



# ACA Provides Members Comprehensive Health Care Standards

By Leslee Hunsicker

**T**he delivery and quality of health care services provided to offenders has rapidly evolved in recent years. Inmate trustees and unlicensed staff were, at one time, the primary providers of correctional health care. They were assessing and treating illness and injury with whatever means they had at hand. Correctional health care has become a specialty field of practice and offenders' right to access care delivered by qualified health care providers is now guaranteed (*Estelle v. Gamble*, 1976).

As the quality of care has significantly improved, the delivery of health services to the offender population has become increasingly complex. Extended sentences, aging offenders' chronic care needs and the threat of infectious diseases are placing additional strains on staff and budgets. Correctional health care providers are treating complex acute and chronic conditions that include diabetes, respiratory and cardiovascular problems, and renal failure requiring long-term dialysis. Treatment-resistant strains of bacterial and viral infections such as methicillin-resistant *Staphylococcus aureus* (MRSA), tuberculosis and hepatitis present a greater risk of transmission in jails and prisons. Agencies are dealing with the question of organ and tissue transplants and gender identity issues. Jails and prisons have become ad hoc mental health hospitals as an increasing number of acutely mentally ill

individuals are incarcerated. Health care costs continue to escalate, professional staff vacancies are difficult to fill, and budgets are severely constrained.

An often cited Pew Center on the States report from March 2009 notes that in the U.S., 1 in every 31 adults are incarcerated or on parole. Offenders present with increasingly challenging and complex treatment needs related to substance abuse, infectious diseases, chronic illness, aging and mental illness. State agencies struggle to provide the necessary services and meet their budget constraints as health care costs continue to escalate in an environment of declining resources. Adequately meeting the treatment needs of this population in a cost-effective manner requires adopting treatment strategies and procedures, empirical observation, and clinical guidelines based on reliable data. Valid information on "what works" is fundamental motivation for the continued evaluation of current practice and exploration of future procedures. The best determinants for effective treatments provided in a cost-efficient, clinically responsible manner are the ongoing evaluation and study of outcomes resulting from the application of evidence-based procedures and treatments.

## Example of a Partial Health Care Outcome Measure Worksheet

Sample of Health Care Outcomes				
Standard	Outcome Measure	Numerator/Denominator	Value	Outcome Measure
1A	(1)	Number of offenders with a positive tuberculin skin test in the past 12 months	10	
	divided by	Annual number of admissions in the past 12 months	100	0.1
	(2)	Number of offenders diagnosed with active tuberculosis in the past 12 months	25	
	divided by	Average daily population in the past 12 months	500	0.05
	(3)	Number of conversions to a positive tuberculin skin test in the past 12 months	2	
	divided by	Number of tuberculin skin tests given in the past 12 months	100	0.02
	(4)	Number of offenders with a positive tuberculin skin test who completed prophylaxis treatment for tuberculosis on an annual basis	25	
	divided by	Number of offenders with a positive tuberculin skin test on prophylaxis treatment for tuberculosis in the past 12 months	25	0
	(5)	Number of hepatitis C positive offenders in the past 12 months	75	
	divided by	Average daily population in the past 12 months	500	0.15
	(6)	Number of HIV-positive offenders in the past 12 months	34	
	divided by	Average daily population in the past 12 months	500	0.068
	(7)	Number of HIV-positive offenders who are being treated with highly active antiretroviral treatment in the past 12 months	53	
	divided by	Number of known HIV-positive offenders in the past 12 months	125	0.424
	(8)	Number of offenders diagnosed with an Axis I diagnosis (excluding sole diagnosis of substance abuse) in the past 12 months	183	
	divided by	Average daily population in the past 12 months	500	0.366

Criminal justice agencies cannot post a “no vacancy” sign, and health care providers cannot limit the number of patients in their correctional practice. Providers do not know who they are going to get and have little or no opportunity for advance preparation to meet potentially acute and/or chronic treatment needs. Health providers in the criminal justice arena must be prepared to meet every treatment challenge, and they must have access to the appropriate resources.

### ACA Mission and Standards

The American Correctional Association, established in 1870 as the American Prison Association, recognized the responsibility corrections professionals have for public, staff and offender safety. The founding principles of ACA, humanity, justice, protection, opportunity, knowledge, competence and accountability, recognize that the humane provision of comprehensive treatment services to incarcerated and detained persons is an imperative. As the majority of offenders are released to the community, it is in the interest of public health and safety that they are released in an optimal state of well-being with continued access to adequate follow-up care in the community. ACA established nationally recog-

nized minimum standards for prisons and jails for voluntary accreditation, the first step in improving the treatment of offenders and ensuring a safe environment for staff. This was a major initial step in the early prison reform movement. As the criminal justice system grew and evolved, ACA’s professional membership and governing bodies continued to revise the organization’s standards and accreditation process to meet operational and provision-of-services challenges faced in this rapidly changing profession.

With the leadership and support of then-President Bobby Huskey, the ACA Standards Committee began the process, in 1996, of developing standards that moved beyond the evaluation of simply “how things are done” to assessing the outcomes of procedures and programs through a process of collection and analysis of relevant data. The revision of compliance standards to a system of performance-based standards was initiated, and it received continued support of subsequent ACA presidents, administrators and members. Following numerous drafts, and the work of more than 30 experts in the profession, the ACA Standards Committee approved the *Performance-Based Standards for Adult Community Residential Services* for field testing in 1999. These standards were adopted and published in 2000.

## Example of ACA Health Care Standard

### Chronic Care

IHC-1A-16  
(Ref. New)

**(Mandatory) There is a plan for the treatment of offenders with chronic conditions such as hypertension, diabetes, and other diseases that require periodic care and treatment. The plan must address the monitoring of medications, laboratory testing, the use of chronic care clinics, health record forms, and the frequency of specialist consultation and review.**

*Comment:* Professionally recognized chronic care guidelines are available from disease-specific organizations and various medical and physician associations.

*Protocols:* Written policy and procedure. Chronic care protocols and forms.

*Process Indicators:* Health records. Chronic care logs. Specialist schedules.

Under the leadership of former ACA President Richard Stalder (1998 – 2000), an ACA Performance-Based Standards Committee was formed to begin the process of drafting performance-based health care standards. As the health care advisor to the ACA president, Elizabeth Gondles, Ph.D., enlisted the participation of nationally recognized correctional health care providers from across the country in the revision of the standards. The committee was led by Kenneth Moritsugu, M.D., who went on to become the acting U.S. surgeon general. As the process evolved, ACA was privileged to work with other nationally respected practitioners, such as Lester Wright, M.D., Dianne Rechline, M.D., Robert Hofacre, Anita Lockhart, DDS, David Thomas, M.D., Newton Kendig, M.D., Art Beeler, Bonita Sweeney, Lannette Linthicum, M.D., Kay Northrup, RN, and Michael Hegmann, M.D., among many others. Their dedicated work and that of many others formed the basis for the revision and publication of performance-based health care standards and clinically relevant outcome measures for adult correctional institutions and jails, therapeutic communities, and juvenile facilities.

Compliance with ACA performance-based standards leads to accreditation based on results, changing the focus from what is being done to how well it is succeeding. Even with flawless paperwork, the actual process or resulting outcomes may identify deficiencies. Associated outcome measures include the ongoing collection and analysis of measurable events, occurrences, behaviors or conditions to determine actual progress toward a desired objective. Reliable data derived from accurate outcome measure data collection and analysis verifies the effectiveness of a process that allows comparison over time. This is a useful element of comprehensive quality assurance process. Clinically relevant outcome measures based on expected practices can positively impact the cost-effective delivery of health care services and programs.

As clinicians and health care providers learn from new research and as available treatments are developed, ACA continually responds to the needs of correctional health care by involving experts in the delivery of treatment services. The review and proposal of standards revisions and new standards will ensure the compliance process meets current expected practices while also anticipating future expectations. This is evidenced by the *Performance-Based Standards for Juvenile Correctional Facilities, Fourth Edition*, published by ACA in 2009, which will be followed by the 2010

publication of the *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions, Second Edition*. The utilization of performance-based standards and the ongoing analysis of collected outcome data enable agencies to make informed administrative decisions related to the allocation of increasingly limited resources in the delivery of health care. It provides reliable information on what is working, where improvements are needed, and where deficiencies exist. Performance-based standards are a critical element that should be used to analyze the delivery of services, maintain continuous quality assurance, assess systemic needs, and control unnecessary or ineffective expenditures. Calculated outcome measures provide information related to the achievement of the desired condition. Decision-makers have real data to drive budgetary considerations.

## An Evolving Field

The delivery of cost-effective quality health services to the offender population is an essential, albeit challenging, part of achieving agency goals and objectives. As agencies balance budget belt-tightening and a declining pool of qualified health service professionals, they must focus on effectively allocating diminishing resources. Accreditation that imparts performance-based standards has many benefits, including defense against litigation, a continuous process of quality management and risk assessment, and the ability to make informed decisions based on results.

Correctional health care has a responsibility to continue to develop and evaluate efficient and effective methods of delivering quality, evidence-based treatment and programs to the offender population. It has a financial, legal and ethical obligation to return offenders to the community in a reasonable state of health in order to facilitate their successful reentry and prevent the transmission of infectious disease. And it has a responsibility to base professional decisions on current information and evaluate what may be effective tomorrow. Correctional health professionals must commit to remaining current and contribute to the continuing evolution of the profession, providing appropriate care and meeting expected guidelines and outcomes for the patients under their care.

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*Leslee Hunsicker, RN, BSN, is health services administrator for the American Correctional Association.*