer request shall be forwarded to the CMHC Director of Mental Health and Psychiatric Services/designee who shall review and coordinate all transfer agreements with the appropriate state agency. Transfer criteria to other state agencies shall be in accordance with the following:

1. **CT Department of Children and Families.** Inmates shall be under 18 years old. Procedures for transfer shall be in accordance with Connecticut General Statutes, Section 18-87.
2. **Connecticut Valley Hospital - Whiting Forensic Division.** Inmates shall be age 18 or older and require maximum security hospitalization.
3. **CT Regional Mental Health Hospitals.** Inmates shall be age 18 or over with security status of Level 1 or 2.
4. **CT Department of Developmental Disability Services** Procedures for transfer shall be in accordance with Connecticut General Statutes.

**TRANSFER OF INMATES WITH
SEVERE MENTAL ILLNESS/INTELLECTUALLY CHALLENGED**

Transfers to the Department of Mental Health and Addiction Services.

All transfers to the Department of Mental Health initiated by the CDOC shall require, at a minimum, the following documentation:

- W-10 Form (Interagency Transfer Form) completed by CMHC staff
- Voluntary or involuntary cover letter, signed by the Warden/designee
- Physician's 15-Day Emergency Certificate or Voluntary Commitment Application form;
- Copy of the sentence mittimus;
- Copy of Detainers (State of Connecticut, Federal Immigration and other States);
- Copy of RT50 highlighting Max Release Date and Contact Information. ;
- Copy of inmate's RT 60 highlighting any escapes;
- Copy of inmate's RT 67 highlighting assaultive behavior; and
- Any other pertinent material that may be considered relevant to the inmate's commitment to the Department's custody.

REFERENCES: *Administrative Directive 6.4, Transportation and Community Supervision of Inmates.*2007 Connecticut Department of Corrections.
 Administrative Directive 8.5, Mental Health Services. 2008. Connecticut Department of Correction.
 Standards for Health Services in Prisons (P-G-02). 2014. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____	
Title: CDOC Director Health Services, Kathleen Maurer MD _____	
Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____	

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.06

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COURT APPEARANCES OF INMATES HOUSED IN THE INFIRMARY

Effective Date: 05/07/04

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that any Connecticut Department of Correction (**CDOC**) inmate housed in an infirmary prior to a Court Appearance will be evaluated by CMHC Health Services staff.

PROCEDURE: CDOC facility staff shall notify CMHC facility health care staff of a court trip scheduled for an inmate housed in the infirmary (due to acute medical illness, acute psychosis, suicidality, etc.) as early as possible before the Court appearance.

- For a MH 5 inmate CMHC MH staff (nursing staff if MH staff not available) shall notify the court (jail diversion) Social Worker of the inmate's status and document the contact in the inmate's health record. CDOC shall be notified of the need for custody escorts to court.

Upon return from court the inmate shall be reevaluated by CMHC staff. CMHC health care staff shall ensure appropriate care is provided.

Custody staff shall be responsible to notify the court as appropriate.

See attached memorandum: Mental Health 5 Inmates Who Bond Out From Court or Discharge From Court

REFERENCES: *Administrative Directive 6.4, Transportation and Community Supervision of Inmates.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-02). 2008. National Commission on Correctional Health Care. Chicago IL..

Approved: UHC - CMHC

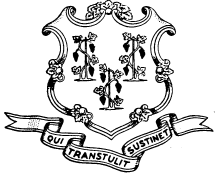
Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____



STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION
OFFENDER CLASSIFICATION & POPULATION MANAGEMENT
1153 EAST STREET SOUTH
SUFFIELD, CONNECTICUT 06080



Lynn Milling
Director

Tel (860) 292-3469
Fax (860) 292-3422

MEMORANDUM

TO: All Wardens

FROM: Lynn Milling, Director
Offender Classification & Population Management

DATE: August 17, 2012

RE: Mental Health 5 Inmates Who Bond Out From Court or
Discharge From Court

If an inmate with a mental health 5 score goes to court and either discharges from court or posts bond at court, and there are no other legal holds on file with the Department of Correction that would require their return, the inmate is **not** to be returned to the facility.

When possible, CMHC (Correctional Managed Health Care) staff shall notify Jail Diversion staff early the day prior to the inmate's court date. This will allow Jail Diversion staff time to coordinate with the offender's attorney and to make provisions for someone to be at court that is authorized to write an Emergency Transportation Certificate (ETC). The inmate would then be taken to the Emergency Room by ambulance for an evaluation.

If the inmate leaves for court without prior notification to Jail Diversion staff, for example an inmate's mental health score is raised just before transport to court or CMHC is not aware of the court date until that day, CMHC staff shall contact Jail Diversion staff as soon as possible. Jail Diversion staff will try to have someone in court who can write an ETC. If Jail Diversion staff are not in court, Department of Correction transporting staff (CTU or facility) shall call the originating facility to notify their mental health staff (CMHC). CMHC mental health staff shall confirm his/her MH 5 status and specifically his/her need for further psychiatric assessment/treatment. If CMHC indicate the inmate should be assessed at an Emergency Department, DOC transport staff shall request the Judicial Marshals contact an ambulance. If the Judicial Marshals are not available, DOC staff shall contact an ambulance or the local police for assistance. CMHC mental health staff shall arrange for the necessary information to be provided to the hospital Emergency Room where the individual will be evaluated and a determination made regarding need for treatment and/or hospitalization.

If the inmate leaves for court with a Physicians Emergency Commitment (PEC), the form needs to be provided to the Judicial Marshals as soon as the inmate arrives at court so they can take the necessary action if the inmate discharges. If a Judicial Marshal is not present, either DOC or Jail Diversion staff can contact an ambulance to have the inmate transported to the hospital. The PEC needs to be given to the ambulance in order for them to transport the client.

Please ensure the appropriate facility staff is notified of this. Please ensure your facility has the necessary procedures in place for CMHC staff to be notified of pending court dates for mental health 5 inmates.

Please note the above clarification does not change the procedures outlined in UCHC/CMHC Policy Number G 4.08, Discharge of Mental Health Level 5 Inmates. It does not change DOC protocol for the handling of inmates where police intervention/assistance is appropriate.

cc: Deputy Commissioners Cepelak and Dzurenda
Directors Rinaldi, Weir, Haggan and Garnett
Director Maurer and Bannish
Dr. Berger, UCHC/CMHC
O'Donovan Murphy, Judicial Marshals
Loel Meckel, DMHAS
Gary Roberge, CSSD
District Administrators Lajoie and Quiros
Legislative Liaison Ferguson
Director Colon, Operations
Captain DeVore, CTU
OCPM Supervisors

**UNIVERSITY OF CONNECTICUT HEALTH CENTER
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.07

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INMATE ABSTAINING FROM FOOD/FLUIDS

Effective Date: 05/07/04

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**), in conjunction with the Connecticut Department of Correction (**CDOC**), shall ensure that appropriate monitoring, assessment and treatment are provided to each inmate abstaining from food/fluids in a CDOC facility.

DEFINITION:

When an inmate abstains from food and/or fluids for more than forty-eight (48) hours without a clear medical explanation (ie. Anorexia due to chemotherapy) he/she will be assessed by medical and mental health staff and notification and monitoring begun to protect the inmate from self-harm.

PROCEDURE:

Notification

The inmate's abstinence from food/fluids shall be reported in accordance with **CDOC Administrative Directive 6.6 Reporting of Incidents** and the following facility staff shall be notified:

- The Custody Supervisor.
- The CMHC Health Services Administrator, and Nursing Supervisor or the Registered Nurse in charge of the shift.

Assessment and Documentation

A registered nurse shall conduct a baseline health assessment and document the findings on **Form HR 914 Food/Fluid Intake Monitoring Sheet**. This shall include vital signs, weight, and dipstick urinalysis for ketones. The assessment shall also include any subjective health complaints from the inmate such as the level of fatigue, irritability, and the stated reason for the abstinence from food/fluids, and observation of objective health conditions, such as the inmate's color, mucous membrane hydration, and skin elasticity. The inmate's **HR** shall be reviewed to determine if the inmate has an acute physical condition or pre-existing chronic condition.

Nursing health assessments of nutritional status, weight, and physical condition will be documented daily in the health record. Based upon nursing, medical, and psychiatric assessments and evaluations, the physician will order appropriate treatment, medical tests, and monitoring, including frequency of vital signs, and or transfer to a designated CDOC referral facility or infirmary in consultation with the CDOC Director of Psychiatric Services and the CMHC Director of Medical Services.

INMATE ABSTAINING FROM FOOD/FLUIDS

Hunger strikes differ widely in their potential lethality, with some being mere gestures and some indicating a very serious attempt to cause death, or to risk death. Some involve abstention from solid food, but generous intake of liquids; others involve complete refusal of all oral intake. The latter may move to a critically dangerous state much faster than the former. In addition, pre-existing medical conditions might accelerate the path from physiologic wellness to dangerous imbalance. The physician monitoring the hunger strike must consider this in planning a response to the hunger strike. If the hunger strike is prolonged, or may follow a rapid course due to lack of fluid intake, the physician must intensify monitoring and consultation. In addition, the facility psychiatrist shall document on the chart an evaluation of whether the inmate's abstinence is the result of a mental illness and/or cognitive defect. If the former is present and effective treatment is available, the inmate will be offered the treatment; if the inmate refuses, he/she will be referred for involuntary psychotropic medication.

Treatment

Prolonged abstinence from food and/or fluid intake shall be considered serious self-injurious behavior and the inmate considered to be in a decompensated state. The HSA/designee will notify the CDOC Director of Psychiatry, the CMHC Director of Medical Services, the facility Nursing Supervisor and the facility Warden.

- When clinically indicated, the inmate will be placed in an infirmary cell on MH observation and a safety gown and blanket utilized, as per CMHC Policy for Mental Health Observation.
- Since unsupervised time out of cell is potentially dangerous for a patient who is acutely self-injurious, the inmate will be confined to his/her cell except when supervised by staff.
- Daily counseling, as well as a concerted effort to provide food and encourage eating, will be the focus of the Mental Health intervention. Nursing will carefully document all intake and output as well as refused meals.
- Daily updates will be provided by the facility Nursing Supervisor/designee to the HSA/designee who shall notify the facility Warden, the CMHC Director of Medical Services, and the CDOC Director of Psychiatry for inmates who engage in a prolonged abstinence from food/fluid.
- Sensationalism or unnecessary attention toward the abstinence of food/fluids should be avoided. In the event there is more than one inmate at a facility abstaining from food/fluids at the same time, the inmates should be separated.

When abstinence from food and/or fluid intake is associated with a serious mental illness, psychotropic medication shall be used as needed. Emergency involuntary medication shall be used as needed to prevent further decompensation and death as clinically indicated. A panel for involuntary medication treatment can be utilized if the situation is non-emergent.

If the physician and psychiatrist following the patient concur that the inmate is on a trajectory that within the near future may produce an imminent risk of danger to him or herself, they will consult with the CDOC Director of Psychiatry and the CMHC Director of Medical Services. If the team concludes that a risk of imminent danger exists, the CDOC Director of Psychiatry will notify the CDOC Attorney General's Office (AAG) of the situation and will provide appropriate updates, cooperating with the office of the Attorney General in providing medical records, other requested

INMATE ABSTAINING FROM FOOD/FLUIDS

documentation, and testimony or affidavits as necessary. The CDOC Director of Psychiatry shall provide as much advance notice to the Attorney General's office as possible.

Involuntary Feeding

The CMHC Director of Mental Health and Psychiatric Services will inform the CDOC AAG of any hunger striking inmate who may need a court order for involuntary feeding.

An integrated Behavioral Management Plan must be devised by the facility psychologist for any inmate requiring involuntary feeding or requiring either emergency or paneled involuntary psychotropic medication treatment.

Medical interventions shall be done in the infirmary setting in a private room. In order to minimize sensationalism and unnecessary attention to the hunger strike and its treatment, actual interventions will not be videotaped. However, before each forcible intervention (such as insertion of an intravenous line or naso-gastric tube), the CDOC or CMHC health professional delivering the treatment will be videotaped speaking with the inmate, explaining the need for and nature of the procedure, and offering the inmate the opportunity to make the treatment unnecessary by ingesting significant amounts of food and fluids.

Meals

Regular, normally scheduled meals shall be provided by CDOC facility kitchen staff and served to an inmate abstaining from food/fluids, despite refusal of meals. The meal shall be left with the inmate for at least one hour. Nursing staff shall document food and liquids consumed. Water shall be provided to the inmate for drinking and hygiene.

Upon resuming Food and/or Fluid Intake

When the inmate resumes eating and drinking consistently, a health assessment of the inmate shall be conducted by a CMHC Registered Nurse and reported to the responsible physician. The observation and assessment of the inmate who has resumed intake shall continue for at least one week. Further treatment and appropriate housing will be determined by the inmate's treatment team and the responsible custody staff. When the inmate is able to return to regular housing and no longer requires ongoing monitoring, the facility Warden, the CMHC Director of Medical Services, and the CDOC Director of Psychiatry will be notified by the facility Nursing Supervisor and the CMHC charge nurse shall complete **Form CN 6602, Medical Incident Report**, in accordance with **CDOC Administrative Directive 6.6, Reporting of Incidents**.

Documentation

INMATE ABSTAINING FROM FOOD/FLUIDS

Documentation of all health data relative to an inmate who is monitored for abstinence from food/fluids shall be completed by qualified nursing staff on **Form HR 914 Food/Fluid Intake Monitoring Sheet**, as well as on **HR 401 Clinical Record Form** and filed in the inmate HR.

REFERENCES: *NCCHC Standard P-G-05, Suicide Prevention Program (essential) Program Statement, Hunger Strikes, U.S. Department of Justice, Federal Bureau of Prisons, 7/29/2005.*

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD	_____
Title: CMHC Director MH and Psychiatric Services, Robert Berger MD	_____
Title: CMHC Director Medical Services, Mark Buchanan MD	_____
Title: CDOC Director Health Services, Daniel Bannish PsyD	_____

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 2.08

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ANTICOAGULATION MANAGEMENT GUIDELINES

Effective Date: 03/01/12

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) will ensure that all inmates in Connecticut Department of Correction (**CDOC**) facilities who are prescribed anticoagulant therapy are afforded clinical care equivalent to the standard of care afforded patients in the community.

PROCEDURE:

When CMHC staff has determined from **Form HR 001, Intake Health Screening** or by new diagnosis that an inmate has been prescribed anticoagulant therapy, an immediate referral will be made to the CMHC prescriber assigned to the facility for the purpose of determining initial therapy.

- When the CMHC prescriber is not available for any reason, the on-call physician will be contacted immediately for treatment orders in accordance with the provisions contained herein.

In addition, CMHC staff will implement the following procedures:

1. History and Physical Exam

A health assessment, consisting of a health history and physical exam will be performed following admission unless **Form HR 002, Physical Exam M/F** was completed within the last 3 months.

The history will focus on relevant information known at the time of the visit.

- The reason (diagnosis) for which anticoagulation therapy has been prescribed.
- The name, dose, route, time and frequency of anticoagulation therapy.
 - Also, for newly incarcerated inmates, the date/time of the last dose, name and contact information of the last clinic or prescriber who prescribed the medication, and expected duration of anticoagulation therapy (if known).
- A review of other current medications, including dosage, time and frequency
- History of potential adverse side effects such as gastrointestinal bleeding

Revision Date: 05/16/14

ANTICOAGULATION MANAGEMENT GUIDELINES

- Hospitalizations(reasons and approximate dates)

2. Clinical Management

- Physician/APRN/or PA **orders are required** for initiation, continuation, and modification of anticoagulant therapy. This includes medications and laboratory testing. Therapy is based on its indication and known side effect risk factors. Although the following evidence-based resources are recommended, individual inmate therapeutic responses may require deviation.
 - Recommended INR (International Normalized Ratio) Target and Duration of Warfarin Therapy by Indication (Appendix A)
 - Recommended Warfarin Initial Dosing Algorithm (Appendix B)
 - Warfarin Dosage Adjustment Algorithms (Appendix C)
 - Management of High INR Values (Appendix D)
 - Warfarin Interactions (Appendix E)
- Due to the potential for increased serious bleeding risk, **bottom bunk** status is **required**.
- For **any reported or suspected overdose**: **Call Poison Control Hotline: 860-679-3456** (*If a prescriber is not on site, nursing staff is to initiate this action and also contact the on-call physician*)
- For **any serious bleeding refer immediately to the emergency department** (*If a prescriber is not on site, if vital signs are unstable, nursing staff is to initiate this action and also contact the on-call physician*)
- **Nursing staff is responsible for notifying the on-site** medical physician/APRN/PA (**or on-call** physician if there is no **medical prescriber** on site) **of reported INR** (International Normalized Ratio) **values above the upper therapeutic limit established** by the physician, APRN, or PA (see documentation of anticoagulation treatment plan below).
 - At the time of notification, nursing staff should be prepared to provide information documented on the Anticoagulation Flowsheet (**Form 704**). This includes any treatment adherence (compliance) and/or complication issues.

3. Documentation:

ANTICOAGULATION MANAGEMENT GUIDELINES

- The initial anticoagulation treatment plan and any modifications are to be documented by the physician/APRN/PA on the Anticoagulation Flowsheet (**Form 704. Parts 1 and 2**). In addition:
 - Orders for anticoagulant medications are to be documented on the Physician’s order Sheet (**Form HR924**).
 - Orders for laboratory testing are to be entered into PSS (Patient Safety System). (See CMHC policy **P1.05** Laboratory Test Ordering and Test Reports, **P1.01** Downtime Procedures, and related policies).
- Nursing staff is responsible for completing Part 3 of the Anticoagulation Flowsheet (**Form 704**).
- Adherence to treatment (compliance) and complication findings are to be documented fully in the Clinical Record (Form **HR401**)

REFERENCES:

American College of Chest Physicians: Guidelines,2008; <http://www.mdcalc.com/chads2-score-for-atrial-fibrillation-stroke-risk>.

Ebell MH. A systematic approach to managing warfarin doses. *Fam Pract Manage.* 2005;77-83. Available from: <http://www.aafp.org/fpm/20050500/77asys.html>

Federal Bureau of Prisons 2008 Clinical Practice Guidelines

Hirsh J, Guyatt G, Albers GW, et al. Executive summary: American College of Chest Physicians evidence-based clinical practice guidelines [8th edition]. *Chest.* 2008;133:72S.)

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

Title: CMHC Director of Medical Services, Johnny Wu MD

Title: CDOC Director Health Services, Kathleen Maurer MD

Appendix A: CMHC Policy G 2.08 Anticoagulation Management Guidelines

Recommended INR Target and Duration of Warfarin Therapy by Indication

Indication	Target INR (range)	Duration of therapy
Deep venous thrombosis (DVT) and pulmonary embolism (PE)^α		
First episode secondary to reversible risk factor(s)	2.5 (2.0-3.0)	3 months
First episode (idiopathic)		6-12 months (consider indefinitely)
In patients with cancer		LMWH for 3-6 months; then warfarin indefinitely
In patients with antiphospholipid antibodies <i>or</i> who have 2 or more thrombophilic conditions		12 months (consider indefinitely)
In patients with a deficiency of antithrombin III or proteins C or S, gene mutation for factor V Leiden or prothrombin 2010, homocystinemia, or high factor VIII levels		6-12 months (consider indefinitely)
Two episodes of objectively documented unprovoked (i.e. isolated non-traumatic) events		Indefinitely
Atrial fibrillation (AF) or flutter		
High risk of stroke ^β	2.5 (2.0-3.0)	Indefinitely
Elective Cardioversion		3 wks before & 4 wks after conversion
Valvular Disease		
Rheumatic mitral valve disease with atrial fibrillation or a history of systemic embolism	2.5 (2.0-3.0)	Indefinitely
St. Jude Medical bileaflet, Carbometrics, or Medtronic Hall mechanical valves in aortic position	2.5 (2.0-3.0)	Indefinitely
Valve (any design) in mitral position	3.0 (2.5-3.5)	Indefinitely
Ball/Cage (any design, any position)	3.0 (2.5-3.5)	Indefinitely with aspirin
Mechanical valves <i>plus</i> an additional risk factor (such as atrial fibrillation, myocardial infarction, left atrial enlargement, low ejection fraction)	3.0 (2.5-3.5)	Indefinitely
Bioprosthetic valves (any position)	2.5 (2.0-3.0)	Three months
Coronary heart disease		
High risk patients ^Ω with myocardial infarction	2.5 (2.0-3.0)	3 months with aspirin (indefinitely)

INR = International Normalized Ratio

LMWH = low molecular weight heparin

^α Recommendation is to start warfarin therapy on the first treatment day with LMWH or unfractionated heparin.

^β Risk factors for embolic events based on the CHADS2 scoring system:

One point each: History of CHF €, Hypertension €, diabetes €, or age ≥ 75 €

Two points: Prior TIA or stroke symptoms €

Total score: _____

Estimated risk based on total CHADS2 score: 0=Low; 1=Moderate; ≥2 High.

^Ω Patients with large anterior wall myocardial infarction, significant heart failure, intracardiac thrombus visible on Echocardiography, history of thromboembolic event.

Adapted from: Federal Bureau of Prisons, Clinical Practice Guidelines, 2008. References: ACCP Guidelines, 2008; <http://www.mdcalc.com/chads2-score-for-atrial-fibrillation-stroke-risk>.

Effective Date: 03/01/12

Appendix B: CMHC Policy G 2.08 Anticoagulation Management Guidelines

Recommended Warfarin Initial Dosing Algorithm

The results of a baseline INR should be obtained prior to initiating therapy. Patients who are prescribed both LMWH and warfarin should continue LMWH until a therapeutic INR has been achieved. Once warfarin is initiated, an INR ideally should be obtained from “Day 3” on until two consecutive INRs are in therapeutic range. For settings without on-site INR capability, INRs should be obtained every 1–3 days. Lacking availability of daily INRs, adjust warfarin dose more gradually than in the schedule outlined below.

Day	INR	Warfarin Dose
Day 1 (Administer LMWH)	Baseline INR	5 mg (3 mg if age >65 or if decreased dose is indicated ³)
▼		
Day 2 (Continue LMWH)	No INR required	Same dose as Day 1
▼		
Day 3 (Continue LMWH)	<1.5	5–7.5 mg
	1.5–1.9	2.5–5 mg
	2–2.5	0–2.5 mg
	>2.5	hold
▼		
Day 4 (Continue LMWH)	<1.5	10 mg
	1.5–1.9	5–7.5 mg
	2–3	0–5 mg
	>3	hold
▼		
Day 5 (Final dose of LMWH if therapeutic INR x2)	<1.5	10 mg
	1.5–1.9	5–10 mg
	2–3	0–5 mg
	>3	hold
▼		
Day 6 (Final dose of LMWH if therapeutic INR x2)	<1.5	7.5–12.5 mg
	1.5–1.9	5–10 mg
	2–3	0–7.5 mg
	>3	hold

Notes:

- ¹ This algorithm applies to patients who are either treated with LMWH and warfarin in combination, or treated with warfarin alone. LMWH can be discontinued when two consecutive therapeutic INR values are achieved (see Note #5 below.)
- ² This algorithm applies for therapeutic INR targets of 2.5 and 3.0. Therapeutic INR goals vary based on indication (see [Appendix A](#)).
- ³ Initial warfarin dose should be decreased to 3 mg or less if age >65 or if liver disease, congestive heart failure or high risk of bleeding.
- ⁴ All dosing changes are made after lab error, drug-drug interactions, changes in diet, and non-compliance issues are ruled out. Provider may recheck PT/INR before changing dose if one of these issues is suspected and resolved.
- ⁵ Once the INR has been within the therapeutic range for two consecutive tests and after at least 5 doses, consult [Appendix C: Warfarin Dosage Adjustment Algorithms](#) for dosing adjustments.
- ⁶ Warfarin should generally be administered via pill-line during the initial dosing. For patients on long-term therapy, administering warfarin via pill-line should be evaluated individually, based on his or her record of compliance with therapy.
Adapted from: Claremore Indian Hospital. Anticoagulation Services protocol. Oklahoma City, OK: Claremore Indian Hospital; 2001.

Physician/APRN/ or PA orders are required for all medication or test orders
Orders are to be documented on the Physician’s Order Sheet (HR925)

Taken from FBOP 2008 Clinical Practice Guidelines

Effective Date: 03/01/12

Appendix C: CMHC Policy G 2.08 Anticoagulation Management Guidelines

Warfarin Dosage Adjustment Algorithms

For target INR of 2.0 to 3.0, no bleeding						
INR	<1.5	1.5 to 1.9	2.0 to 3.0	3.1 to 3.9	4.0 to 4.9	> 5.0
Adjustment	Increase dose by 10–20%; consider extra dose	Increase dose by 5–10% †	No change	Decrease dose by 5–10% †	Hold for 0–1 day, then decrease dose by 10%	See Management of High INR Values*
Next INR	4–8 days	7–10 days	1 week x the number of consecutive in-range INRs (max: 4 wks) ‡	7–10 days	4–8 days	See Management of High INR Values*

For target INR of 2.5 to 3.5, no bleeding						
INR	<1.5	1.5 to 2.4	2.5 to 3.5	3.6 to 4.5	4.6 to 5.0	> 5.0
Adjustment	Increase dose by 10–20%; consider extra dose	Increase dose by 5–10% §	No change	Decrease dose by 5–10%; consider holding one dose §	Hold for 1–2 days, then decrease dose by 5–15%	See Management of High INR Values*
Next INR	4–8 days	7–10 days	1 week x the number of consecutive in-range INRs (max: 4 wks) ‡	7–10 days	2–8 days	See Management of High INR Values*

Physician/APRN/ or PA orders are required for all medication or test orders

Orders are to be documented on the Physician's Order Sheet (HR925)

* See, *Management of High INR Values* for further guidance.

† If INR is 1.8–1.9 or 3.1–3.2, consider no change with a repeat INR in 7–10 days.

‡ For example, if a patient has had 3 consecutive INRs within therapeutic range, then schedule a return visit for 3 weeks. If a patient has had 4 or more consecutive INRs within therapeutic range, the return visit should be scheduled within 4 weeks.

§ If INR is 2.3–2.4 or 3.6–3.7, consider no change with a repeat INR in 7–10 days.

Taken from FBOP Clinical Guidelines which were adapted from (permission pending): Ebell MH. A systematic approach to managing warfarin doses. Fam Pract Manage. 2005;77-83. Available at: www.aafp.org/fpm/20050500/77asys.html

Management of High INR Values

INR	Clinical Presentation		Action
ANY		Reported or Suspected Overdose	<ul style="list-style-type: none"> ➤ Call Poison Control Hotline: 860-679-3456 <i>(If a prescriber is not on site, nursing staff is to initiate this action and also contact the on-call physician)</i>
ANY		Serious Bleeding	<ul style="list-style-type: none"> ➤ Refer immediately to the emergency department <i>(If a prescriber is not on site, if vital signs are unstable, nursing staff is to initiate this action and also contact the on-call physician)</i>
5 to 9*	AND	No bleeding or risk factors for significant bleeding	<ul style="list-style-type: none"> ➤ Omit the next 1 to 2 warfarin doses ➤ Recheck INR ➤ Resume therapy at an appropriately adjusted, reduced dose when INR is therapeutic. ➤ Monitor INR more frequently
		No bleeding, but at risk for significant bleeding	<ul style="list-style-type: none"> ➤ Omit the next 1 to 2 warfarin doses AND Administer vitamin K (<i>phytonadine</i> = Mephyton) 2.5 mg orally. (INR should be reduced in 24 to 48 hours.) ➤ Recheck INR ➤ Resume warfarin therapy at an appropriately adjusted, reduced dose when INR is therapeutic. ➤ Monitor INR more frequently.
>9*	AND	No clinically significant bleeding	<ul style="list-style-type: none"> ➤ Hold warfarin therapy AND ➤ Give vitamin K (<i>phytonadine</i> = Mephyton) 5 mg orally. (INR should be reduced substantially in 24 to 48 hours.) ➤ Repeat vitamin K, as needed. ➤ Resume warfarin therapy at an appropriately adjusted, reduced dose when INR is therapeutic. ➤ Monitor INR more frequently

***Physician/APRN/ or PA orders are required for all medication or test orders
Orders are to be documented on the Physician's Order Sheet (HR925)**

Adapted from FBOP 2008 Clinical Practice Guidelines (*Reference: Hirsh J, Guyatt G, Albers GW, et al. Executive summary: American College of Chest Physicians evidence-based clinical practice guidelines [8th edition]. Chest. 2008;133:72S.*)

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
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FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 3.01

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INFIRMARY ADMISSION AND CARE

Effective Date: 04/01/01

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that infirmaries operating within Connecticut Department of Correction (**CDOC**) facilities shall be utilized to provide health care to medical and mental health inmates that do not require community hospitalization and are properly equipped and appropriately staffed to provide twenty-four (24) hour nursing care to patients admitted to these Infirmaries.

The status of patients in the Infirmary shall be designated as Overnight Stay (medical or MH), Short-term Stay (medical or MH), MH4 (temporary), Long-term Stay (medical), or Hospice (medical).

The Nursing Supervisor or designee shall conduct Infirmary unit tours at least once per week, and the Health Services Administrator shall tour at least monthly. Tours shall be documented in the DOC facility log book.

DEFINITION:

Infirmary: A designated area within a CDOC facility that maintains and operates organized care and services for patients formally admitted to that area for medical and/or mental health treatment for a period of 24 hours or longer, and operated for the purpose of providing nursing care to those patients requiring a level of care greater than outpatient, but who do not require hospitalization in the community.

Mental Health 4: An inmate with a mental health disorder severe enough to require specialized housing or ongoing intensive mental health treatment. These are patients who need a higher level of care than general population (MH3) but less than acute, crisis level infirmary care (MH5). Therefore in facilities that do not have a specialized housing location required for MH4 patients, these patients can be temporarily housed in the infirmary. These patients are in transition for either transfer internally to general population if improved, or, transfer to a MH 4 level facility if intensive services continue to be required.

PROCEDURE:

Admission

Initial orders for admission to CDOC Infirmaries shall occur upon the order of the appropriate CMHC physician, APRN or Physician's Assistant on **Form HR 925G, Infirmary Admission Orders**.

INFIRMARY ADMISSION AND CARE

For mental health patients identified for potential admission, the on-site psychologist, social worker, or professional counselor when available, shall document in HR 401 the findings of their assessment and rationale for admission. The nurse shall obtain a prescriber order from an on-site prescriber or on-call psychiatrist.

An admission note, including the reason for the admission and a clinical assessment shall be documented in the health record on **Form HR 401 Clinical Record** by the admitting nurse.

- *All existing medication orders (Medical and Mental Health) shall be reviewed.*
- *All **existing** medication orders (Medical and Mental Health) shall be rewritten if to be continued, with the exception of inmates assigned to Overnight Stay or MH4's.*
- *All order sheets shall be scanned to the pharmacy even if there are no medication orders, so pharmacy is aware of the inmate's new location.*

For inmates newly admitted to the infirmary for mental health:

- If a patient has been in the infirmary for 72 hours, and “routine” blood tests have not been done, the nurse shall discuss with a prescriber the appropriateness of obtaining these tests. The prescriber may order them or may affirmatively state that they are not necessary.
 - “Routine” tests are defined as CBC, Chem 7, and liver function, and for those over 40 years old, an EKG.
 - The nurse need not seek “routine” orders for blood tests if they had been performed within 2 weeks prior to admission, or for an EKG if it had been performed within 12 months prior to admission.
- For patients prescribed Lithium, Depakote, and/or Tegretol blood levels shall be ordered as appropriate.

Care Management

The physician, APRN, PA, or doctoral level psychologist for MH treatment, shall be responsible for the health care of inmates admitted to the infirmary and shall at a minimum, evaluate patients and document findings based on the patient’s designated status (see Level of Care descriptions at the end of this policy). A physician shall be available, on-call, 24 hours a day for telephone consultation.

HIV Inmates/Inmates Requiring IDS

- HIV Inmates admitted to the infirmary for HIV infection or any condition requiring the specialized expertise of an Infectious Disease Specialist (IDS), shall be examined by the IDS weekly, or more frequently if medically indicated. Documentation in the health record shall reflect the IDS encounter/examination.
- If the admitting prescriber is other than an IDS, the medical prescriber shall notify the IDS, at the time of admission, by telephone or e-mail of the admission and need for follow-up.
- The admitting prescriber or the infirmary nurse shall notify the facility HIV Coordinator/designee of the admission within the shift admitted, but no later than 24 hours.

INFIRMARY ADMISSION AND CARE

- After initial examination by the IDS, the IDS shall determine whether the admission requires oversight by the IDS.
- The HIV Coordinator/designee shall tour the infirmary daily when in the facility but no less than twice weekly and document at least weekly in the health record, unless more frequent documentation is required.
- The HIV Coordinator shall communicate pertinent issue to the IDS between visits.

A Mental Health Clinician and/or Nurse Clinician shall conduct tours at least every 24 hours on patients admitted to the Infirmary for psychiatric care and document the tour in the DOC facility log book.

For admissions involving a transfer from a different DOC facility, form **HR 005 Transfer Summary** and clinical documentation on **HR 401 Clinical Record** is required. A verbal report shall occur between the sending and receiving DOC functional unit/facility regarding the patients' clinical orders.

A Registered Nurse shall be available in the facility 24 hours a day and be responsible for planning, organizing, and administering nursing services in the in accordance with provisions contained in CMHC policies and procedures. A Registered Nurse shall write a plan of care/treatment plan.

Only an RN may administer IV medications (diluted or undiluted).

CMHC nursing staff shall:

- Complete **Admission Record (Form HR 404) – Nursing, and Nursing Care Plan (Form HR 405)** on all patients, with the exception of Overnight Stay inmates and MH4 patients temporarily housed in the infirmary. CMHC licensed staff (LPN) may initiate nursing care plans, but they shall be co-signed by an RN.
- If Overnight Stay extends beyond 24 hours, a new level of care (*Short-term Stay, Long-term Stay, or Hospice*) needs to be ordered and **Forms HR 404** and **HR 405** shall be completed.
- Weigh patients, unless there is a documented reason to the contrary (i.e., wheelchair, over 400 lbs. etc.)
- Take patient vital signs in the Infirmary per guidelines for Overnight, Short-term or Long-term stay or Hospice Care (see next page) and record on form **HR 105** unless directed otherwise by a physician order.
- Consult with a physician, APRN, PA, about the need for an order for intake and output upon admission and as needed throughout the stay.
- Provide communication from one shift to the next (report). This report shall include nursing staff and other staff (i.e., mental health) as appropriate.
- Following report, at a minimum, the charge nurse shall conduct a tour on all patients and sign the facility log book each shift.

No separate health record shall be created for the admission.

The documentation shall include at a minimum:

- Documentation in SOAP format
- An admission note
- Nursing care plan (except for Overnight Stay)

INFIRMARY ADMISSION AND CARE

- Mental Health treatment plan
A Qualified Mental Health Clinician shall review/revise **Form HR 514 Mental Health Services Treatment Plan** on all mental health patients with the exception of inmates on Overnight Stay (< 24 hours).
- If Overnight Stay extends beyond 24 hours, a new level of care (*Short-term Stay, Long-term Stay, or Hospice*) needs to be ordered and **Form HR 514** shall be reviewed/revise.

- Prescriber note required:
 - Overnight Stay (medical/MH): As appropriate.
 - Short-term Stay (medical and MH) and MH4: minimum of twice a week (signs of worsening disease or newly identified problems would indicate a need for more frequent documentation).
 - Long-term Stay (medical): minimum of twice a month (signs of worsening disease or newly identified problems would indicate a need for more frequent documentation).
 - Hospice: minimum of twice a month (signs of worsening disease or newly identified problems would indicate a need for more frequent documentation).

- Nursing note required:
LPN's may document in the HR without the co-signature of an RN.
 - Overnight Stay: initial placement note, significant event (s), exit note; minimum once q shift.
 - Short-term Stay: minimum of once q shift and for significant event; I & O, VS, q shift unless otherwise ordered.
 - Long-term Stay and temporary MH4: unless significant event, minimum of once/day; VS, I& O and other assessments as ordered, or indicated by nursing protocols.
 - Hospice Care: minimum of once/week and for significant event, unless otherwise ordered.

- Complete record of the care and treatment given to the patient while in the Infirmary.

Discharge From Infirmary

- Discharges from CDOC Infirmaries shall occur upon the order of the appropriate CMHC physician, APRN or Physician's Assistant .

INFIRMARY ADMISSION AND CARE

- For patients admitted for MH, a doctoral level psychologist may write a clinical discharge treatment note on form **HR 401 Clinical Record**, and the nurse shall obtain a CMHC physician, APRN or Physician’s Assistant order from an on-site prescriber or on-call physician.
 - Nurses shall complete a discharge summary on all discharged patients with the exception of inmates assigned to Overnight Stay and MH4’s.
- CMHC licensed staff shall complete **Form HR 406A, Medical Discharge Summary** or **Form HR 522 Mental Health Inpatient/Housing Discharge Summary**, with the exception of inmates assigned to Overnight Stay and MH4’s.
- *All existing medication orders (Medical and Mental Health) shall be rewritten if to be continued, with the exception of inmates assigned to Overnight Stay and MH4’s.*

Admission to Short-term Stay, Long-term Stay, or Hospice Following Discontinuation of Short-term Stay

- If Overnight Stay extends beyond 24 hours, a new **Infirmary Admission Orders, Form HR 925G** shall be completed for designation as Short-term Stay, Long-term Stay, or Hospice. All orders (including medications) shall be reviewed and rewritten if to be continued.

Levels of Care: Descriptions and Examples

Overnight Stay: Medical, MH

1. Description	A. Medical/Mental Health overnight stay (<24 hrs)
2. Examples	<ul style="list-style-type: none"> A. Newly returned from a community ER B. NPO pending diagnostic test C. Pending MH review D. Observation for acute medical issue (injury sustained during an altercation) E. Acute reaction to stress

Short-term Stay: Medical, MH

1. Description	<ul style="list-style-type: none"> A. Expected stay ≤ two weeks. B. Acute care hospitalization is not indicated
1. Examples	<ul style="list-style-type: none"> A. Recovery following release from hospital B. Exacerbation of a medical problem: <ul style="list-style-type: none"> • Asthma or COPD • Pneumonia • Suspected or confirmed tuberculosis • Seizures • Uncontrolled diabetes • Cellulitis

INFIRMARY ADMISSION AND CARE

C. MH Admissions

Long-term Stay: Medical

1. Description	A. Expected stay > 2 weeks B. Monitoring activity restriction, and/or assistance with ADLs are needed
2. Examples	A. Chronic medical problems <ul style="list-style-type: none"> • Paralysis • Non-healing surgical wounds • Decubitus or peripheral vascular ulcers • End-stage (organ or systemic) disease

Hospice: Medical

1. Description	A. Admitted to CTDOC Hospice for end-of-life care
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REFERENCES: *Administrative Directives 8.1, Scope of Health Services.* 2007; 6.1, Tours and Inspections, 2005. Connecticut Department of Correction.
Prison Health Care: Guidelines for the Management of an Adequate Delivery. 1991. National Institute of Corrections. U.S. Department of Justice.
Standards for Health Services in Prisons (P-G-03). 2014. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director Robert Trestman MD PhD _____	
Title: CMHC Director of Medical Services Johnny Wu MD _____	
Title: CMHC Dir. MH and Psychiatric Services Robert Berger MD _____	
Title: CDOC Director Health Services, Kathleen Maurer MD _____	
Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____	

**UCONN HEALTH
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MENTAL HEALTH SERVICES: TREATMENT PLANNING

Effective Date: 10/01/04

POLICY: UConn Health, Correctional Managed Health Care (CMHC) staff shall develop and implement an individualized plan of treatment to guide clinically appropriate mental health care to inmates with a Mental Health classification score of MH3 or higher in the custody of the Connecticut Department of Correction (**CDOC**).

Individualized treatment plans shall be developed through a collaborative team approach with the over-all expectation that the inmate be able to function in the least restrictive environment.

Treatment plans shall be developed with input from staff and the patients. Identified goals shall be measurable and interventions shall include input from both inmate and staff. American Disabilities Act (ADA) accommodations, including recommendations shall be part of the plan when indicated.

PROCEDURE:

A preliminary Treatment Plan shall be developed when an inmate is made a MH 3 or higher and will be documented on **HR 504 Mental Health Screening, or HR 508 Mental Health Assessment, or HR 401 Clinical Record. The inmate shall be scheduled and seen within 30 days for a treatment plan review and the patient's treatment needs assessed and the frequency of clinical sessions identified and documented in the health record.** If the inmate/patient remains a MH 3 or higher for longer than 90 days, the mental health treatment plan shall be documented using **Form HR 514 Mental Health Services Interdisciplinary Treatment Plan (MHTP).**

1. The MHTP includes the following documentation at a minimum:
 - a. Frequency of follow-up for evaluation and adjustment of treatment modalities,
 - b. Adjustment of psychotropic medication, if indicated,
 - c. Referrals for psychological testing, medical testing, and evaluation, including blood levels for medication monitoring as required,
 - d. When appropriate, instructions about diet, exercise, personal hygiene issues, and adaptation to the correctional environment and

TREATMENT PLANNING-MENTAL HEALTH SERVICES

- e. Treatment goals and notation of clinical status progress (stable, improving, or deteriorating).
- 2. The MHTP shall be reviewed/revised every 90 days and documented on **Form HR 514 MHTP**.
- 3. The MHTP is reviewed/revised upon admission to and discharge from the infirmary for mental health reasons and may be documented in **Form HR 522 Mental Health Infirmary Discharge Summary**.
- 4. Patient care shall be coordinated between inpatient staff and outpatient staff. Treatment coordination shall occur prior to inmate's release from the inpatient setting. A discharge note shall be documented in the health record.
- 5. The treatment plan shall be reviewed by the facility discharge planner prior to discharge.

REFERENCES: *Administrative Directives, 8.5, Mental Health Services*. 2008. Connecticut Department of Correction.
Standards for Adult Correctional Institutions (4-4373). 2003. American Correctional Association.
Standards for Health Services in Prisons (P-G-04). 2014. National Commission on Correctional Health Care. Chicago IL.

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____	
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**UConn Health
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PLANNED USE OF FORCE ON INMATES

Effective Date: 05/09

POLICY: Prior to the planned use of force the QMHP at the request of CDOC shall attempt to verbally counsel the inmate to cease the behavior that has led to the planned use of force. These efforts shall be documented on a medical incident report CN 6001. Refer to DOC AD 6.5 Use of Force.

DEFINITION: **Qualified Mental Health Professional/Practitioner (QMHP)** means psychiatrists, mental health APRNs, psychologists, social workers, licensed professional counselor, nurses, and any 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. Social workers, licensed professional counselors, and nurses may consult with a mental health supervisor or psychiatric prescriber whenever possible.

REFERENCES: *Administrative Directive, 8.8 Psychoactive Medication. 2008; 6.5 use of Force 9.5 Code of Penal Discipline, 2008. Connecticut Department of Correction.*
Connecticut General Statutes 18-81d(a)(b). 1998.
Standards for Health Services in Prisons (P-G-04). 2014. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

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MENTAL HEALTH REVIEW OF DISCIPLINARY REPORTS

Effective Date: 06/28/06

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure collaboration with custody staff members prior to the delivery of a disciplinary report to an inmate with a MH classification score of 4 or 5, or when custody staff request a mental health review.

PROCEDURE: A QMHP shall complete **Form CN 9510 Mental Health Disciplinary Review** (rev, March 2014). **Within 24 hours or as soon as inmate and staff are available.**

This will include:

- A review of the healthcare record
- A review of the incident report, if available.
- An interview with the inmate when possible in private.
- A copy of the completed MH Disciplinary Review Form CN 9510 shall be placed in the health record, and a note documenting the review shall be written on Clinical Record HR 401.
- Social workers, licensed professional counselors, and nurses may consult a mental health supervisor or prescriber prior to or subsequent to completing the form.
- MH information relevant to the disciplinary process shall be communicated to custody in the appropriate venue.

The custody supervisor shall ensure form **CN 9510** is reviewed, signed, and the disciplinary report is delivered when appropriate.

REFERENCES: *Administrative Directive 9.5, Code of Penal Discipline.* 2008.
Connecticut Department of Correction.
Standards for Health Services in Prisons P-G-04, Mental Health Services.
2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. Of MH and Psychiatric Services, Robert Berger MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

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BEHAVIORAL OBSERVATION STATUS (BOS)

Effective Date: 12/28/06

POLICY:

Behavioral Observation Status (BOS) may be initiated for inmates who are using maladaptive behaviors, such as threatening self harm without intent or destroying property to avoid compliance with custody requirements such as housing or disciplinary actions. Behavioral Observation Status is utilized in areas other than the infirmary but shall be limited to a housing area in which custody staff routinely conduct 15 minute tours. Safety gown and blanket should be ordered and limitations to the provision of in-cell items and out of cell time shall be noted. BOS is not used as a punishment or as an alternative to disciplinary action. The purpose of BOS is to enhance safety and observation when infirmary placement is not clinically indicated.

DEFINITION:

Behavioral Observation Status: An intervention to extinguish maladaptive behaviors while maintaining safety and security of the inmate.

PROCEDURE:

1. Behavioral Observation Status is initiated by the psychiatrist, psychologist, mental health APRN, social worker, or licensed professional counselor for inmates with a MH classification of 1-4 who are exhibiting maladaptive behaviors, following face-to-face assessment of the inmate and review of the current health record, including completion of Form HR 517 Suicide Risk Assessment. Staff shall document the findings and reason for initiating BOS in the HR. If none of the above staff are on-site, a registered nurse may initiate BOS upon consultation with the on-call psychiatrist and document the telephone content in the HR.
2. The custody supervisor shall be notified of the Behavioral Observation Status.
3. The use of a safety gown and/or blanket and the limitation of in-cell items shall be implemented and out of cell time/movement shall be determined as clinically indicated. MH staff shall work with the inmate to diminish maladaptive behaviors. After 4 days of BOS placement there should be some documentation regarding formulation of a plan for removal from BOS. In the event an inmate continues on BOS for 7 (seven) days, the psychologist shall establish a written Behavior Management Plan (BMP) to help extinguish maladaptive behaviors, and ensure the safety of the inmate.
4. Inmates on Behavioral Observation Status shall be evaluated daily by a qualified mental health professional and the outcome documented in the inmate's health record.

BEHAVIORAL OBSERVATION STATUS

- 5. Behavioral Observation Status shall be concluded by a psychologist, psychiatrist, or mental health APRN and documented in the health record.
- 6. Upon conclusion of Behavioral Observation Status, mental health staff shall see the inmate the following day to evaluate current condition and document the encounter in the HR. Subsequent follow-up shall occur as clinically indicated.

REFERENCES

Administrative Directives, 8.5, Mental Health Services. 2008. Connecticut Department of Correction.
Standards for Adult Correctional Institutions 4th Edition. 2003. American Correctional Association.
Standards for Health Services in Prisons (P-G-04). 2014. National Commission on Correctional Health Care. Chicago IL.

Approved: UConn Health - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

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**UCONN HEALTH
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PSYCHOACTIVE MEDICATION

Effective Date: 04/01/01

POLICY:

Psychoactive medication shall be prescribed for inmates in Connecticut Department of Correction (**CDOC**) facilities when medically indicated by order of a psychiatrist or mental health APRN. Each inmate prescribed a psychoactive medication shall have a diagnosis in accordance with DSM. CMHC Disease Management Guidelines shall be available to the prescriber for review and consideration.

PROCEDURE:

1. Inmates newly admitted to CDOC intake facilities who are currently prescribed psychoactive medications in the community shall have that medication or its equivalent prescribed, when deemed clinically indicated, within twenty-four hours of admission by either an on-site psychiatrist/APRN or if not available, the on-call psychiatrist.
 - Any patient who reports benzodiazepine use in the community shall be placed on a CIWA-B (Clinical Institute Withdrawal Assessment - Benzodiazepine) protocol until assessed by a provider.
 - If a benzodiazepine is prescribed for a psychiatric indication in the community the inmate shall be referred to a psychiatrist or psychiatric APRN for evaluation for continuation, titration, or substitution.
 - If a benzodiazepine is prescribed by a medical doctor/APRN in the community for a medical indication or the patient reports benzodiazepine abuse he/she shall be referred to medical provider for appropriate care including detoxification when clinically indicated.
2. Mental health, nursing staff and/or pharmacy staff, will verify the community prescribed medication and the nurse shall contact the on-site psychiatrist/APRN or if unavailable, the on-call psychiatrist.
3. An on-call psychiatrist shall order medication for inmates newly admitted to CDOC intake facilities for a maximum of seven days. The on-call psychiatrist may specifically request that the inmate be seen by the facility psychiatrist/APRN as soon as deemed clinically necessary or at the next scheduled clinic or if clinically necessary, an overnight infirmary

PSYCHOACTIVE MEDICATION

placement shall be ordered. This shall be documented by nursing on the Physician's Order form HR925.

4. Inmates newly admitted to CDOC intake facilities who are currently prescribed psychoactive medication shall be evaluated by the facility psychiatrist/APRN preferably within seven days, sooner if clinically indicated, but not to exceed fourteen days. An Initial Psychiatric Evaluation HR507 (IPE) shall be completed at that time.
5. For inmates on psychoactive medication transferred from one CDOC facility into another facility, the receiving nurse will refer these inmates to the nurse clinician or designated nurse, who shall screen the inmate within 72 hours to determine when the inmate needs to see a prescriber.
6. To request a non-formulary medication, the prescriber shall complete **Form HR 708, Non-Formulary or Restricted Drug Request**, and provide appropriate justification. The CMHC Director of Mental Health and Psychiatric Services or designee will evaluate the non-formulary requests.
7. All psychoactive medication shall be ordered to be administered "DOT" direct observation therapy. Each time a new psychoactive medication is ordered, a discussion between the patient and the prescriber will be conducted to include risks, benefits, and alternatives to the medication being prescribed and the patient's consent to treatment. This discussion will be clearly documented in the health record by the mental health prescriber on form **HR 401F Clinical Record** (Psychoactive Medication Agreement), with the following language:
"Side effects, risks, possible benefits, alternatives and indication with the use of _____discussed. The patient verbalizes and is assessed as having understanding and agreement with the plan of treatment."
8. **Form HR 306, Consent for Treatment of Minor** should be placed in the inmate's **health record**. In addition, for minors under the custody of the Department of Children and Families (DCF) the following forms shall be completed and placed in the inmate's health record and faxed or e-mailed to DCF (directions are noted on the forms).
 - **DCF Form 465, Psychotropic Medication Consent Requests**
 - **DCF Form 465A, Discontinuation of a Psychotropic Medication**
 - **DCF Form 465B, Suspected Drug Reaction Reporting Form**
9. Patients who are refusing medication and/or exhibit mental deterioration shall be evaluated by the psychiatrist/APRN and considered for infirmary placement and/or involuntary medication.
10. If a psychiatrist/APRN is not available in the facility and a registered nurse has determined that an urgent and/or emergency prescription of psychoactive medication may be needed, the on-call psychiatrist shall be contacted for consultation. If an emergency situation exists and involuntary medication is necessary, policy **I 2.01 Psychoactive Medication: Involuntary Medication, Procedure #1 Emergency Psychoactive Medication** shall be followed.

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11. An on-site psychiatrist/APRN shall co-sign telephone orders within 72 hours of the order or when a physician/APRN is not on site, during the next physician/APRN visit. The on-call psychiatrist shall document any orders given by telephone on the **CMHC Telephone Orders Log**.
12. There shall be no PRN orders for benzodiazepine medication except in an infirmary setting. PRN, or as needed, orders for benzodiazepine medications parenteral medications are to be used in the infirmary setting only .
13. The order "PO/IM" and the order "IM if PO refused" can only be used when involuntary medication administration has been authorized by a panel.
14. If a psychoactive medication order expires, the nurse shall not discontinue the medication unless specifically ordered to be discontinued, and otherwise the nurse shall contact the on-site prescriber or on-call psychiatrist. If the on-site prescriber is not available an on-call psychiatrist may renew medication for established patients (i.e., has an Initial Psychiatric Evaluation) for up to 14 days.

Monitoring

- A psychiatrist or APRN with psychiatric certification shall examine the inmates who are stable on psychoactive medications at a minimum of once every 90 days and more often as clinically indicated. When psychoactive medications are discontinued, the psychiatrist/APRN shall have a follow up appointment with the patient within 90 days.
- The prescriber shall ensure that each inmate prescribed psychoactive medication has basic laboratory screening when initiating therapy and annually thereafter (or more frequently as clinically indicated). For women, pregnancy tests should be ordered or results of recent tests reviewed.
- When drug reaction problems (. e.g., reaction to Lithium, etc.) or potentially complicating conditions (e.g., Diabetes) are known, other pretreatment tests should be performed as indicated.
- When initiating therapy with antipsychotic medications, a psychiatrist/APRN shall conduct an assessment of the inmate to include a review of the most recent physical examination, vital signs, a review of past medical history, and any indicated physical or neurological examinations.
- For patients prescribed antipsychotic medications, an AIMS Assessment (**Form HR 506, Abnormal Involuntary Movement Scale, AIMS**), should be conducted by the psychiatrist, APRN, or trained nurse at a minimum :
 - Upon initiation
 - One month from initiation

PSYCHOACTIVE MEDICATION

- Three months from initiation
 - Six months from initiation
 - And every six months thereafter
-
- For patients prescribed antipsychotic medications, metabolic monitoring should be conducted upon initiation and periodically thereafter. A fasting blood sugar and/or hemoglobin A1c (HbA1c) as well as lipid panel shall be ordered annually. Abnormal values shall be addressed through consultation and collaboration with the medical prescriber.
 - The psychiatrist/APRN shall order blood levels of psychoactive medications when prescribing mood stabilizers and anticonvulsants. Lithium, Depakote, and Tegretol levels shall be ordered every 6 months.
 - Medication adherence shall be documented prior to or during each visit with the psychiatrist/APRN. Adherence and any side effects shall be documented in the inmate's health record and addressed as indicated.
 - When an inmate refuses three consecutive doses of a psychoactive medication or demonstrates a pattern of missed doses of medication, the inmate is referred to the designated nurse for evaluation and medication education and this encounter with the patient shall be documented in the health record and communicated to the health prescriber to inform treatment.

Discharge Medications

- The psychiatrist/APRN shall be advised whenever an inmate receiving psychoactive medication is scheduled for release to the community by discharge, furlough, parole, transitional supervision, probation, or half way house placement. If the continuation of medication is clinically indicated the prescriber shall order the relevant medication in accordance with CMHC policy E 13.01. Medical/Mental Health Discharge Planning. If any prescribed medication is not continued upon discharge, the rationale shall be documented in the health record.

Refer to policy I 2.01 Psychoactive Medication: Involuntary Medication

REFERENCES: *Administrative Directive, 8.8, Psychoactive Medication.* 2008. Connecticut Department of Correction.
Connecticut General Statutes 18-81d(a)(b). 1998.
Standards for Health Services in Prisons (P-G-04). 2014. National Commission on Correctional Health Care. Chicago, IL.
CMHC Patient Safety System/PSS User Manual (Rev.3/2008).

See policy attachment: Nurse Clinician Responsibilities

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall provide a Sex Offender Program (**SOP**) at designated institutions within the DOC.

The SOP shall implement psycho-educational and psychotherapeutic programming that addresses treatment needs based on a best practices model that is evidence informed. This may include cognitive-behavioral therapy, social competence training, and relapse prevention training.

DEFINITION: Sex Offender: An inmate who has been convicted of a sexual assault pursuant to the provisions of the Connecticut General Statutes or if convicted of a sexual assault in another state in which the essential elements of the offense correspond with the provisions of the Connecticut General Statutes. Included in this category is an inmate with a sex treatment needs score of 2, 3, 4 or 5 as assigned in accordance with Administrative Directive 9.2 , Offender Classification.

PROCEDURE: SOP will be provided at designated Connecticut Department of Correction (**CDOC**) facilities determined by the CDOC Director of Programs and Treatment.

Sex Offender Programming

SOP staff shall provide an assessment for eligible inmates to determine program needs. Group programming is available to eligible inmates and includes: Orientation, Track 1, and Track 2. Discharge planning and collaboration with community agencies and community supervision agencies (e.g., Parole & Probation) will be provided to facilitate continuity of care and management of inmates returning to the community.

Referral

During Classification reviews a classification counselor may refer an inmate with a sex treatment needs score to SOP staff for an assessment; or an inmate may request to participate in sex offender programming to classification or health services staff at any point during their incarceration. Upon receipt of a referral, the SOP staff shall conduct an assessment to determine eligibility for participation in SOP. Inmates will be prioritized for

services based on clinical needs, motivation, available resources, and release date.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

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Title: CMHC Acting Dir. of Medical Services, Ricardo Ruiz MD _____

Title: CMHC Dir. Of MH and Psychiatric Services, Robert Berger MD _____

Title: CODC Director of Health Services, Kathleen Maurer MD _____

**UCONN HEALTH
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION
SEX OFFENDER PROGRAM: ORIENTATION**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall conduct an orientation at Connecticut Department of Correction (**CDOC**) at the **Walker building of the MacDougall-Walker Correctional Institution** that introduces inmates who have been convicted of sex offenses to the SOP.

PROCEDURE: All CDOC sentenced sex offenders, processing through **the Walker building of the MacDougall-Walker Correctional Institution**, shall be scheduled for a group session that includes orientation/introduction to the CDOC SOP.

In addition to the overview of the CDOC SOP, content of the orientation session shall include (but not be limited to) benefits of treatment, how to access programming, and community follow-up treatment.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.2007.* Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

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Title: CMHC Acting Dir. of Medical Services, Ricardo Ruiz MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

**UCONN HEALTH
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION
SEX OFFENDER PROGRAM (SOP):
TRACK 1 - INTAKE PROCESS**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**), Sex Offender Program (**SOP**) shall be made available to all inmates in the custody of the Connecticut Department of Correction (**CDOC**) who meet the risk and motivation criteria.

PROCEDURE: CMHC SOP staff shall complete the following assessment steps of the Track 1, Intake Process:

- **Comprehensive Record Review:**

CMHC SOP staff shall review the inmate's master file, including arrest history, police report and pre-sentence investigations. This step shall be completed prior to the inmate interview.

- **Interview:**

CMHC SOP staff shall explore the following topic areas and document findings on the intake progress note and/or **Form HR 516B, Sex Offender Assessment Addendum to Mental Health Assessment:**

Education level;
Developmental history;
Psychosexual history
Personal victimization/abuse history;
Masturbation history and erotic interests;
Sex offense history;
Description of sex offenses;
Inmate's beliefs about harm to the victim;

**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION
SEX OFFENDER PROGRAM (SOP):
TRACK 1 - INTAKE PROCESS**

- **Risk Assessment**

Completion of **Form HR 516A, Static 99R or Static 2002R** (Attachment A).

- **Inmate Completion and Staff Analysis of Written Autobiography**

Outline (Attachment D) provided to the inmate; History shall be taken verbally for illiterate inmates.

Autobiography shall be completed prior to the inmate beginning Track 1 of the SOP.

- **Completion of Required Documentation:**

- Intake progress note
- Form HR 508, Mental Health Assessment
- Form HR 516B, Sex Offender Addendum to Mental Health Assessment
- Form HR 516C, Sex Offender Initial Assessment Summary
- Form HR 516D, Contract for Sex Offender Program
- Form HR 514, Mental Health Treatment Plan (Track 1 Treatment Plan Template)

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.*2007.Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. Of MH and Psychiatric Services, Robert Berger MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
TRACK 1 GROUP PROGRAMMING**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall utilize a standardized cognitive behavioral group format for Track 1 level programming in Connecticut Department of Correction (**CDOC**) facilities.

Track 1 shall be a one-year (approximately 80 hours), once per week, cognitive behavioral group that utilizes a cognitive behavioral approach to sexual offending behavior.

PROCEDURE: A full curriculum of educational materials and a sequential outline of program content shall be developed, maintained and augmented to allow standardization among program groups in CDOC facilities.

Track 1 participants are expected to participate in every meeting and to pass Track 1 examinations in order to demonstrate understanding of the educational materials presented.

Groups shall be conducted in a confidential setting.

Group attendance shall be documented on **Form HR 908, Health Services Group Log** for each participant. The completed form shall be filed in the inmate's Health Record (**HR**).

Upon completion of each Track 1 group component, the corresponding **Form HR 516E, Summary of Group Progress** shall be completed.

An inmate who is terminated from a SOP program shall receive a completed **Form HR 516G, Termination Form** and a copy shall also be filed in both the inmate's HR and the inmate's master file.

Whenever an inmate or CDOC custody staff member requests documentation of participation in Track 1, it shall be provided utilizing the SOP **Form HR 516F, Participation Form**. A copy of the completed form shall also be filed in the inmate HR.

**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
TRACK 1 GROUP PROGRAMMING**

All Track 1 participants shall have SOP **Form HR 516, Track 1 Discharge Summary** completed upon leaving the group (i.e., successful completion, dropout, terminated). The completed form shall be filed in the inmate HR.

- REFERENCES:** *Administrative Directive 8.13, Sex Offender Programs. 2007.* Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. Of MH and Psychiatric Services, Robert Berger MD _____

Title: CMHC Acting Dir. of Medical Services, Ricardo Ruiz MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
TRACK 2**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall provide access to advanced sex offender group therapy for inmates in the custody of the Connecticut Department of Correction (**CDOC**) who have successfully completed Track 1 programming.

PROCEDURE: Upon successful completion of Track 1, inmates may be referred or may self-refer to the Track 2 program. Track 2 treatment focuses on the review and strengthening of concepts learned in Track 1.

Track 2 groups may be conducted at custody level 3 or 4 facilities.

Only experienced program clinicians shall facilitate Track 2 groups.

In addition to attendance documented on **Form HR 908, Group Monitoring Log**, a monthly progress note shall be entered in the inmate's Health Record.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.2007.* Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
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NUMBER: G 4.07e

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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP): SPECIAL POPULATIONS**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall provide services to that subset of the Connecticut Department of Correction (**CDOC**) sex offender population that have co-morbid psychiatric and substance abuse disorders, or other disabilities.

PROCEDURE: Mental Health, Risk Level 4 (as defined in the CDOC Classification Manual) sex offenders shall receive case management services during their incarceration, including treatment and discharge planning that addresses both mental health and sex offending issues.

Sex offender inmates that have conditions that fall under the American with Disabilities Act shall be carefully screened to determine if placement into general Track 1 programming is appropriate or if alternative treatment is warranted.

Specialized sex offender groups, with modified curriculum materials, may be implemented at the major CDOC mental health treatment institutions for mentally ill sex offenders and at MYI and York CI for youthful and female sex offenders respectively.

To enhance the sex offender evaluation, risk assessment and treatment process, psychiatric evaluation, neuropsychological evaluation and psychological testing may be utilized, as appropriate.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

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Title: CDOC Director Health Services, Daniel Bannish PsyD _____

**UCONN HEALTH
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
DENIERS GROUP PROGRAMMING**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall utilize Track 1 cognitive behavioral training materials to implement programming for sex offenders that categorically deny their sex offense(s) but who agree to participate in programming.

Deniers Groups shall run for a minimum of 6 months and may run for up to one year utilizing all Track 1 psycho-educational materials.

PROCEDURE: At a minimum, Deniers Groups shall utilize the Understanding Sexual Assault (**USA**) and Relapse Prevention (**R/P**) sub group components from Track 1.

The goal of Deniers Groups is to enable offenders to break down their denial and begin accepting responsibility for their sexually assaultive behavior(s).

Deniers Group participants are expected to attend every meeting and pass examinations in order to demonstrate understanding of educational materials presented.

A full year Deniers Group participant, who completes all 5 Track 1 sub group components and accepts responsibility for his/her sexual assault(s), may be granted Track 1 completion status at the discretion of the Group facilitator.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

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**UCONN HEALTH
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
USE OF PHARMACOLOGICAL AGENTS**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall ensure that sex offenders in the custody of the Connecticut Department of Correction (**CDOC**) have access to psychiatric assessment and pharmacological intervention where appropriate.

PROCEDURE: Candidates for pharmacologic intervention shall be determined by the treating psychiatrist. These may include:

- High risk to re-offend inmates
- Multiple treatment failure inmates
- Predatory and violent inmates
- Inmates reporting compulsive fantasies with inability to control their arousal.

Inmates receiving anti-androgen treatment shall:

- Have the medical risks associated with this treatment explained
- Sign **Form HR 503, Consent for Treatment with Psychoactive Medication.**
- Have thorough documentation in the inmate Health Record including **Form HR 507, Initial Psychiatric Evaluation.**

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs. 2007.* Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
RELEASE TO COMMUNITY**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) staff shall maintain a collaborative relationship with the Connecticut Department of Correction (**CDOC**), Connecticut Board of Parole, Community-based sex offender treatment providers and Department of Mental Health and Addiction Services (**DMHAS**) to facilitate a continuity of supervision and treatment for sex offenders discharging from CDOC facilities.

PROCEDURE: All sex offenders discharging from CDOC facilities with mental health need scores of 3 or greater shall be screened and evaluated for DMHAS eligibility, sex offense recidivism risk, and community follow-up treatment needs 6 months prior to the estimated release date. Inmates who appear to be DMHAS eligible shall be referred to DMHAS utilizing the **DMHAS/DOC Referral for Mental Health Services**.

High risk and high profile sex offenders known to CMHC and CDOC shall be evaluated for community follow-up treatment, supervision and community adjustment needs prior to their release date. Connecticut Department of Probation and Special Services shall be informed in advance of the estimated release date to allow for appropriate planning.

All discharge planning contacts and efforts shall be documented in the inmate health record.

CMHC Mental Health staff shall make mental health and SOP information (must complete **Form HR 303 or CN 4401, Authorization for the Release of Information**) available to Special Services Center for the Treatment of Problem Sexual Behaviors clinicians who evaluate parole eligible sex offender inmates.

**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP): RELEASE TO COMMUNITY**

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.2007.*Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-0)4. 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

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**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
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NUMBER: G 4.07i

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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP): RISK INSTRUMENTS**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall implement the utilization of risk instruments.

PROCEDURE: The risk instrument to be utilized by CMHC staff in evaluating risk levels of sex offenders in the custody of the Connecticut Department of Correction (**CDOC**) shall be **Form 516A, Static 2002R** (Attachment A). This instrument scores sex offenders on 14 variables, with a total score that places the inmate in one of 5 risk categories: low, low-moderate, moderate, moderate-high, and high.

- A review of collateral information from the inmate's CDOC master file, including police reports, pre-sentence investigations, family/social history, arrest records etc., is necessary for proper scoring of the **Static 2002R** instrument.

The **Static 2002R** risk instrument shall be completed under any of the following circumstances:

- Completion of an intake assessment for a Track 1 program candidate.
- At Walker as part of the SOP needs scoring process.

All completed risk instruments shall be filed in the Mental Health section of the inmate Health Record.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

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**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
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NUMBER: G 4.07j

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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
CLASSIFICATION RISK SCORES**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) staff, in conjunction with Connecticut Department of Correction (**CDOC**) staff, shall ensure that all inmates in the custody of the CDOC are assigned a sex offender needs score.

PROCEDURE: Assigned sex offender treatment needs scores shall be consistent with guidelines in the CDOC Objective Classification Manual (Attachment B).

CMHC and CDOC personnel at each CDOC facility shall assign sex offender treatment needs scores.

At Walker RSMU, CMHC staff, in collaboration with classification staff, shall recommend placement of program eligible sex offenders at CDOC facilities where the SOP is conducted. Sub code scores shall be assigned as appropriate.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

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**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
REFERRALS**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) shall screen inmates in Connecticut Department of Correction (**CDOC**) facilities who self- refer for sex offender programming, or who are referred by CDOC classification/custody staff, or by CMHC staff.

PROCEDURE: Referrals for SOP can be initiated by the inmate or staff by completing **Form CN 9602, Inmate Request** or **Form HR 501 Request for Mental Health Services**. SOP staff will respond by scheduling an intake screening interview.

Inmates refusing treatment shall be encouraged to reconsider their position on non-involvement in treatment and may be reevaluated at a future time.

Total deniers who request to participate in sex offender programming shall be considered for a Denier's Treatment Group (similar to Track 1) if a sufficient number of candidates exist.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

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NUMBER: G 4.071

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**MULTIDISCIPLINARY TREATMENT PROGRAM DESCRIPTION:
SEX OFFENDER PROGRAM (SOP):
STAFF CREDENTIALS AND TRAINING**

Effective Date: 05/01/02

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) Sex Offender Program (**SOP**) Administrator shall develop and implement procedures that maximize the training and experience of the SOP Clinical team consistent with the National Standards of the Association for the Treatment of Sexual Abusers (**ATSA**).

PROCEDURE: At a minimum, SOP designated clinicians shall be masters level trained in Psychology, Sociology, Social Work, Clinical Nursing, Criminology or Counseling. Bachelor's level clinicians must demonstrate competence in specialized professional experience, work under the supervision of a licensed mental health professional, or designee. All clinical team members are encouraged to obtain membership in the Connecticut Association for the Treatment of Sexual Offenders (**CATSO**). Existing SOP clinical team members (as of 12/01/01) who do not meet these credentialing guidelines shall be grandfathered as approved clinicians.

All CMHC SOP clinicians shall work towards clinical membership in CATSO. Clinicians are also encouraged to obtain membership in ATSA, the national organization that sets standards and principles for sex offender management and treatment.

At a minimum, all CMHC SOP clinicians shall participate in 16 hours of annual training in sex offender treatment.

REFERENCES: *Administrative Directive 8.13, Sex Offender Programs.* 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-04). 2008. National Commission on Correctional Health Care. Chicago, IL

Approved: UCHC - CMHC

Date:

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**UCONN HEALTH
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NUMBER: G 4.08

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CDOC RELEASE/DISCHARGE OF MENTAL HEALTH LEVEL 5 INMATES

Effective Date: 04/01/01

POLICY: Connecticut Department of Correction (**CDOC**) Mental Health Level 5 (**MH 5**) inmates shall be evaluated by Health Services staff prior to being released from a CDOC facility on bond, or at the end of sentence.

PROCEDURE: **As soon as it is evident that an inmate is a mental health level 5, who is bonding out or near end of sentence, requiring a community mental health bed upon discharge, the CMHC mental health staff shall notify the Department of Health & Addiction Services (DMHAS) Transitional Services Manager, CT Valley Hospital, Russell Hall. The DMHAS Transition Services Manager shall attempt to locate a DMHAS community bed appropriate for the inmate or for transport to an appropriate emergency department.**

In the event of a Bond Out or End of Sentence (EOS) of an MH5 inmate, the facility shall hold the inmate until Health Services staff can assess the inmate for safety as follows:

In facilities where there is an on-site psychiatrist:

The psychiatrist shall directly evaluate the inmate within 72 hours of known discharge, and determine if the inmate is an imminent risk to self or others or is gravely disabled.

If the psychiatrist determines that the inmate is an imminent risk to self or others or gravely disabled, the psychiatrist shall initiate a Physician's Emergency Certificate (**PEC**) to transport the inmate to the nearest Hospital Emergency Department.

In addition to the initiation of the PEC, the psychiatrist or Health Services designee shall:

- Consult with the Emergency Department regarding the inmate's status.
- Notify the **DMHAS Transitional Services Manager, CT Valley Hospital, Russell Hall, 860-262-5879.**
- Complete two copies of a **W-10 (State of CT Interagency Referral Report) form** upon the inmate's discharge from the facility. One

CDOC RELEASE/DISCHARGE OF MENTAL HEALTH LEVEL 5 INMATES

copy shall be sent with the inmate to the receiving health care institution. The other copy shall be faxed to the receiving health care institution.

- Make recommendations to Custody staff regarding transportation of the inmate either by ambulance, or by CDOC vehicle.

If an ambulance is recommended, Health Services staff shall make the arrangements with an area ambulance company.

Health Services staff shall document the disposition in the health record on **HR 401 Clinical Record Form**.

The Health Services Administrator shall be notified regarding the inmate's status and disposition.

In facilities where there is no on-site psychiatrist:

- Health Services staff shall consult with the on-call psychiatrist.
- Based upon the consultation with Health Services staff, the on-call psychiatrist shall make a judgement regarding the inmate's clinical status and disposition.
- If in the opinion of the on-call psychiatrist, the inmate is a potential imminent risk to self or others or is gravely disabled, the psychiatrist shall give a telephone order to transfer the inmate to a designated Hospital Emergency Department for further assessment.

If transfer to a designated Hospital Emergency Department is ordered for the inmate, Health Services staff shall:

- Consult/notify the Emergency Department regarding the inmate's status.
- Notify the **DMHAS Transitional Services Manager, CT Valley Hospital, Russell Hall**.
- Complete two copies of a **W-10 (State of CT Interagency Referral Report) form** upon the inmate's discharge from the facility. One copy shall be sent with the inmate to the receiving institution and the other copy shall be faxed to the receiving institution.

CDOC RELEASE/DISCHARGE OF MENTAL HEALTH LEVEL 5 INMATES

- Make recommendations to Custody staff regarding transportation of the inmate either by ambulance, or by CDOC vehicle.
- Notify custody staff to transport the inmate to the receiving Institution.

Health Services staff shall document the disposition in the Clinical Record section of the inmate’s health record.

The Health Services Administrator shall be notified regarding the inmate’s status and disposition.

See attached memorandum: Mental Health 5 Inmates Who Bond Out From Court or Discharge From Court

REFERENCES: *Policy and Procedure Manual G 2.04 Psychoactive Medication.* University of Connecticut Health Center, Correctional Managed Health Care. Farmington, Connecticut.

Standards for Health Services in Prisons (P-G-04). 2014. National Commission on Correctional Health Care. Chicago IL.

Approved: UConn Health - CMHC

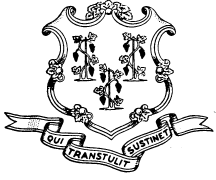
Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

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Title: CDOC Director of Health Services, Kathleen Maurer MD _____

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STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION
OFFENDER CLASSIFICATION & POPULATION MANAGEMENT
1153 EAST STREET SOUTH
SUFFIELD, CONNECTICUT 06080



Lynn Milling
Director

Tel (860) 292-3469
Fax (860) 292-3422

MEMORANDUM

TO: All Wardens

FROM: Lynn Milling, Director
Offender Classification & Population Management

DATE: August 17, 2012

RE: Mental Health 5 Inmates Who Bond Out From Court or
Discharge From Court

If an inmate with a mental health 5 score goes to court and either discharges from court or posts bond at court, and there are no other legal holds on file with the Department of Correction that would require their return, the inmate is **not** to be returned to the facility.

When possible, CMHC (Correctional Managed Health Care) staff shall notify Jail Diversion staff early the day prior to the inmate's court date. This will allow Jail Diversion staff time to coordinate with the offender's attorney and to make provisions for someone to be at court that is authorized to write an Emergency Transportation Certificate (ETC). The inmate would then be taken to the Emergency Room by ambulance for an evaluation.

If the inmate leaves for court without prior notification to Jail Diversion staff, for example an inmate's mental health score is raised just before transport to court or CMHC is not aware of the court date until that day, CMHC staff shall contact Jail Diversion staff as soon as possible. Jail Diversion staff will try to have someone in court who can write an ETC. If Jail Diversion staff are not in court, Department of Correction transporting staff (CTU or facility) shall call the originating facility to notify their mental health staff (CMHC). CMHC mental health staff shall confirm his/her MH 5 status and specifically his/her need for further psychiatric assessment/treatment. If CMHC indicate the inmate should be assessed at an Emergency Department, DOC transport staff shall request the Judicial Marshals contact an ambulance. If the Judicial Marshals are not available, DOC staff shall contact an ambulance or the local police for assistance. CMHC mental health staff shall arrange for the necessary information to be provided to the hospital Emergency Room where the individual will be evaluated and a determination made regarding need for treatment and/or hospitalization.

If the inmate leaves for court with a Physicians Emergency Commitment (PEC), the form needs to be provided to the Judicial Marshals as soon as the inmate arrives at court so they can take the necessary action if the inmate discharges. If a Judicial Marshal is not present, either DOC or Jail Diversion staff can contact an ambulance to have the inmate transported to the hospital. The PEC needs to be given to the ambulance in order for them to transport the client.

Please ensure the appropriate facility staff is notified of this. Please ensure your facility has the necessary procedures in place for CMHC staff to be notified of pending court dates for mental health 5 inmates.

Please note the above clarification does not change the procedures outlined in UCHC/CMHC Policy Number G 4.08, Discharge of Mental Health Level 5 Inmates. It does not change DOC protocol for the handling of inmates where police intervention/assistance is appropriate.

cc: Deputy Commissioners Cepelak and Dzurenda
Directors Rinaldi, Weir, Haggan and Garnett
Director Maurer and Bannish
Dr. Berger, UCHC/CMHC
O'Donovan Murphy, Judicial Marshals
Loel Meckel, DMHAS
Gary Roberge, CSSD
District Administrators Lajoie and Quiros
Legislative Liaison Ferguson
Director Colon, Operations
Captain DeVore, CTU
OCPM Supervisors

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NUMBER: G 5.02

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SUICIDE PREVENTION

Effective Date: 04/01/00

POLICY: All UConn Health, Correctional Managed Health Care (**CMHC**) staff, with direct inmate contact, shall receive Connecticut Department of Correction (**CDOC**) Pre-Service training, CDOC facility orientation training, ongoing in-service training, and roll call notices where appropriate, on suicide prevention.

All CMHC staff training curriculums shall be pre-approved by CMHC Program Administrators and the CDOC Monitoring Panel.

PROCEDURE: IDENTIFICATION, INTERVENTION, AND REFERRAL

Inmates who are identified as at risk for suicide or self-injury shall be evaluated immediately by a mental health or medical clinician, optimally in a room that offers auditory privacy. CMHC **Form HR517, Suicide Risk Assessment** shall be completed.

In assessing an inmate's potential for suicide mental health staff shall utilize relevant historical data including but not limited to the following:

- **W-10**
- **Discharge Summaries**
- **Court Mittimus**
- **Judicial Marshal Svcs Prisoner Behavior Report (JD-MS-5)**
- **HR001 Intake Health Screening**
- **Records of prior treatment if available particularly within CDOC**
- **Self-referral**
- **Reports from family members and friends**
- **Attorney and advocate correspondence**
- **Custody information and reports**
- **RT Information**
- **Information from other Inmates**
- **Documentation, direct information, or treater-to-treater phone contact, from recent inpatient psychiatric hospitalizations (within the last 30 days).**

SUICIDE PREVENTION

Inmates with a court mittimus alert indicating “suicide watch”, “mental health watch”, “mental health evaluation” or other similar alert shall be evaluated by a Qualified Mental Health Professional to determine the appropriate level of mental health intervention and housing placement.

Inmates who enter a CDOC facility either directly from a community inpatient psychiatric hospitalization where he/she was treated for suicide-related risk or who were discharged within the past week for the same, shall be admitted to the infirmary for Mental Health Observation

CDOC/CMHC staff shall communicate suicide risk information verbally. In the event there is no medical or mental health staff at the facility, the ranking custody officer shall contact the facility or on-call Health Services Administrator.

Health services staff shall respond immediately to referrals of inmates who may be suicidal. Medical staff shall respond immediately if an injury has occurred or is in progress.

Documentation of all referrals, assessments and interventions of suicidal inmates shall be made in the health record. Completed **Suicide Risk Assessment, Form HR517** shall be filed in the mental health section of the health record. MH Classification score shall be reviewed and revised as appropriate.

SUICIDE PREVENTION TRAINING**CDOC Pre-Service Orientation Training**

- CMHC orientees with direct inmate contact shall complete a suicide prevention training curriculum when they attend the CDOC training academy.

CDOC Facility Orientation Training

- CMHC staff with direct inmate contact shall receive CDOC facility-specific orientation/training that includes the general provisions of the facility’s Suicide Prevention Unit Directive, Post Order Procedures, suicide intervention techniques, response to a suicide in progress, emergency response, notification, communication, coordination and use of emergency equipment.

In-Service Training

- CMHC staff with direct inmate contact shall complete two (2) hours of CDOC suicide prevention and emergency procedures training annually using structured curricula, pre and post tests, employee

SUICIDE PREVENTION

training evaluations, and whenever possible, incorporating the case study method.

- CMHC staff shall have access to professional development workshops, staff development programs, and other training based upon their position requirements.

Suicide prevention training shall be provided by mental health staff or specially trained CDOC or CMHC staff.

Mental health staff providing training shall maintain copies of lesson plans and rosters of all participants in a secure file for at least four years and shall forward copies of training files to the CMHC Central Office, Department of Education and Training. CDOC training documentation shall be forwarded to the CDOC Staff Development and Training Center.

An annual review of suicide prevention training shall be conducted to ensure that current research and corrective actions have been reflected in the curricula.

Roll Call Notices

The CMHC Health Services Administrator (HSA) is responsible for providing pertinent written and verbal communication to facility staff as needed via roll call notices during periods of higher potential for suicides, or as determined by the CDOC Unit Administrator and in consultation with the CDOC Chief of Psychiatric Services

NOTIFICATION OF DEATH BY SUICIDE

Any health services staff person shall immediately report all incidents of death by suicide to the Health Services Administrator. The HSA shall notify by telephone the CDOC Director of Health Services, CDOC Chief of Psychiatric Services, and the CMHC Director of Mental Health and Psychiatric Services.

In the event of an inmate suicide, a comprehensive report and clinical administrative review shall occur in accordance with CDOC Administrative Directive 6.6, Reporting of Incidents and Administrative Directive 8.2, Inmate Death, CMHC **Policy G 5.08, Critical Incident Response** and CMHC **Policy G 5.07, Multidisciplinary System Case Review**.

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REPORTING

Each facility health services unit shall forward a monthly statistical report of the number of inmates placed on mental health Observation, suicide assessments, suicide threats, suicide attempts, and successful suicides to the Unit Administrator, CDOC Director of Health Services/designee, and the CMHC Director of Mental Health & Psychiatric Services.

- REFERENCES:** *Administrative Directives, 8.5, Mental Health Services 2008; 8.14 Suicide Prevention and Intervention. 2006.*
 Connecticut Department of Correction.
Administrative Directive 6.4, Transportation and Community Supervision of Inmates. 2007. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-05). 2014. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Dir. MH and Psychiatric Services, Robert Berger MD _____	
Title: CDOC Director Health Services, Kathleen Maurer MD _____	
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**UCONN HEALTH
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NUMBER: G 5.05

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Infirmiry Level of Care: MENTAL HEALTH OBSERVATION

Effective Date: 10/01/04

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) shall provide Mental Health Observation in Connecticut Department of Correction (CDOC) facilities. The use of Mental Health Observation shall require clinical justification and shall be employed to protect the inmate from suicide or self-injury, to prevent injury to others, and to observe inmates who have a need for close observation as clinically indicated.

Mental Health Observation shall be implemented in an infirmary for inmates with the DOC designation Mental Health level 5. Mental Health Level 4 inmates may be housed in an infirmary temporarily (see definition). If an inmate is placed on Mental Health Observation, but is housed elsewhere (cells, rooms) as “overflow” from the infirmary, this policy and policy G 3.01 Infirmiry Admission and Care shall be followed. By protocol, “overflow” MHO/MH5 patients are maintained on 1:1 observation pending placement in an infirmary. Two patients may be observed by one officer.

DEFINITIONS:

Mental Health Observation: Designated for inmates identified who have bona fide risks and/or intent for self-injurious behavior or other acute mental health illness. Mental Health Observation may include the following levels of observation in accordance with identified clinical needs and risk factors:

Mental Health Observation (MH4): This is a temporary infirmary housing placement in facilities that do not have a specialized housing location required for MH4 patients. These are inmates with a mental health condition severe enough to require specialized housing or ongoing intensive mental health treatment. These are patients who need a higher level of care than general population (MH3) but less than acute, crisis level infirmary care (MH5). These patients are in transition for either transfer internally to general population if improved, or, transfer to a MH 4 level facility if intensive services continue to be required.

Mental Health Observation (MH5) with Privileges: housed in an infirmary, usually in correctional attire, with authorized items and/or identified privileges, (**Form HR 524, Mental Health Observation Items Authorization Checklist** is to be used and placed on the cell door).

MENTAL HEALTH OBSERVATION

Mental Health Observation (MH5) Staggered Observation (formerly known as “Physician Ordered Q15”): These patients are of high clinical acuity and/or a risk to self or others. Visual checks made on these patients at irregular intervals not to exceed 15 minutes. These patients are dressed in a safety garment and safety blanket. In-cell items are highly restricted **Form HR 524 Mental Health Observation Items Authorization Checklist is to be used and placed on the cell door).**

Mental Health Observation: Constant observation - continuous uninterrupted visual observation of a patient. Cell door may remain open though a direct clear and unobstructed view must be maintained. One staff member may provide constant observation to one or more patients in the same room.

- *Constant* observation can be recommended by any QMHP or custody supervisor, but an order must be obtained from the on-site psychiatrist/APRN or on-call psychiatrist if recommended by mental health. Constant observation can be ordered for up to 24 hours, at which time the inmate must be re-evaluated for the need to continue constant observation and a new order obtained. An order to discontinue constant observation may be obtained if clinically indicated any time prior to 24 hours. An order to continue constant observation beyond 48 hours shall be reviewed with the CMHC Director of Mental Health & Psychiatric Services or CDOC Chief of Psychiatric Services (or designee).

PROCEDURE:

Mental Health Observation (MHO), MH5, may be recommended by any QMHP or Registered Nurse. However, Mental Health Observation (MHO), MH5, requires a prescriber order for admission to and discharge from an infirmary. Temporary placement of a MH4 in the infirmary may be initiated by a QMHP and transferred according to routine protocol.

Documentation

Upon placement on Mental Health Observation an entry shall be made in the health record as well as on Form HR925G by mental health or nursing staff that includes, but is not limited to the following information:

- Psychiatrist/APRN admission order
- The reason for the placement in Mental Health Observation
- The level of observation
- The provisional diagnosis
- Time and date of placement in Mental Health Observation

MENTAL HEALTH OBSERVATION

- Current medications, if any, to be continued at current doses unless contraindicated (if contraindicated, consult facility psychiatrist/APRN or on-call psychiatrist)
- Mental status at time of placement in Mental Health Observation
- Mental Health classification score shall be changed.
- Mental health observation check list for items authorized for use in cell

Monitoring

Trained custody staff shall be responsible for performing and documenting staggered 15-minute visual observations when ordered.

Behaviors shall be documented by custody on **Form HR505, Close Observation/Watch Checklist**.

Mental Health and/or nursing staff:

- Document consumption of meals and fluids, and note any significant changes in the inmate's behavior or demeanor.
- Emergency medication and/or therapeutic restraints may be ordered by the facility psychiatrist/APRN or on-call psychiatrist if clinically indicated to treat a mental health emergency see policy I 1.01 Therapeutic Restraints and policy I 2.01 Psychoactive Medication: Involuntary Administration.
- A qualified mental health professional shall provide counseling and/or crisis intervention to inmates in Mental Health Observation at least once daily for the duration of the Mental Health Observation.
- Documentation of the inmate's behavior and/or mental status shall be made in the health record as changes occur, at the end of each shift, and at the termination of the observation period. This shall be documented on **Form HR 401, Clinical Record**.

Management

The removal of the basic gown, blanket and/or mattress may be ordered by the psychiatrist/APRN if these items are being used in a self-injurious or potentially harmful manner. The order shall have a start and end time, not to exceed 12 hours maximum without review and renewal.

Changes in the levels of observation and authorized items shall be accomplished by the facility psychologist or the psychiatrist/mental health

MENTAL HEALTH OBSERVATION

APRN, or by the on-call psychiatrist telephonically following discussion with a facility mental health professional.

Upon removal from Mental Health Observation (discharge from the Infirmary), documentation shall be made in the health record that includes:

- Psychiatrist/MH APRN discharge order
- Summary of events which occurred during the inmate's stay in Mental Health Observation
- Current behavior and mental status, including assessment of current suicide risk
- Diagnostic impression.
- Mental Health Treatment plan review/revision as appropriate

Completed **Form HR 505, Close Observation/Watch Checklist** and **Form HR 524, Mental Health Observation Items Authorization Checklist for Use in Cell** shall be filed in the mental health section of the health record under the mental health assessment section on the right hand side.

Patients who are removed from Mental Health Observation (discharge from the Infirmary) shall be assigned appropriate housing and seen by mental health staff for follow-up daily for a period of five (5) consecutive days. These follow-up encounters shall be documented in the health record. Mental health classification scores shall not be lowered to less than Mental Health Level 3 for a minimum of 30 days following the discontinuation of MH Observation (discharge from the Infirmary). Post-infirmary follow-up for overnight, weekend and/or MH4 infirmary stays can be an exception based on clinical indication.

Facilities shall maintain a monthly log of patients placed on Mental Health Observation status which includes inmate name and ID number, date and time of placement, authority for placement and date and time of release.

REFERENCES: *Administrative Directives 8.5, Mental Health Services.* 2008; *8.14 Suicide Prevention.* 2006. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-05). 2008. National Commission on Correctional Health Care. Chicago IL.

Approved: UConn Health - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. Of MH and Psychiatric Services, Robert Berger MD _____

Title: CDOC Director of Health Services, Kathleen Maurer MD _____

MENTAL HEALTH OBSERVATION

Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____

**UCONN HEALTH
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MULTIDISCIPLINARY SYSTEM CASE REVIEW

Effective Date: 12/06/07

POLICY: A Multidisciplinary System Case Review shall be conducted by UConn Health, Correctional Managed Health Care (**CMHC**) Director of Mental Health or Director of Medical Services (or designee) following a critical incident as appropriate. This Multidisciplinary System Case Review is independent of any ongoing investigation, and is designed to focus on quality of care improvement.

DEFINITION: A “Critical Incident” is defined as an unexpected occurrence, involving death or serious physical or psychological injury, or the risk thereof.

A “Multidisciplinary System Case Review” is a timely, confidential review of a critical incident conducted at the facility by senior CMHC clinical leads.

PROCEDURE: The CMHC Director of Mental Health and Psychiatric Services or Director of Medical Services shall determine whether to conduct a multidisciplinary system case review. If so, the CMHC Director of Mental Health and Psychiatric Services (or designee) or Director of Medical Services (or designee) shall conduct the review as soon as possible, preferably within 10 business days of the incident.

Components of the multidisciplinary system case review process may include an inquiry of:

- The circumstances surrounding the incident
- Inmate’s health record/selected part of the health record and/or related reports
- Facility procedures relevant to the incident
- Training received by involved staff
- Possible precipitating factors leading to the incident
- Recommendation and identification of system and process improvement opportunities including: policy, training, physical plant, medical or mental health services, and operational procedures.

MULTIDISCIPLINARY SYSTEM CASE REVIEW**The Review Process:**

- The CMHC Director of Medical Services or Director of Mental Health (or designee) shall chair the meeting.
- Health services staff who responded to the incident and/or who had direct contact in caring for the inmate shall be asked to participate in the review.
- The review meeting may include the following CMHC staff: HSA, CHNS, other health services staff as appropriate (i.e. supervising psychologist, etc.), and CDOC Health Services staff.
- CDOC custody and security personnel, and UCHC-CMHC labor relations and investigations personnel will not be present during the review.
- The review shall be conducted verbally; no minutes will be taken.
- The appropriate CMHC health services clinician shall present the clinical information. Optimally, the following data shall be available at the time of the review:
 - Inmate name, number and date of birth, ethnicity
 - Duration of incarceration
 - Inmate classification scores
 - Housing Unit
 - Immediate location of incident (tier, medical unit, outside hospital, etc.)
 - Medical and/or Mental Health Diagnosis (including dates of diagnosis)
 - Cause of Death (if deceased)
- The presentation will focus on the actions of CMHC staff and will review case appropriate information that may include:
 - Identifying data
 - Review of the incident, Code White management and resuscitation efforts (if applicable to the incident)
 - Relevant preceding clinical history
- The presentation shall conclude with a discussion of any system, process, or procedural changes that would likely lead to improved care or care management.

A confidential report of this review, with recommendations and an action plan for system or policy changes, training, and/or performance improvement monitoring shall be communicated verbally to the CMHC Executive Director.

MULTIDISCIPLINARY SYSTEM CASE REVIEW

The CMHC Executive Director, in collaboration with the appropriate Director(s) shall consider the recommendations contained in the report to determine if more information is needed, additional steps might be needed to implement, or accept the recommendations and action plan as submitted.

The final recommendations and action plan shall be reviewed with the HSA(s) and Designated Director(s) for implementation and follow-up.

REFERENCES: *Administrative Directive 8.14, Suicide Prevention.* 2006. Connecticut Department of Correction.

Standards for Health Services in Prisons (P-G-05). 2014. National Commission on Correctional Health Care. Chicago IL.

Approved: UConn Health - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____	
Title: CDOC Director of Health Services, Kathleen Maurer MD _____	
Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____	

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
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CRITICAL INCIDENT RESPONSE

Effective Date: 02/01/01

POLICY: A critical incident response shall be conducted following any critical incident involving an inmate or staff in a Connecticut Department of Correction (**CDOC**) facility.

PROCEDURE: All UConn Health, Correctional Managed Health Care (**CMHC**) Program staff, CDOC staff and inmates who have the potential to be affected by a critical incident in a CDOC facility shall be offered supportive services.

The UConn Health Employee Assistance Program (**EAP**) Manager shall be notified of the incident by the HSA. The HSA and the EAP Manager shall collaboratively determine the appropriate level of EAP service to be provided, based upon the needs of CMHC and facility staff.

DOC inmates will be offered appropriate mental health services by CMHC QMHP.

REFERENCES: *Administrative Directive 2.18, Critical Incident Stress Response Program.* 2005. Connecticut Department of Correction.
Standards for Health Services in Prisons (P-G-05). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UConn Health - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Dir. of MH and Psychiatric Services, Robert Berger MD _____

Title: CMHC Director of Medical Services, Johnny Wu MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

Title: CDOC Chief of Psychiatric Services, Craig Burns MD _____

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EMERGENCY MEDICAL RESPONSE TO SUICIDE ATTEMPT

Effective Date: 03/01/00

POLICY:

In the event of an inmate suicide attempt or other mental health/life-threatening emergency in a Connecticut Department of Correction (**CDOC**) facility, facility staff shall immediately provide appropriate medical response.

PROCEDURE:

Each CDOC facility shall have a comprehensive written plan which details:

- The facility staff response to a range of mental health emergencies resulting in injury
- The appropriate level of staff training and communication necessary to ensure competency in emergency situations
- The staff medical response
- The emergency medical equipment and its locations in the facility

Staff shall be trained in emergency medical response and equipment including:

- Methods for handling a suicide in progress;
- Administration of first aid and/or CPR/AED;
- Responsibilities of first and subsequent responders, supervisors, and health services staff.

In the event of a mental health/life-threatening emergency in a CDOC facility, staff shall:

- Initiate the appropriate emergency medical response including the administration of first aid and CPR when medically indicated;
- Place the inmate on Mental Health Observation;
- Notify the on-site or on-call psychiatrist as soon as possible;
- Transfer the inmate to a CDOC designated mental health facility as soon as possible;
- Arrange for transportation to an area Hospital Emergency Room. (Notify CDOC Director of Clinical Services)

EMERGENCY MEDICAL RESPONSE TO SUICIDE ATTEMPT

Documentation

On-site Correctional Managed Health Care (CMHC) staff shall document the incident in the Clinical Record section of the inmate's health record and complete Form CN 6601, Medical Incident Report.

In facilities with no CMHC staff on-site, CDOC custody staff shall follow CDOC Administrative Directive 8.14 Suicide Prevention, Section 9, Emergency Mental Health Intervention.

REFERENCES: Administrative Directive 8.14, Suicide Prevention. 2006 Connecticut Department of Correction. Standards for Health Services in Prisons (P-G-05). 2008. National Commission on Correctional Health Care. Chicago IL.

Approved: UCHC - CMHC Date:
Title: CMHC Executive Director, Robert Trestman MD PhD
Title: CMHC Dir. MH and Psychiatric Services, Robert Berger MD
Title: CDOC Director Health Services, Kathleen Maurer MD
Title: CDOC Chief of Psychiatric Services, Craig Burns MD

**UConn Health
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NUMBER: G 6.01

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INTOXICATION AND WITHDRAWAL

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) staff shall provide appropriate medical treatment, based upon currently accepted standards of practice, for Connecticut Department of Correction (**CDOC**) inmates who require detoxification from alcohol or other substances of abuse, using policies **G 6.01a Intoxication and Withdrawal: Alcohol Withdrawal Guidelines; G 6.01b Intoxication and Withdrawal: Benzodiazepine Withdrawal Guidelines; G 6.01c Intoxication and Withdrawal: Opiate Withdrawal Guidelines.**

PROCEDURE: CMHC staff shall screen all newly admitted inmates for drug and alcohol use/abuse, in accordance with **CMHC Policy E 2.01, Intake Health Screening**, utilizing **CMHC Form HR 001, Intake Health Screening**. At the time of the intake screening (or at any point during incarceration), inmates who appear to be intoxicated or who exhibit acute signs and symptoms of alcohol or substance withdrawal, shall immediately be referred to appropriate CMHC staff for further evaluation, monitoring and treatment.

REFERENCES: *Administrative Directives*. Chapter 8. 2008. Connecticut Department of Correction.
Standards for Health Services in Prisons.(P-G-06) 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Mark Buchanan MD _____

Title: CDOC Director Health Services, Daniel Bannish PsyD _____

**UCONN HEALTH
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**INTOXICATION AND WITHDRAWAL:
ALCOHOL WITHDRAWAL GUIDELINES**

Effective Date: 03/07/06

POLICY: Inmates who report significant or recent alcohol ingestion during intake health screening, or who appear intoxicated upon admission to a CDOC facility, shall receive further screening by CMHC Health Services staff, utilizing the **Alcohol Detoxification Nursing Guidelines** and, if indicated by these Guidelines, form **HR001A, Withdrawal Flowsheet: Alcohol**.

PROCEDURE: This screening shall include the following:

A. Patient History

CMHC staff shall complete a patient history for all inmates reporting use of alcohol, or with signs and symptoms of alcohol ingestion that includes:

- Careful determination of the type of alcohol used
- The amount, frequency and duration of use
- The date, time, and amount of alcohol last consumed
- History of previous withdrawal experiences.
- Current signs and symptoms

This history should be documented on form **HR001, Intake Screening**.

B. Monitoring of Signs and Symptoms

If directed to do so by the **Alcohol Detoxification Nursing Guidelines**, CMHC staff shall monitor the inmate utilizing vital signs and the **CIWA-Ar scale**.

General signs and symptoms of alcohol withdrawal include those listed on form **HR001A, Withdrawal Flowsheet: Alcohol**.

**INTOXICATION AND WITHDRAWAL:
ALCOHOL WITHDRAWAL GUIDELINES****Management of Alcohol Withdrawal**

- A. When directed to do so by **Alcohol Detoxification Nursing Guidelines**, CMHC nursing staff shall report the findings of the inmate monitoring to the medical prescriber who will determine appropriate treatment, making reference to dosing guidelines given in **Alcohol Detoxification Prescriber Guidelines**.
- B. All inmates being treated for alcohol detoxification shall be classified as a **Medical Level 4Y and placed on *Medical Hold*** until the alcohol detoxification protocol ends or higher level of care is needed.
- C. Inmates who are experiencing alcohol withdrawal shall be educated by CMHC staff regarding the signs and symptoms of withdrawal, the anticipated treatment, and the patient responsibilities.
- D. Inmates with the potential for or exhibiting symptoms of alcohol withdrawal (CIWA AR) shall be encouraged to increase their fluid intake.
- E. Newly-admitted inmates, who give a history of long-standing (more than two weeks) daily heavy (more than six drinks per day) alcohol usage, should receive oral multivitamins and thiamine according to the **Alcohol Related Imbalanced Nutrition Nursing Protocol**, whether or not they meet criteria for beginning the Withdrawal Flowsheet section of the detox protocol.
- F. Inmates shall be considered for a mental health referral at the completion of the protocol, if not already done.

Special Considerations in the Assessment of Alcohol Withdrawal

General signs and symptoms of recent alcohol ingestion may include:

- Drowsiness
- Odor of alcohol
- Slurred speech
- Disorientation to person, place or time/date
- Lack of coordination of movements
- Changes in pupil size.

**INTOXICATION AND WITHDRAWAL:
ALCOHOL WITHDRAWAL GUIDELINES**

Mild (early) signs and symptoms of alcohol withdrawal include gastrointestinal distress, anxiety, irritability, elevated blood pressure, and rapid heart rate.

Moderate symptoms may develop including insomnia, tremor, fever, anorexia and diaphoresis. Withdrawal seizures can occur at various times during alcohol withdrawal, but generally begin within 48 hours of the last drink.

Delirium tremens (DT's) or withdrawal delirium

- Severe late onset syndrome which usually begins 48 – 72 hours after the last drink, sometimes later
- Individuals can present with fever, tachycardia, hypertension or hypotension, vivid hallucinations (bugs crawling), agitation, confusion, fluctuation in mental status, combativeness
- If allowed to progress, changes in consciousness, marked autonomic instability, electrolyte imbalance, hallucinations and death can result.
- Mortality rate for patients with *delirium tremens* may be as high as 10%, but is markedly reduced to 1% or less with appropriate, intensive treatment.

Wernicke's encephalopathy: Wernicke's disease is characterized by ophthalmoplegia, ataxia and confusion, and is often undetected and under-diagnosed. Left untreated it can advance to ***Korsakoff's syndrome*** (alcohol amnestic syndrome) that is associated with significant morbidity. Thiamine is given early in the cycle in hopes of averting these complications.

- Alcohol withdrawal syndrome can develop in any individual who has a history of regular, heavy use of alcohol, known dependence on alcohol, or has clinical signs of intoxication.
- Severity of the syndrome is difficult to predict.
- A history of previous problems with withdrawal indicates a high probability of a similarly severe withdrawal syndrome in the future.
- Persons who show signs of withdrawal even while substantial alcohol remains in their system are at particularly high risk for a severe syndrome.
- Alcohol withdrawal symptoms can develop within a few hours of decreasing or discontinuing use, and generally peak within 24-36 hours after abstinence begins.
- Uncomplicated alcohol withdrawal is generally completed within 5 days.

**INTOXICATION AND WITHDRAWAL:
ALCOHOL WITHDRAWAL GUIDELINES**

- REFERENCES:** *Federal Bureau of Prisons, Clinical Practice Guidelines, Detoxification of Chemically Dependent Inmates*, December 2000.
Administrative Directives. Chapter 8. 2008. Connecticut Department of Correction.
Standards for Health Services in Prisons. (P-G-06), 2014. National Commission on Correctional Health Care. Chicago, IL.
West vs. Manson Consent Judgment. 1988. CT Department of Correction.

Approved: UCHC - CMHC

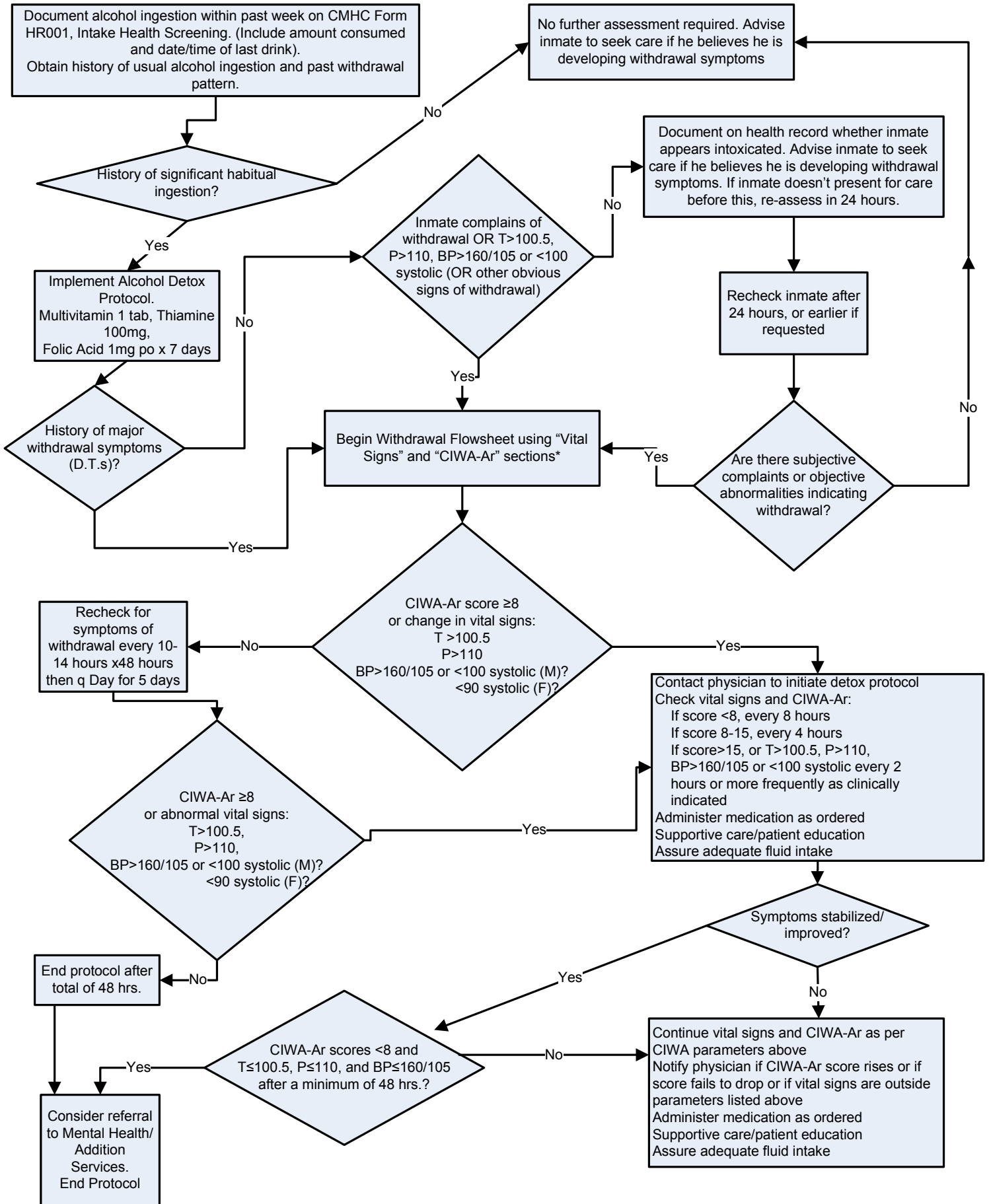
Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Johnny Wu MD _____

Title: CDOC Director Health Services, Kathleen Maurer M D _____

Alcohol Detoxification Nursing Guidelines



* Note: Signs of Intoxication section should also be utilized for assessment of sedation due to medications administered for withdrawal.

University of Connecticut Health Center
Correctional Managed Health Care

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-Ar)

NAUSEA AND VOMITING – Ask “Do you feel sick to your stomach? Have you vomited?”

Observation.

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves and vomiting

TREMOR – Arms extended and fingers spread apart.

Observation.

- 0 no tremor
- 1 not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 moderate, with patient’s arms extended
- 5
- 6
- 7 severe, even with arms not extended

PAROXYSMAL SWEATS –

Observation.

- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 2
- 3
- 4 beads of sweat obvious on forehead
- 5
- 6
- 7 drenching sweats

ANXIETY – Ask “Do you feel nervous?”

Observation.

- 0 no anxiety, at ease
- 1 mild anxious
- 2
- 3
- 4 moderately anxious, or guarded, so anxiety is inferred
- 5
- 6
- 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION –

Observation.

- 0 normal activity
- 1 somewhat more than normal activity
- 2
- 3
- 4 moderately fidgety and restless
- 5
- 6
- 7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES – Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?”

Observation.

- 0 none
- 1 very mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

AUDITORY DISTURBANCES – Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?”

Observation.

- 0 not present
- 1 very mild harshness or ability to frighten
- 2 mild harshness or ability to frighten
- 3 moderate harshness or ability to frighten
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

VISUAL DISTURBANCES – Ask “Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things you know are not there?”

Observation.

- 0 not present
- 1 very mild sensitivity
- 2 mild sensitivity
- 3 moderate sensitivity
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD – Ask “Does your head feel different? Does it feel like there is a band around your head?”

Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0 not present
- 1 very mild
- 2 mild
- 3 moderate
- 4 moderately severe
- 5 severe
- 6 very severe
- 7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM –

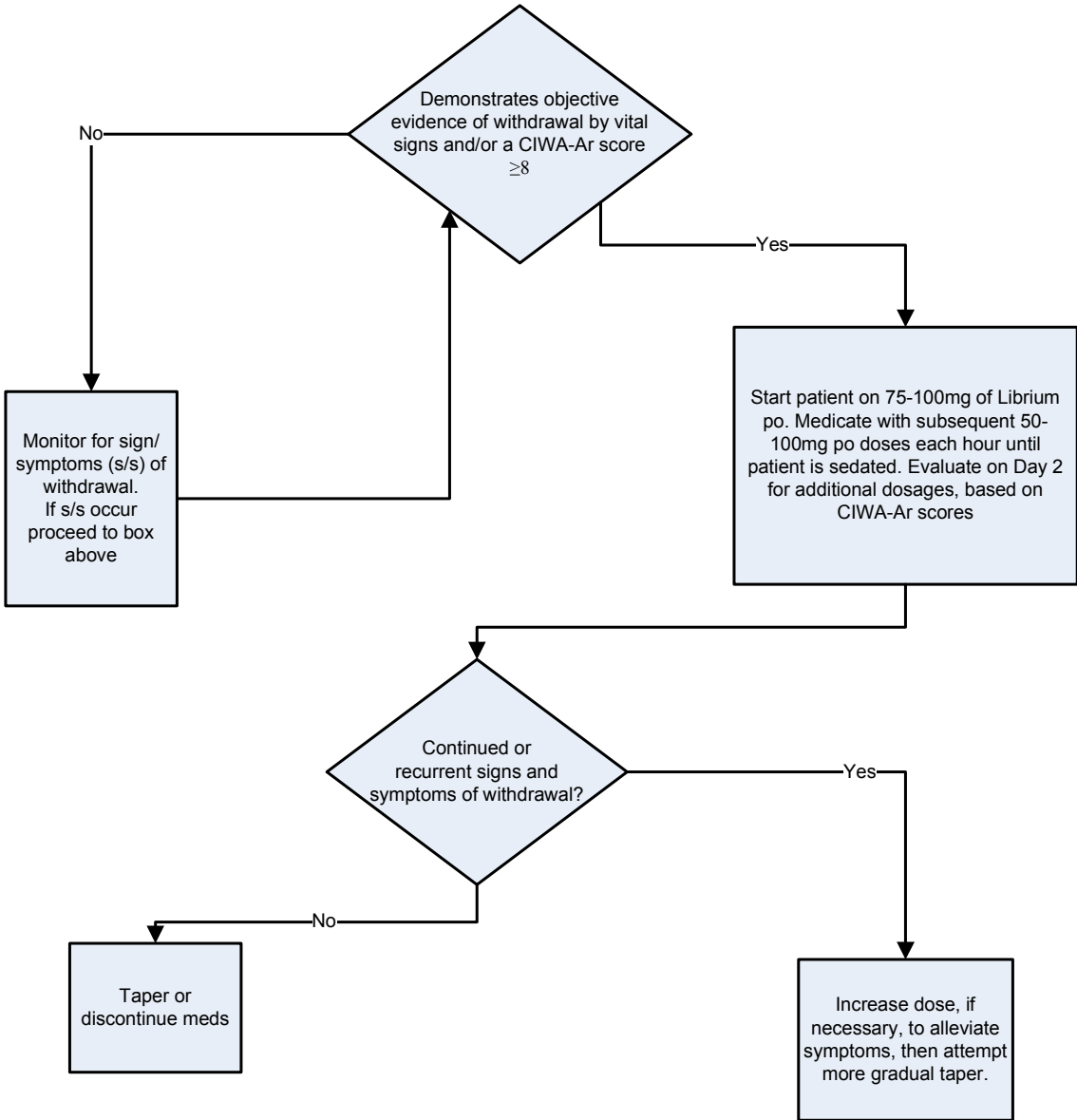
Ask “What day is it? Where are you? Who am I?”

- 0 oriented and can do serial additions
- 1 cannot do serial additions or is uncertain about date
- 2 disoriented for date by no more than 2 calendar days
- 3 disoriented for date by more than 2 calendar days
- 4 disoriented for place/or person

Alcohol Detoxification Prescriber Guidelines

Note: All patients with chronic alcoholism receive oral thiamine and multivitamins per Nursing Protocol. If the inmate is vomiting or shows neurologic signs, consider IM thiamine.

These guidelines do not replace sound clinical judgment, nor are they intended to strictly apply to all patients.



Effective Date: 3/06
Revision Date: 12/11

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**INTOXICATION AND WITHDRAWAL:
BENZODIAZEPINE WITHDRAWAL GUIDELINES**

Effective Date: 03/07/06

POLICY: Inmates who report significant recent use of benzodiazepines during the intake health screening or are exhibiting signs and symptoms of benzodiazepine withdrawal shall receive further screening by CMHC Health Services staff, utilizing the **Benzodiazepine Detoxification Nursing Guidelines** and, if indicated by these Guidelines, form **HR001B, Withdrawal Flowsheet: Benzodiazepine**.

PROCEDURE: This screening shall include the following:

A. Patient History

CMHC staff shall complete a patient history on all inmates reporting the use of, or with signs and symptoms of withdrawal from, benzodiazepines. The history shall include:

- Careful determination of the type of medications used
- Reasons for use
- The amount, frequency and duration of use
- The date, time, and amount of drug last consumed.
- History of previous withdrawal experiences and associated problems
- Withdrawal symptoms that occur when doses are missed or medication has been discontinued
- CMHC staff may attempt to contact the community prescriber and/or pharmacy to confirm the drug history.

This history should be documented on form **HR001, Intake Health Screening**.

B. Monitoring of Signs and Symptoms

If directed to do so by the **Benzodiazepine Detoxification Nursing Guidelines**, CMHC staff shall monitor the inmate utilizing vital signs and the **CIWA-B scale**.

**INTOXICATION AND WITHDRAWAL:
BENZODIAZEPINE WITHDRAWAL GUIDELINES**

General signs and symptoms of benzodiazepine withdrawal include those listed on form **HR001B, Withdrawal Flowsheet: Benzodiazepine.**

Management of Benzodiazepine Withdrawal

- A. CMHC nursing staff shall report the findings of the inmate monitoring to the medical prescriber who will determine appropriate treatment, according to **Benzodiazepine Detoxification Prescriber Guidelines.**
- B. All inmates being treated for benzodiazepine withdrawal shall be classified as a **Medical Level 4Y and placed on *Medical Hold*** until the detoxification protocol ends or higher level of care is needed.
- C. Inmates who are experiencing benzodiazepine withdrawal shall be educated by CMHC staff regarding the signs and symptoms of withdrawal, the anticipated treatment, and the patient responsibilities.
- D. All inmates with the potential for or exhibiting symptoms of benzodiazepine withdrawal shall be encouraged to increase their fluid intake.
- E. Inmates shall be considered for a mental health referral at the completion of the protocol, if not already done.

Special Considerations in the Assessment of Benzodiazepine Withdrawal

Mild Withdrawal: Increasing pulse and blood pressure, anxiety, panic attacks, restlessness, and gastrointestinal upset.

Moderate Withdrawal: In addition to the above, may progress to include tremor, fever, diaphoresis, insomnia, anorexia and diarrhea.

Severe Withdrawal: If left untreated, a delirium may develop with hallucinations, changes in consciousness, profound agitation, autonomic instability, seizures and death. ***Patients showing signs of late (severe) withdrawal should be followed in an infirmary or hospital setting.***

- Benzodiazepine withdrawal syndrome can begin within a few hours of last drug use, especially in the context of use of short-acting drugs, but may take several weeks to resolve. Because of the high risk of delirium, seizures and death, benzodiazepine withdrawal should always be treated.

**INTOXICATION AND WITHDRAWAL:
BENZODIAZEPINE WITHDRAWAL GUIDELINES**

- Unlike alcohol dependence, benzodiazepine dependence can be a physiological phenomenon that occurs even when the medication is taken only as prescribed.
- Physiological dependence develops within 3 – 4 weeks of regular use.
- Although recreational use and abuse of benzodiazepines does occur, most inmates who present with benzodiazepine dependence have been previously prescribed these medications to treat an Axis I or Axis II diagnosis. Previously treated psychiatric symptoms are likely to recur during detoxification from benzodiazepines. Therefore, a full psychological or psychiatric evaluation is indicated when the inmate has developed drug dependence while taking prescribed benzodiazepines.
- Subclinical signs of withdrawal (e.g. insomnia and anxiety) may take months to resolve. Treatment of these symptoms with a nonaddictive medication is usually advisable before the symptoms dominate the clinical picture. Delaying detoxification until the inmate has been on a therapeutic dose of an antidepressant or other appropriate medication for several weeks may be necessary.
- The withdrawal syndrome from benzodiazepines is similar to that of alcohol and barbiturates. The time course varies depending upon the half-life of substances used.
- In addition, individuals with benzodiazepine dependence often concurrently abuse alcohol, thus complicating their withdrawal course.

REFERENCES: *Federal Bureau of Prisons, Clinical Practice Guidelines, Detoxification of Chemically Dependent Inmates*, December 2000.
Administrative Directives. Chapter 8. 2008. Connecticut Department of Correction.
Standards for Health Services in Prisons. (P-G-06), 2014. National Commission on Correctional Health Care. Chicago, IL.
West vs. Manson Consent Judgment. 1988. CT Department of Correction.

Approved: UCHC - CMHC

Date:

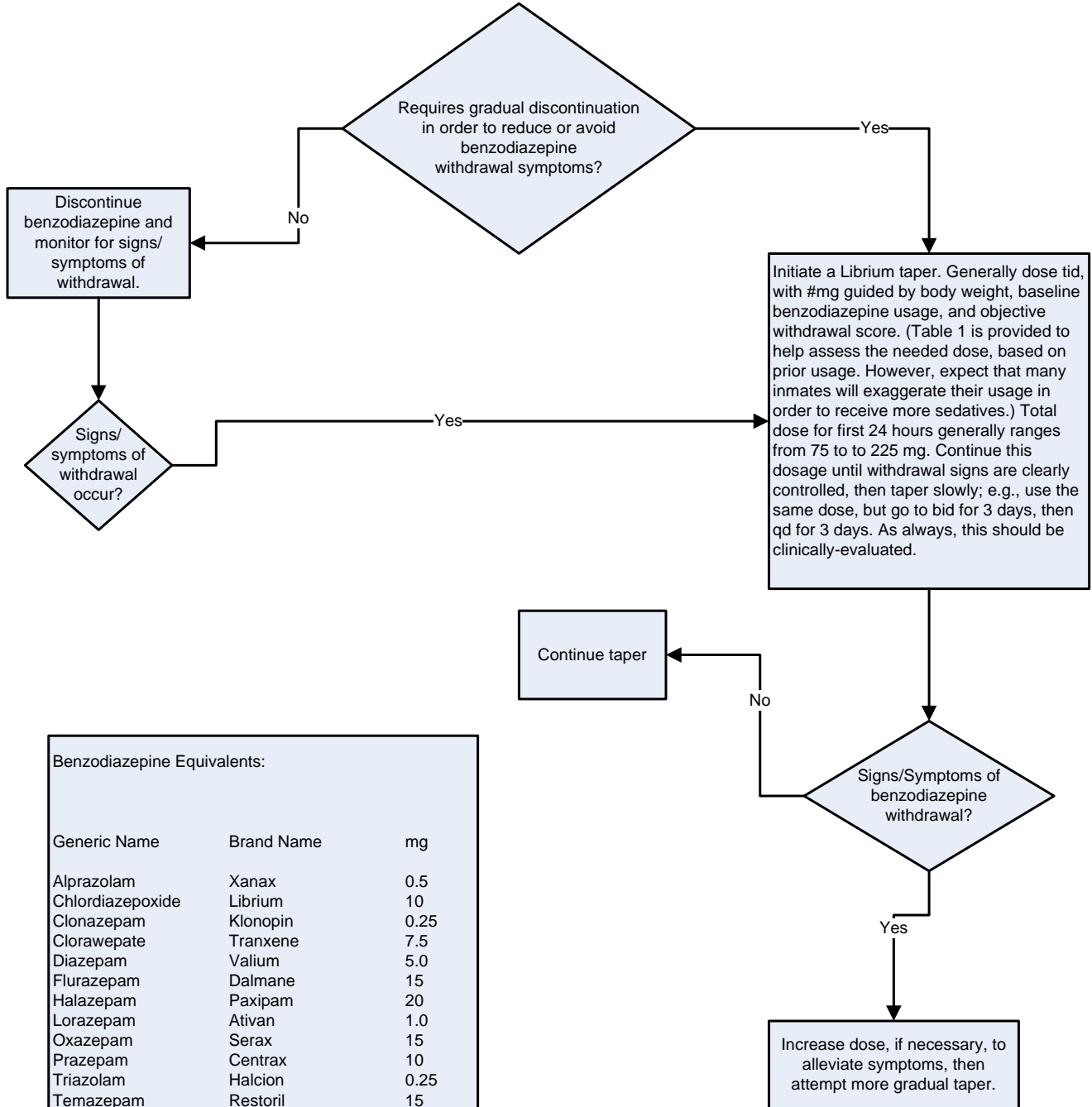
Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services , Johnny Wu MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

Benzodiazepine Detoxification Prescriber Guidelines

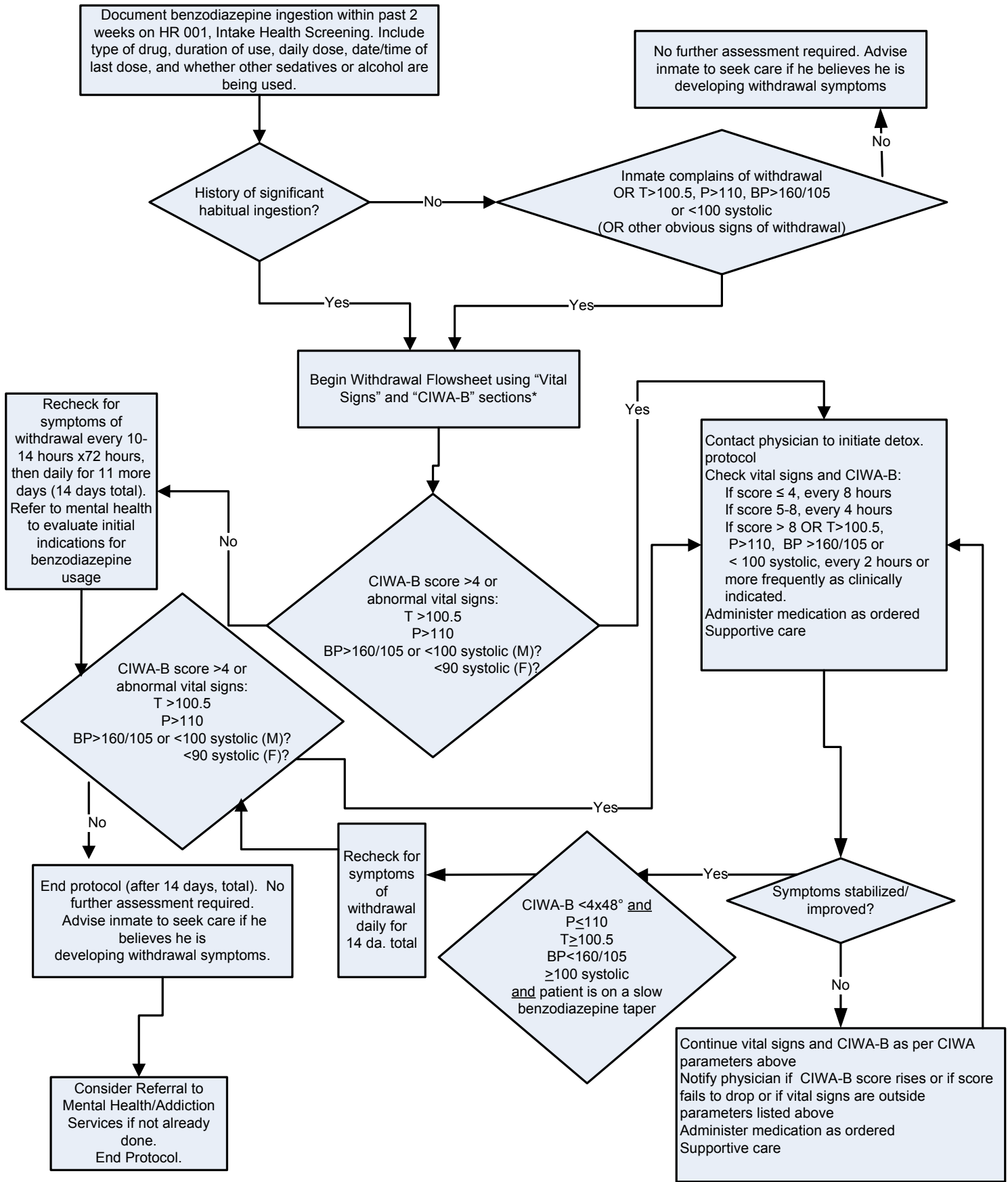
These guidelines do not replace sound clinical judgment, nor are they intended to strictly apply to all patients.



Benzodiazepine Equivalents:

Generic Name	Brand Name	mg
Alprazolam	Xanax	0.5
Chlordiazepoxide	Librium	10
Clonazepam	Klonopin	0.25
Clorazepate	Tranxene	7.5
Diazepam	Valium	5.0
Flurazepam	Dalmane	15
Halazepam	Paxipam	20
Lorazepam	Ativan	1.0
Oxazepam	Serax	15
Prazepam	Centrax	10
Triazolam	Halcion	0.25
Temazepam	Restoril	15

Benzodiazepine Detoxification Nursing Guidelines



* Note: Signs of Intoxication section should also be utilized for assessment of sedation due to medications administered for withdrawal.

**MODIFIED CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT –
BENZODIAZEPINES
(MODIFIED CIWA-B) SCALE**

<p>Restlessness and Agitation <i>Observe behavior.</i></p> <p>0 none 1 2 restless 3 4 paces back and forth unable to sit still</p>	<p>Palpitations <i>Ask patient if they feel their heart racing.</i></p> <p>0 no disturbance 1 2 3 4 constant racing</p>
<p>Tremor <i>Ask patient to extend arms with fingers apart. Observe for tremor.</i></p> <p>0 no tremor 1 not visible, can be felt in fingers 2 visible but mild 3 moderate with arms extended 4 severe with arms not extended</p>	<p>Muscle Aches / Stiffness <i>Ask patient if they feel muscle aches or stiffness.</i></p> <p>0 not at all 1 2 3 4 severe stiffness or pain</p>
<p>Sweating <i>Observe for sweating. Feel palms.</i></p> <p>0 no sweating visible 1 barely perceptible sweating, palms moist 2 palms and forehead moist, reports armpits sweating 3 beads of sweat in forehead 4 severe drenching sweats</p>	<p>Visual Disturbances <i>Ask patient if they have any visual disturbances (sensitivity to light, blurred vision).</i></p> <p>0 not at all 1 2 3 4 very sensitive to light, blurred vision</p>
<p>Numbness / Burning Sensations <i>Ask patient if they have any numbness or burning sensations on face, hands, feet.</i></p> <p>0 no numbness 1 2 3 4 intense burning or numbness</p>	

Score: ≤ 4 = mild, 5-8 = moderate, > 8 = severe withdrawal.

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
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FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 6.01c

Page 1 of 4

**INTOXICATION AND WITHDRAWAL:
OPIATE WITHDRAWAL GUIDELINES**

Effective Date: 03/07/06

POLICY: Inmates who report recent significant use of opiates during intake screening, or are exhibiting signs and symptoms of opiate withdrawal, shall receive further screening by CMHC Health Services staff, utilizing the **Opiate Detoxification Nursing Guidelines** and if indicated by these Guidelines, form **HR001C, Withdrawal Flowsheet: Opiate**.

PROCEDURE: This screening shall include the following:

A. Patient History

CMHC staff shall complete a patient history for all inmates reporting or suspected of clinically significant opiate use that includes:

- The type of drug used
- The amount, frequency and duration of use
- The date and amount of drug last consumed.
- Symptoms of withdrawal when use is decreased or discontinued
- Determination of past medical history with focus on symptoms of medical conditions associated with chronic opiate use such as malnutrition, tuberculosis infection and disease, trauma, skin infections, endocarditis, and sexually transmitted diseases

This history should be documented on form **HR001, Intake Health Screening**.

B. Monitoring of Signs and Symptoms

If directed to do so by the Opiate Detoxification Nursing Guidelines, CMHC staff shall monitor inmate utilizing vital signs and the **COWS score**.

General signs and symptoms of opiate withdrawal include those listed on form **HR001C, Withdrawal Flowsheet: Opiate**.

**INTOXICATION AND WITHDRAWAL:
OPIATE WITHDRAWAL GUIDELINES****Management of Opiate Withdrawal**

- A. When directed to do so by the **Opiate Detoxification Nursing Guidelines**, CMHC nursing staff will report the findings of the inmate assessment to the medical prescriber who will determine appropriate treatment.
- B. Treatment shall be aimed at reducing the signs and symptoms of opiate withdrawal. Treatment shall be individualized based upon the inmate's condition.
- C. All inmates being treated for opiate withdrawal shall be classified as a **Medical Level 4Y and placed on *Medical Hold*** until the opiate withdrawal protocol ends or higher level of care is needed.
- D. Inmates who are experiencing opiate withdrawal shall be educated by CMHC staff regarding the signs and symptoms of withdrawal, the anticipated treatment, and the patient responsibilities.
- E. All inmates with the potential for or exhibiting symptoms of opiate withdrawal shall be encouraged to increase their fluid intake.
- F. All inmates on Clonidine for the management of detox shall be housed in an infirmary or hospital setting.
- G. Inmates shall be considered for a mental health referral at the completion of the protocol, if not already done.
- H. Inmates shall be offered either a vistaril-based regimen or a buprenorphine-based .
- I. Inmates who leave unexpectedly, such as from court, should not be provided with an additional supply of buprenorphine to take with them.

Special Considerations in Opiate Withdrawal

- Inmates with opiate dependence often express significant fear and anticipatory anxiety regarding detoxification.
- Symptoms of withdrawal from short-acting opiates such as heroin can develop a few hours after the last use, peak within 36 to 72 hours and subside over 5 to 10 days.
- Longer-acting opiates such as methadone produce a more protracted withdrawal syndrome, beginning in 24 to 48 hours, peaking in 72 hours and subsiding over 1 to 3 weeks.

**INTOXICATION AND WITHDRAWAL:
OPIATE WITHDRAWAL GUIDELINES**

- Opiate withdrawal is rarely dangerous except in medically debilitated and pregnant individuals.
- ***If Clonidine is the chosen agent for detoxification:*** Vital signs shall be carefully monitored before **each** dose of Clonidine. **Hold Clonidine** if the systolic blood pressure drops below 85 mmHg or if bradycardia develops. Inmates treated with Clonidine shall be observed in an infirmary.
- Inmates with opiate dependence have often experienced multiple episodes of withdrawal prior to incarceration, and are typically highly anxious while withdrawing from opiates, even when symptoms are well controlled.
- Psychological support is often necessary to help ease the inmate's anxiety.
- The inmate's mental status should be monitored on an ongoing basis during withdrawal.
- Buprenorphine can displace other opiates from receptor sites, theoretically precipitating withdrawal in those on a potent long-acting opiate such as methadone. Thus, buprenorphine should not be used in a patient on methadone or long-acting oxycontin unless withdrawal is unequivocally present. Using the COWS cut-off of 12 should insure this. Long-acting opiates tend to lead to withdrawal symptoms that occur more slowly and are less dramatic than with heroin. In the early withdrawal period, patients may complain of a great deal of anxiety, but have low COWS score, and they should not be given buprenorphine during this time.
- Contraindications for use of buprenorphine include: age 15 or under and sensitivity or known allergy.
- Buprenorphine prescribing is tightly regulated, and the drug cannot be given except by physicians who are available to the patient for management of medication usage and monitoring of abstinence from illicit drugs. Therefore it cannot be a 'discharge medication' if an inmate leaves CDOC during the detoxification period. An inmate who goes to court or bonds out during this period should be advised to seek appropriate care in the community.
- Buprenorphine occasionally builds up to levels that causes excess sedation, especially in the presence of medications that inhibit certain hepatic enzymes or have one of several medical conditions such as hypothyroidism, toxic psychosis, acute alcohol usage or delirium tremens, or severe impairment of liver, lung, or kidney function. Hence the nurse should check for a normal level of alertness before administering each dose.

**INTOXICATION AND WITHDRAWAL:
OPIATE WITHDRAWAL GUIDELINES**

REFERENCES: *Federal Bureau of Prisons, Clinical Practice Guidelines, Detoxification of Chemically Dependent Inmates*, December 2000.
 Administrative Directives. Chapter 8. 2008. Connecticut Department of Correction.
 Standards for Health Services in Prisons. (P-G-06), 2014. National Commission on Correctional Health Care. Chicago, IL.
 West vs. Manson Consent Judgment. 1988. CT Department of Correction.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

Title: CMHC Director of Medical Services, Johnny Wu MD

Title: CDOC Director Health Services, Kathleen Maurer MD

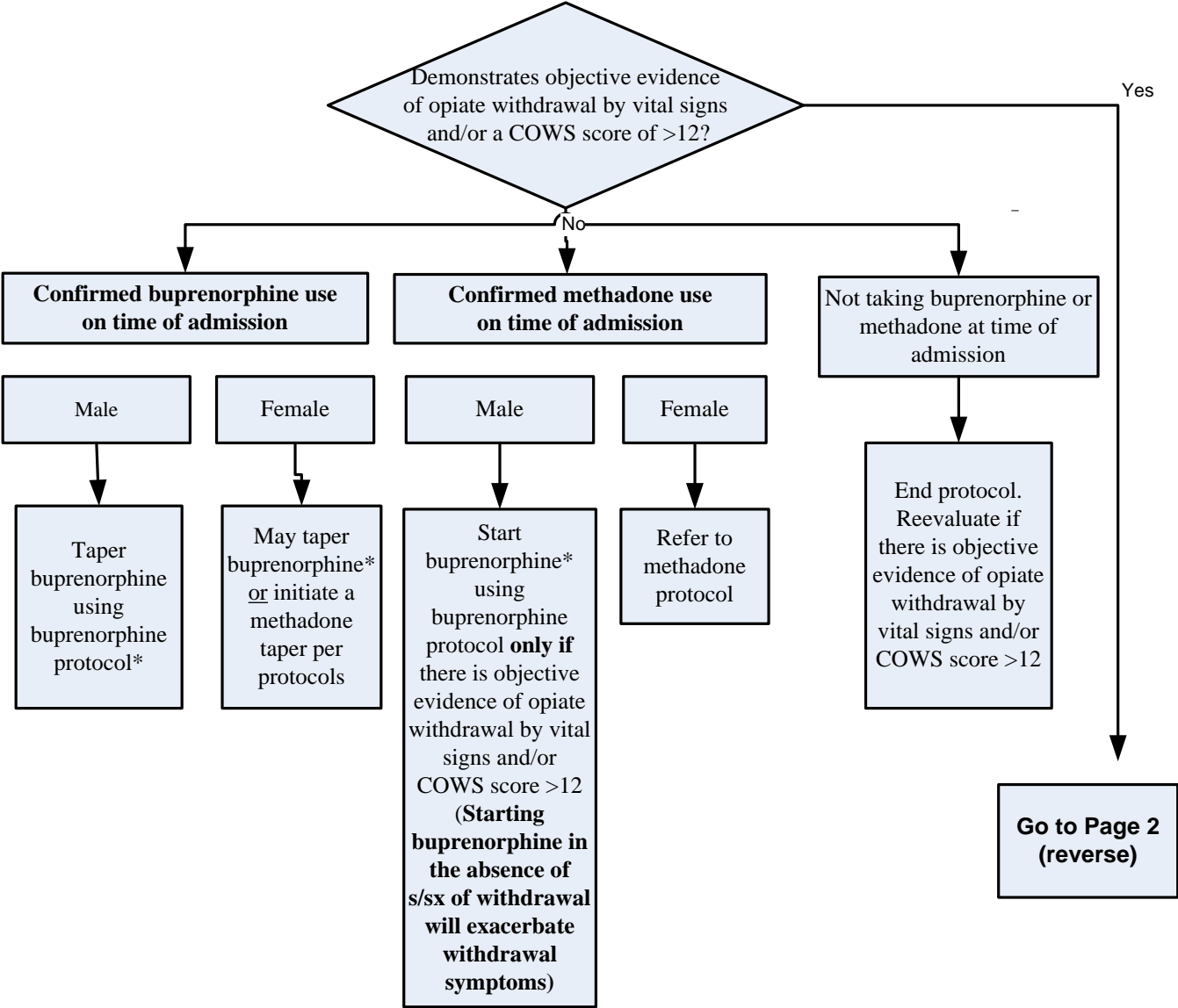
CLINICAL OPIATE WITHDRAWAL SCALE (COWS)

<p>Resting Pulse Rate: <i>Measured after patient is sitting or lying for one minute</i></p> <p>0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120</p>	<p>GI Upset: <i>over last ½ hour</i></p> <p>0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting</p>
<p>Sweating: <i>over past ½ hour not accounted for by room temperature or patient activity.</i></p> <p>0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face</p>	<p>Tremor: <i>observation of outstretched hands</i></p> <p>0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching</p>
<p>Restlessness: <i>Observation during assessment</i></p> <p>0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds</p>	<p>Yawning: <i>Observation during assessment</i></p> <p>0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute</p>
<p>Pupil Size:</p> <p>0 pupils pinned (small) or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible</p>	<p>Anxiety or Irritability</p> <p>0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult</p>
<p>Bone or Joint aches: <i>If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored</i></p> <p>0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</p>	<p>Gooseflesh skin</p> <p>0 skin is smooth 3 pilo-erection of skin can be felt or hairs standing up on arms 5 prominent pilo-erection</p>
<p>Runny nose or tearing: <i>Not accounted for by cold symptoms or allergies</i></p> <p>0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks</p>	

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Opiate Detoxification Prescriber Guidelines

These guidelines do not replace sound clinical judgment, nor are they intended to strictly apply to all patients.



* Special DEA license required. (Contact CMHC Director of Medical Services or CDOC Physician Consultant if needed)

Opiate Detoxification Prescriber Guidelines

(page 2)

These guidelines do not replace sound clinical judgment, nor are they intended to strictly apply to all patients.

Female from Pg. 1 (reverse)

Male from Pg. 1 (reverse)

Pregnant?

Yes

No

Methadone Protocol

For confirmed methadone use: initiate known dose of methadone.
For non-confirmed methadone use (or other opiates), initiate methadone dose based on VS & COWS, titrating accordingly until the maintenance dose has been achieved.

Methadone Maintenance:
Continue for duration of pregnancy.

Methadone Protocol

For confirmed methadone use: reduce methadone by 5mg every 3 days (takes 7 days to 2 weeks).

For any other opiate usage: initiate 10-30mg/day (based on VS and COWS), tapering by 5mg every other day.

Symptomatic Treatment

May be used to supplement buprenorphine or methadone, or as primary Rx in men not eligible for buprenorphine. In any setting: Symptomatic treatments other than clonidine may be used including:

- Acetaminophen (Tylenol) 650mg po q 4 hrs prn/pain (Preg. Risk Cat: B)
- Ibuprofen (Motrin) 600mg po qid prn/pain (Preg. Risk Cat: B; D in third trimester)
- Flexeril (Cyclobenzaprine) 10mg po qid/prn x5-7 days for muscle spasm (Preg. Risk Cat: B)
- Loperamide (Imodium) 2mg po prn after each loose stool not to exceed 16mg in 24 hours for diarrhea (Preg. Risk Cat: B)
- MOM 30cc po q day prn constipation (Preg. Risk Cat: B)
- Hydroxyzine HCL (Vistaril) 50mg po q 4hrs prn insomnia/anxiety/pruritis/nausea/or vomiting (Preg. Risk Cat: not rated)
- Trazadone (Desyrel) 50-300mg po qhs prn for insomnia (Preg. Risk Cat: C)
- Dicyclomine (Bentyl) 20mg po q 6 hrs prn abdominal cramping (Preg. Risk Cat: not rated)
- Phenegan 25 mg po, IM or PR q 8 hours prn for nausea/vomiting (Preg. Risk Cat: C)

For Pregnant Inmates: Prescribers who are not specialists in OB/GYN are advised to consult with a pharmacist or other resource prior to prescribing symptomatic treatment other than Pregnancy Risk Cat. A or B drugs.

Contra-indication to Buprenorphine:
Age 15 or under.
Known allergy

Yes

Begin Buprenorphine Protocol*

If initial dose is given between noon and midnight:

- Dose 1: 8 mg stat (This is Day 1)
- Dose 2: 8 mg between 6 am and 8 am on Day 2
- Dose 3: 8 mg at 6 pm on Day 2
- Dose 4: 12 mg at morning med pass on Day 3
- Dose 5: 8 mg at morning med pass on Day 4
- Dose 6: 4 mg at morning med pass on Day 5

If initial dose is given between midnight and noon:

- Dose 1: 8 mg stat (This is Day 1)
- Dose 2: 4 mg at 6 pm on Day 1
- Dose 3: 16 mg at morning med pass on Day 2
- Dose 4: 12 mg at morning med pass on Day 3
- Dose 5: 8 mg at morning med pass on Day 4
- Dose 6: 4 mg at morning med pass on Day 5

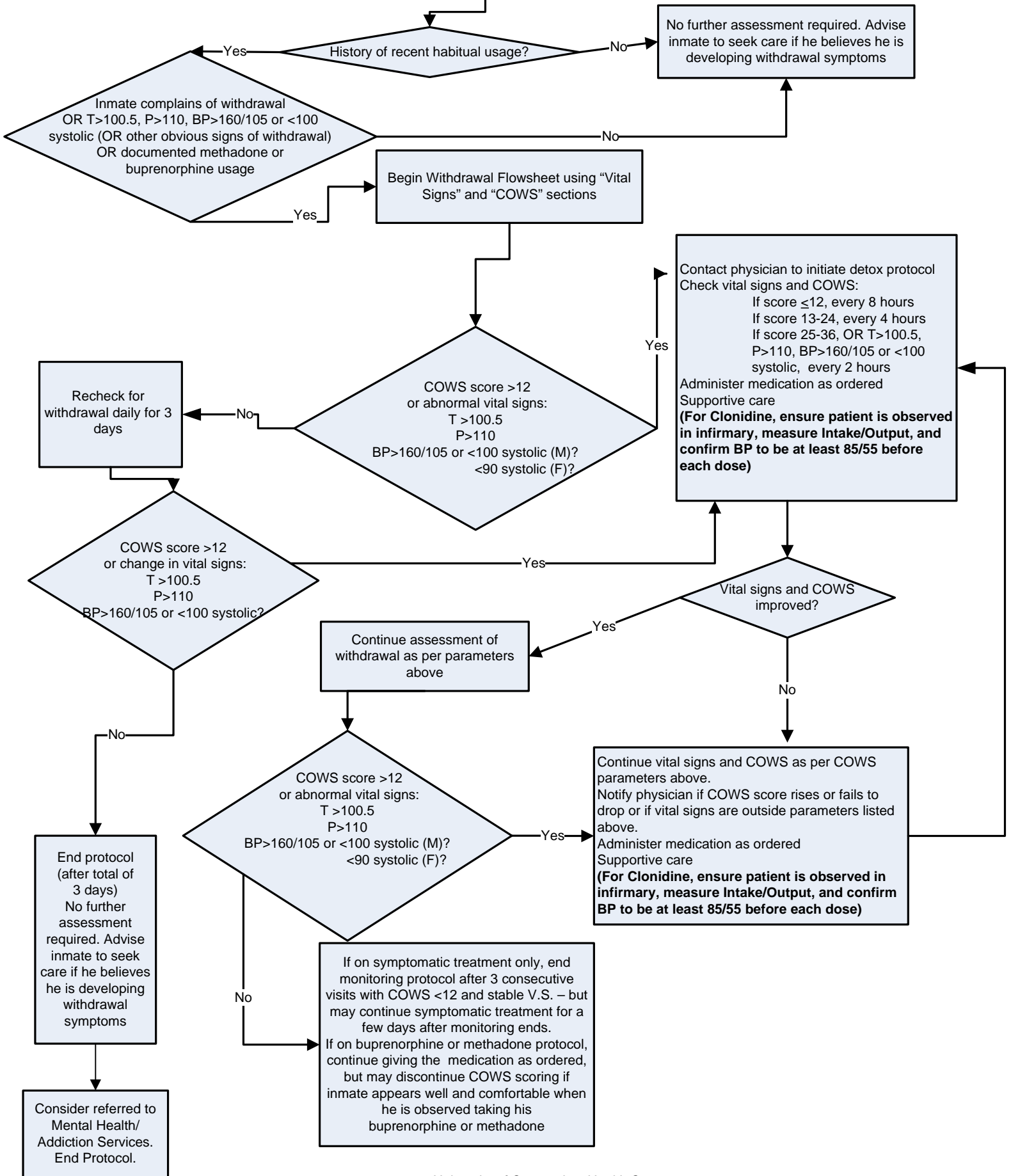
Once ordered, the Buprenorphine protocol should be continued and completed unless inmate status changes markedly. Additional symptomatic medications may be ordered (see box to the left), but these will not usually be necessary.

For Males in the Infirmiry setting only and not on the buprenorphine protocol:

Symptomatic treatment may be supplemented with clonidine (Catapres) at 0.1-0.2 mg po TID, increasing to 0.2-0.4mg TID as indicated by VS and COWS by day 3. Blood pressure must be monitored and confirmed to be at least 85/55mm Hg before clonidine is administered each time. The dose is maintained until the patient's symptoms stabilize for several days and then is reduced by 0.2-0.4 mg/day and stopped. Other symptomatic treatments as outlined

Opiate Detoxification Nursing Guidelines

Document opiate ingestion within past week on CMHC Form HR001, Intake Health Screening. (Include amount used and date/time of last usage).



**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
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FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 7.01

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PERINATAL CARE

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that pregnant inmates in the custody of the Connecticut Department of Correction (**CDOC**) receive perinatal care.

PROCEDURE: Perinatal care shall include regular medical examinations, nutritional guidance, and counseling.

When appropriate and feasible, CDOC pregnant inmates shall be followed by the practitioner who will assist them at birth, and be registered at the hospital where the birth will take place.

In those cases of high-risk pregnancy, specialty care from the community shall be provided to the inmate as needed.

The inmate's prenatal history and ongoing prenatal care shall be documented in her health record and this information shall accompany her to the hospital.

REFERENCES: *Administrative Directives, 8.12, Placement of Children Born to Incarcerated Women.* 2007. Connecticut Department of Correction
Standards for Health Services in Prisons. (P-G-07). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC – CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Mark Buchanan MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 8.01

Page 1 of 1

INMATES WITH SUBSTANCE USE PROBLEMS

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that clinical management of Connecticut Department of Correction (**CDOC**) inmates with substance use problems be provided.

PROCEDURE: Inmates identified by CMHC clinical staff to have problems associated with substance use shall be referred to the on-site physician for evaluation and appropriate treatment, including the CDOC Alcohol and Drug Treatment Program (Addiction Services), when indicated.

Inmates with a history of problems associated with the use of alcohol or other drugs should be given the opportunity for counseling CDOC Alcohol and Drug Treatment Program (Addiction Services), and where available and indicated, specialized assessment and treatment for these problems.

In addition, special attention shall be given to the provisions of the CDOC Doe vs. Meachum Consent Judgment (1990) as they relate to inmates with a history of substance use.

REFERENCES: *Administrative Directive 10.13, Inmate Programs.* 2006. Connecticut Department of Correction.
Doe vs. Meachum Consent Judgment. 1990. Connecticut Department of Correction. *Standards for Adult Correctional Institutions (3-4371).* Third Edition, 1990. American Correctional Association.
Standards for Health Services in Prisons (P-G-08). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD _____

Title: CMHC Director of Medical Services, Johnny Wu MD _____

Title: CDOC Director Health Services, Kathleen Maurer MD _____

**UConn Health
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 9.01

Page 1 of 2

PREGNANCY COUNSELING

Effective Date: 04/01/01

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**) shall ensure that all pregnant inmates in the custody of the Connecticut Department of Correction (**CDOC**) are provided with comprehensive counseling and assistance in keeping with their express desires in planning for their unborn children.

PROCEDURE: In addition to the availability of daily sick call services, pregnant inmates who desire to reach full term shall receive comprehensive prenatal health care, including appropriate diet as ordered by a physician, vitamins, routine obstetrical clinic visits, and laboratory procedures.

HIV testing shall be offered on a routine basis, along with pre/post test counseling.

Prior to delivery, the inmate shall be linked with a community provider to assist with arrangements for the infant's care.

Elective termination of an inmate's pregnancy shall be consistent with Connecticut State statutes.

A pregnant inmate considering elective termination shall submit a written request for evaluation to the CMHC physician.

A facility physician or physician extender shall examine and consult with the inmate on available alternatives to elective termination of her pregnancy.

REFERENCES: *Administrative Directives, 8.12, Placement of Children Born to Incarcerated Women.* 2007. Connecticut Department of Correction.
Doe vs. Meachum Consent Judgment. 1990. Connecticut Department of Correction.
Standards for Adult Correctional Institutions (4-4353, 4-4362). 2003. American Correctional Association.
Standards for Health Services in Prisons.(P-G-09). 2008. National Commission on Correctional Health Care. Chicago, IL.

Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman, MD PhD _____

Title: CMHC Director of Medical Services, Mark Buchanan MD _____

Title: CDOC Director Health Services, Daniel Bannish PsyD _____

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 10.01

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AIDS TO IMPAIRMENT

Effective Date: 04/01/01

POLICY:

UConn Health, Correctional Managed Health Care (**CMHC**) Program Administrators shall ensure that aids to impairment (such as eyeglasses, hearing aids, crutches, or wheelchairs) be provided to inmates in the custody of the Connecticut Department of Correction (**CDOC**) when the health of the inmate would otherwise be adversely affected, as determined by the responsible facility provider or dentist.

PROCEDURE:

The following definitions are provided for the purposes of this policy:

- **Orthoses:** specialized mechanical devices used to support or supplement weakened or abnormal joints or limbs, such as braces, foot inserts, or hand splints.
- **Prostheses:** artificial devices such as limbs, eyeglasses or full and partial dentures, to replace missing body parts such as limbs, teeth, eyes, or heart valves.

Aids to impairment shall be provided to inmates only after referral, evaluation and recommendation of a CMHC provider contractor or dentist. Staff shall document inmate aids to impairment on form **HR 800A Health Summary Sheet** in the appropriate section.

Eyeglasses/Contact Lenses

Eyeglasses shall be provided to inmates as needed, on a prescription basis only. Only a contracted provider, or UCHC ophthalmologist or optometrist shall prescribe eyeglasses.

- Tinted (darkened) eyeglass lenses may be ordered by a CMHC optometrist for specific clinical conditions

New commits shall be permitted to retain their eyeglasses unless an imminent security concern exists.

Inmates may request to have a pair of eyeglasses mailed into or out of the facility when the following conditions are met:

- The eyeglasses are confiscated upon admission due to security concerns,
- The inmate does not have his/her glasses upon admission,

AIDS TO IMPAIRMENT

- A new prescription needs to be filled, or
- An existing pair needs to be repaired or replaced.

The inmate's Unit Counselor shall review and approve the inmate's request before the eyeglasses can be sent into the facility. Each facility shall establish a Policy/Procedure in order for the eyeglasses to be allowed in or out of the facility. Upon receiving the eyeglasses, the facility's Property Officer shall inspect and approve the eyeglasses before the inmate(s) receive them. If the eyeglasses need to be repaired or replaced, the inmate may send the eyeglasses home or to an authorized repair facility. In such case, the Property Officer shall inspect the eyeglasses and approve them before the inmate(s) receive them. No eyeglasses may have a claim value greater than \$100.00.

Eyeglasses will be replaced no earlier than every eighteen months, and then only when determined by an optometrist or ophthalmologist to be necessary.

Since there is some inevitable delay between being referred to eyeglasses and receiving them, inmates shall not be referred for eyeglasses, and UCHC optometrists shall not order eyeglasses, for any inmate who isn't reasonably certain to remain in custody at least two months, unless the inmate is severely disabled from a correctable refractive error.

Documented lost or broken eyeglasses, with no evidence of self-destruction as well as surgical conditions will be considered exceptions. Occupational lenses, e.g., welding, V.D.T., etc, will be evaluated on an individual basis.

New commits shall be permitted to retain their contact lenses if they have no glasses. Health services shall provide contact lens cleaning/soaking solution and a lens container. Inmates may continue to wear their contact lenses until seen by an optometrist or they have glasses sent in from home. The optometrist will make a determination if:

- glasses can be ordered to replace the contact lenses or
- the inmate has a medical condition that necessitates the need to wear contact lenses.

Referrals may be made to optometry clinics, through the CMHC referral process, for prescription safety glasses or pathological or environmentally related ocular conditions. Replacement will be on the same basis as replacement for eyeglasses.

- REFERENCES:** *Standards for Health Services in Prisons (P-G-10)*. 2008. National Commission on Correctional Health Care. Chicago, IL.
Americans With Disabilities Act, 1990.
Administrative Directive 10.19. Americans with Disabilities Act. 2008. Connecticut Department of Correction.


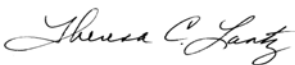
Approved: UCHC - CMHC

Date:

Title: CMHC Executive Director, Robert Trestman MD PhD

Title: CMHC Director of Medical Services, Johnny Wu MD

Title: CDOC Director Health Services, Kathleen Maurer MD

 <p>State of Connecticut Department of Correction</p> <p>ADMINISTRATIVE DIRECTIVE</p>	Directive Number 10.19	Effective Date 9/15/2008	Page 1 of 7
	Supersedes Americans with Disabilities Act, dated 4/9/2004		
Approved By 	Title Americans with Disabilities Act		

1. Policy. The Department of Correction shall make reasonable accommodations or modifications to allow qualified inmates with disabilities the same opportunities as non-disabled inmates unless to do so would be an undue burden to the Department, cause a fundamental alteration to a program or might tend to jeopardize the safety or security of the public, staff, inmates or facility.

2. Authority and Reference.
 - A. United States Code, 42 USC Section 12101 et seq, Americans with Disabilities Act of 1990.
 - B. Connecticut General Statutes, Sections 18-81, 18-84, 46a-51, 46a-63(2) and 46a-77.
 - C. Administrative Directives 9.6, Inmate Administrative Remedies; 10.1, Inmate Assignment and Pay Plan; and, 10.20, Correctional Enterprises of Connecticut.
 - D. American Correctional Association, Standards for Adult Correctional Institutions, Fourth Edition, January 2003, Standard 4-4142.
 - E. American Correctional Association, Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June 2004, Standard 4-ALDF-2A-51.

3. Definitions. For the purposes stated herein, the following definitions apply:
 - A. Blind. Refers to an individual whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses, or whose visual acuity is greater than 20/200 but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees.
 - B. Deaf. Refers to an individual who cannot readily understand spoken language through hearing alone and who may also have a speech defect, which renders speech unintelligible to most people with normal hearing.
 - C. Disabled Inmate. An inmate who has a physical or mental impairment that substantially limits one or more major life activities; who has a record or history of such impairment; or is perceived or regarded as having such impairment.
 - D. Major Life Activities. Functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.
 - E. Mentally Disabled. An individual who has a record of, or is regarded as having one or more mental disorders, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
 - F. Physically Disabled or a Person with a Physical Disability. An individual who has a chronic physical infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes from illness, including but not limited to, epilepsy, deafness or hearing impairment or reliance on a wheelchair or other remedial appliance or device.

Directive Number 10.19	Effective Date 9/15/2008	Page 2 of 7
Title Americans with Disabilities Act		

- G. Qualified Individual with a Disability. An individual with a disability who, with the assistance of a reasonable accommodation, is able to meet the essential eligibility requirements for the receipt of services or the participation in programs or activities.
 - H. Qualified Sign Language Interpreter. Sign language interpreter certified by the National Registry of Interpreters for the Deaf or approved by the Connecticut Commission for the Deaf and Hearing Impaired.
 - I. Reasonable Accommodation. Any change in the environment or the manner in which tasks are completed that enables a qualified individual with a disability to participate in a program or service. Such accommodation shall not impose undue hardship on the Department or compromise the safety or security of the public, staff, inmates or facility.
 - J. Substantially Limit. The impairment imposes a significant barrier in the performance of a major life activity.
4. Department Americans with Disabilities Act (ADA) Coordinator. The Director of Programs and Treatment (Division) shall appoint the Director of Health and Addiction Services or designee as the Department ADA Coordinator. The Department ADA Coordinator shall be knowledgeable regarding the provisions of the Americans with Disabilities Act in order to coordinate the requirements of the ADA. The duties of the Department ADA Coordinator shall include, but not be limited to, the following:
- A. Develop procedures for the prevention of discrimination against qualified inmates with disabilities.
 - B. Analyze the Department's administrative directives, unit directives, policies and procedures and recommend changes to assist in compliance with the ADA.
 - C. In consultation with facility and Department Administrators, coordinate the planning and purchasing of adaptive equipment for qualified inmates with disabilities.
 - D. In consultation with the Director of Facilities Management and Engineering Services recommends structural changes, where warranted, to comply with ADA requirements.
 - E. In consultation with the Director of Offender Classification and Population Management, take steps to enable qualified inmates with disabilities to be placed in facilities appropriate for given disabilities consistent with safety and security.
 - F. Coordinate reasonable accommodations for qualified inmates with disabilities with outside service providers consistent with safety and security.
 - G. Coordinate training for all Unit ADA Coordinators on the requirements of this Directive.
 - H. Provide assistance to staff, including Unit ADA Coordinators in determining whether and how accommodations may be provided.
 - I. Facilitate ongoing training for Unit ADA Coordinators.
 - J. Review monthly unit reports related to ADA activity and compile statistics to track ADA compliance.
5. Unit ADA Coordinator. Each Unit Administrator as well as the Director of Parole and Community Services shall appoint a supervisor/manager to act as Unit ADA Coordinator who shall be trained in the requirements of this Directive and those ADA requirements that are relevant to the Unit ADA Coordinator's duties. The duties of the Unit ADA Coordinator shall include, but not be limited to, the following:

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- A. Review proposed and existing unit directives, policies and procedures to assess compliance with Department guidelines. Provide recommendations to the Unit Administrator for potential corrective action.
 - B. Receive copies of all inmate appeals which relate to ADA issues and conduct initial processing of CN 101902, Requests for Reasonable Accommodation forms.
 - C. In consultation with the Unit Administrator, the ADA Coordinator shall resolve requests for accommodation by arranging for:
 1. necessary evaluation by qualified experts;
 2. transfers to appropriate correctional facilities; and,
 3. ADA required auxiliary aids as required, consistent with the professional evaluation of the disability.
 - D. Ensure adequate copies of the attachments to this Directive are available in each facility housing unit.
 - E. Ensure appropriate documentation on reasonable accommodation is maintained in the inmate's master file.
 - F. Notify unit staff of disability accommodation and any advisable modification of unit procedure and in accordance with Section 7 of this Directive.
 - G. Submit reports to the Unit Administrator and the Department ADA Coordinator as required.
6. Inmate Admission and Orientation.
- A. Admission. Any inmate who appears to have a condition that would limit the inmate's access to and/or participation in, any program or service offered by the facility, shall be handled as follows:
 1. Inmates who are deaf, blind, or have other physical disabilities that significantly limit access to programs and services in the facility, shall be transferred to an appropriate facility within 72 hours of admittance for assessment and classification consistent with safety and security. The determination for transfer shall be made by the contracted health services provider Health Services Administrator or designee. During assessment and classification, the inmate shall be provided with CN 101901, Americans with Disabilities Act - Notice of Rights and CN 101902, Request for Reasonable Accommodations by health services staff or qualified sign language interpreter for the deaf or hard of hearing inmates who know sign language. Inmates shall be advised of their right to reasonable accommodations which may include a qualified sign language interpreter or other auxiliary aids, services and devices, the method for requesting such accommodation and the procedures for seeking an administrative remedy of a denial or modification of such requested accommodation. The inmate shall be required to complete the Request for Reasonable Accommodations indicating whether or not the inmate requests accommodation.
 2. Any inmate newly received into the custody of the Department of Correction who appears to meet the definition for mentally disabled shall be transferred to an appropriate facility within 72 hours of admission for assessment and classification

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consistent with safety and security. The determination for transfer shall be made by the contracted health services provider qualified mental health professional. Upon arrival, inmates shall be advised of their rights to reasonable accommodations, the method for requesting such accommodation and the procedures for seeking an administrative remedy of a denial or modification of such requested accommodation. The inmate shall be required to complete the Request for Reasonable Accommodations indicating whether or not the inmate requests accommodation.

- B. Orientation. Classification and health services staff shall, as a component of the facility orientation process, ask each newly admitted inmate if they require a reasonable accommodation. The inmate shall be provided with CN 101901, Americans with Disabilities Act - Notice of Rights and CN 101902, Request for Reasonable Accommodations. Inmates shall be advised of their right to reasonable accommodations, the method for requesting such accommodation and the procedures for seeking an administrative remedy of a denial or modification of such requested accommodation. The inmate shall be required to complete the Request for Reasonable Accommodations indicating whether or not the inmate requests accommodation. CN 101901, Americans with Disabilities Act - Notice of Rights shall be part of the orientation packet.
- C. Request for Reasonable Accommodations. In accordance with the provisions of this section, if an inmate requests reasonable accommodations, CN 4401, Authorization to Obtain and/or Disclose Protected Health Information shall be signed by the inmate authorizing health services staff to obtain and review all relevant medical history for continuity of care and to determine extent and origin of the disability and need for accommodations for the inmate. The Unit ADA Coordinator shall make arrangements with the contracted health services provider nursing supervisor for evaluation by qualified experts (e.g. audiologist, ophthalmologist, etc.) if necessary to verify any functional impairment and determine the need for reasonable accommodation. As a result of the review and assessment, reasonable accommodations shall be developed if required by the ADA. All recommendations for reasonable accommodations shall be made by the contracted health services provider Health Services Administrator or designee and be forwarded to the Unit ADA Coordinator, who shall review the recommendations for the potential impact on safety and security. Modifications to the recommendations due to safety and security concerns shall be forwarded to the Unit Administrator for final disposition.
7. Reasonable Accommodation Efforts. Reasonable efforts shall be made to provide reasonable accommodation throughout the inmate's incarceration. Documentation of the initial determination as described in this section shall be maintained in section 6 of the inmate's master file. Appropriate reasonable accommodation may differ depending on the ability of the inmate and the nature of the program or activity in question.
- A. A request for reasonable accommodations may include the following and shall be forwarded to the ADA Coordinator immediately to handle in accordance with Section 6 of this Directive:
1. An oral or written request to any staff person; or,

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2. A request for assistance or expressions of difficulty in communication or understanding by deaf or hearing impaired inmates or inmates with mental impairment.
 - B. Requests shall be acted upon within two (2) business days or less if necessary.
 - C. If the request is denied, the inmate shall be notified in writing and advised of the right to review the disposition directly with the Unit ADA Coordinator. Upon such request, the Unit ADA Coordinator shall meet with the inmate within 24 hours and render a subsequent decision within one (1) week. If the disposition has not changed, the inmate shall be advised of the right to appeal the decision in accordance with Administrative Directive 9.6, Inmate Administrative Remedies.
 - D. In order to ensure that an inmate who requires a reasonable accommodation is provided with such, each facility shall develop and maintain a system to alert staff that an inmate requiring a reasonable accommodation is assigned to the housing unit in which the staff are working. Staff shall only be advised of inmates covered by ADA when there is a reasonable accommodation requirement.
8. Appeal of an Americans with Disabilities Act (ADA) Decision. An inmate may file an appeal regarding an ADA decision in accordance with Administrative Directive 9.6, Inmate Administrative Remedies. A copy of each appeal and all decisions rendered regarding the appeal shall be maintained by the Department ADA Coordinator.
9. Facility Placement. In addition to all other factors considered by the Department in making institutional or community assignments of inmates, consideration may be given, consistent with security factors, to facilities and programming available at various institutions or community residential programs to accommodate an inmate's particular disabilities. The Director of Offender Classification and Population Management shall ensure that a facility at each security level is available for reasonable accommodation. Any documentation submitted relating to a transfer of a disabled inmate shall clearly indicate that the inmate is disabled and include what level of accommodation and resulting services are required.
10. Inmate Work Programs. No qualified inmate with a disability shall be discriminated against from participation in work programs. The Department shall make reasonable accommodation to the known disability of qualified inmate applicants consistent with safety and security. Accommodations that exceed the requirements of the ADA shall not be provided. Compensation and assignment shall be in accordance with Administrative Directives 10.1, Inmate Assignment and Pay Plan and 10.20, Correctional Enterprises of Connecticut.
11. Suspensions during Emergency or to Further Legitimate Penological Interests. In an emergency or disruption of normal institutional operation, or in furtherance of the legitimate penological interests of a facility or the Department, any provision or section of this Directive may be suspended, for any inmate or all inmates, by the Commissioner or designee.
12. Unit Directives. Each Unit Administrator as well as the Director of Parole and Community Services shall develop unit directives in order to address the needs of inmates with disabilities at the local level.

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13. Auxiliary Aids and Services. Unless legitimate penological interests warrant otherwise, auxiliary aids and services shall be provided to assist an inmate in the following areas:

- A. Educational/Vocational activities;
- B. Appeal procedures;
- C. Administrative or disciplinary proceedings to include protective custody and restrictive status hearings;
- D. Orientation and classification proceedings;
- E. Mental Health Counseling; and,
- F. Medical Services.

14. Assistance Devices for Deaf, Hearing-Impaired, Blind or Visually Impaired Inmates. The following assistance devices shall be made available as needed:

A. Deaf and Hearing-Impaired.

- 1. TDD/TTY for telephone use - access to TDD/TTY shall be equivalent to access to telephones by hearing inmates except that additional time for each call shall be allotted because the assistance devices take additional time to communicate through the system;
- 2. Amplified telephone handsets;
- 3. Closed caption television/VCR decoder;
- 4. Sound amplification and assistance listening devices;
- 5. Sound signals and flashing alarms;
- 6. Visual smoke alarms;
- 7. Hearing aids and batteries; and,
- 8. Any other item that might be required.

Oral announcements and commands, whether through public address system or other means, shall be communicated to the deaf and hard of hearing inmates in a manner which can be understood. Deaf and hearing impaired inmates shall not be disciplined for failure to obey an order or rule which may not have been communicated to the inmate at all or in a manner which could be understood by a deaf or hard of hearing inmate.

The facility shall ensure that visual alarms or manual means of notifying deaf or hard of hearing inmates of such things as emergencies, counts, and announcements shall be utilized whenever and wherever the inmate may be in the facility.

B. Blind and Visually Impaired.

- 1. Large print books;
- 2. Books on tape;
- 3. Escorts;
- 4. Orientation and Inmate Handbook in Braille or large print, as needed;
- 5. Cane; and,
- 6. Any other item that might be required.

The facility shall ensure that an escort be provided for visually impaired inmates during an emergency or any type of movement, as necessary.

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15. Training. The Director of Training and Staff Development shall develop an ADA training curriculum for all direct contact employees and direct contact contract employees. All new direct contact employees shall receive ADA training as a component of pre-service training. Existing direct contact employees shall receive ADA training as a component of annual in-service training.
16. Forms and Attachments. The following forms are applicable to this Administrative Directive and shall be utilized for the intended function:
 - A. CN 101901, Americans with Disabilities Act - Notice of Rights; and,
 - B. CN 101902, Request for Reasonable Accommodations.
17. Exceptions. Any exceptions to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

**UCONN HEALTH
CORRECTIONAL MANAGED HEALTH CARE
POLICY AND PROCEDURES
FOR USE WITHIN THE CONNECTICUT DEPARTMENT OF CORRECTION**

NUMBER: G 11.01

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**CARE OF TERMINALLY ILL INMATES
AND INMATES WITH A CHRONIC DEBILITATING DISEASE**

Effective Date: 11/19/03

POLICY: UConn Health, Correctional Managed Health Care (**CMHC**), shall ensure that the needs of terminally ill Connecticut Department of Correction (**CDOC**) inmates are met through an established program in a safe, secure manner.

DEFINITION: A *terminally ill* inmate is one whose physical condition has deteriorated to the point where he or she has been given a prognosis of less than a year to live.

Early release refers to the release of an inmate before the expiration of his or her sentence based on the inmate's terminal condition.

A *Hospice Program* delivers medical care and support services aimed at providing comfort. Hospice is regarded as a concept, not a place, where end-of-life care is provided for patient and family, encompassing body, mind, and spirit. Treatment is focused on symptom control and quality of life issues, rather than attempting to cure conditions.

Palliative Care is the active total care of inmates housed in general population designed to improve quality of life and minimize suffering of someone who has been diagnosed with a terminal illness or chronic, debilitating illness, but as yet may not require 24-hour infirmary care.

PROCEDURE: When an inmate is diagnosed with a terminal illness, every effort will be made to provide quality end-of-life care.

The following program options are available to address the needs of terminally ill inmates and inmates with a chronic debilitating disease:

Early Release

Consistent with state regulations, health care staff, in collaboration with the CDOC, may initiate and/or facilitate the release of a terminally ill inmate prior to the expiration of his/her sentence.

Hospice Program

A CMHC/CDOC interdisciplinary hospice program is available to male inmates at the MacDougall-Walker and Osborn Correctional Institutions, and to female inmates at the York Correctional Institution. A complete hospice program manual is available at these designated hospice facilities.

Goal

- When a terminal illness prevails, and a medical cure is no longer possible, Hospice recognizes a peaceful and pain-free death as a valid goal

**CARE OF TERMINALLY ILL INMATES
AND INMATES WITH A CHRONIC DEBILITATING DISEASE**Admission Criteria

- Diagnosis with a terminal illness
- Life expectancy of six months or less
- Signed Living Will

Referral Process

- Referral for enrollment is contingent on inmate centered choice
 - ❖ When a patient is incapacitated, the family, personal representative, or legal guardian must evaluate and consent to or refuse hospice care
- Male inmates: To make an inmate referral to the appropriate hospice program, the sending facility nursing supervisor/designee shall contact the hospice volunteer coordinator or nursing supervisor of the hospice program facility.
- Female inmates: Health services or custody staff shall contact the hospice volunteer coordinator or nursing supervisor of the hospice program facility.
- An initial discussion of the referral will be conducted.
- If the referral is determined an appropriate hospice candidate, the sending facility shall complete and fax a fully completed W-10 by the physician at the sending facility; for females this process occurs within the same facility.
- The physician covering the infirmary that has a hospice program will conduct a review of the case and make the final recommendation for approval.
- The sending facility nursing supervisor will be contacted regarding the decision for admission to the hospice program.
- Once the decision to admit the inmate is made, the receiving nursing supervisor/designee will arrange transfer of the inmate (for males) through population management.

Palliative Care Program

Inmates with a terminal illness or who have a chronic debilitating disease who do not meet the medical requirements for immediate admission to the infirmary hospice program shall be assisted with ADLs (activities of daily living) in their respective general population housing unit by a CDOC Trained Hospice Volunteer.

Admission Criteria

- Diagnosed with a terminal illness
 - Life expectancy of one year or less
 - Signed living will
- Diagnosed with a chronic, debilitating disease

Referral Process

- As above, for the hospice program

**CARE OF TERMINALLY ILL INMATES
AND INMATES WITH A CHRONIC DEBILITATING DISEASE**

- The hospice physician makes the final determination for admission.

Communication

- The success of the Palliative Care Program is contingent upon the continued communication between the Hospice Interdisciplinary Team and the Unit Manager and his/her staff of Counselors, CTO's and Correction Officers.

Hospice Volunteer Work Schedule

- The trained DOC inmate hospice volunteer assigned to the palliative care patient shall be assigned a specific work schedule to allow him/her access to the patient's pod/cell.
- Said schedule will be promulgated in writing and signed by the Unit Manager and Correctional Facility Liaison.
- If the Unit Manager desires, the Hospice Volunteer Coordinator/RN will meet with prospective Unit Staff to provide an overview of the palliative care program, and how the program will interact with the patient and the pod/unit.

Change in Patient Status

- In the event the palliative care patient's condition requires 24-hour care, the patient will automatically be admitted into the hospice infirmary program.

Other

For those terminally ill inmates who are not enrolled in the hospice program or eligible for early release, the following shall take place.

- When an inmate (because of terminal illness) demonstrates progressive deterioration that hinders or prevents compliance with institutional activities, such as walking to the dining area or completing ADLs, the inmate shall be transferred to a facility that can accommodate his physical limitations and/or special needs.
- Inmates shall be admitted to an infirmary for the final stages of life.

**CARE OF TERMINALLY ILL INMATES
AND INMATES WITH A CHRONIC DEBILITATING DISEASE**

REFERENCES: *Standards for Health Services in Prisons (P-G-11)*. 2008. National Commission on Correctional Health Care. Chicago, IL.
 Hospice Program Manuals, MacDougall-Walker and York Correctional Institutions.

Approved: UCHC - CMHC	Date:
Title: CMHC Executive Director, Robert Trestman MD PhD _____	
Title: CMHC Director of Medical Services, Mark Buchanan MD _____	
Title: CDOC Director Health Services, Daniel Bannish PsyD _____	