

ACA Is Leading the Way in the New Generation of Health Care Standards

By James A. Gondles, Jr., CAE

The American Correctional Association (ACA) is taking another important step in leading the correctional health care accreditation process. In early 2008, ACA will unveil a revised edition of the *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions*, originally published five years ago. In addition, ACA will soon release its performance-based health care standards for juvenile facilities, which were approved in 2005. These two publications are the latest examples of the expansion of ACA's health care standards program. The health care standards are constructed in the performance-based format, an approach to accreditation started more than a decade ago that will guide the eventual revision of all ACA standards manuals. ACA was the first accrediting body to use performance-based standards.

A Brief History

In 1996, ACA's Standards Committee began examining ways to develop standards that would do more than prescribe activities or practices for compliance. It wanted these new standards to measure performance and describe particular conditions to be achieved and maintained. The Standards Committee wrestled with different methods of adapting existing standards to encompass this new function. After nearly a year of revising and reformatting, the committee concluded that it needed an entirely new approach.

Under the leadership of President Bobbie Huskey (1994-1996), ACA began discussing the concept of performance-based standards. Since that time, presidents Reginald Wilkerson, Richard Stalder, Betty Adams Green, Charles Kehoe, Gwendolyn Chunn and now Gary Maynard have ensured that new or revised ACA standards are performance-based.

ACA conducted numerous activities in 1997 and 1998 involving more than 30 practitioners and experts that focused on converting standards and accreditation into a "continuous quality improvement" process. After several drafts and changes, *Performance-Based Standards for Adult Community Residential Services* was approved for field testing in 1999. After successful field testing, the standards were adopted and published in August 2000.

Since then, ACA has expanded the performance-based approach to its standards for correctional health care in adult correctional institutions; adult local detention facilities; correctional industries; therapeutic communities; and health care in juvenile facilities.

Health Care Accreditation

The development of national standards and accreditation is perhaps the most significant improvement in the history of correctional reform. In addition to making a facility generally safer and more secure, accreditation confers many specific advantages and benefits to correctional agencies. The process assesses a facility's strengths and weaknesses and identifies important obtainable goals for improvement. Accreditation ensures that state-of-the-art policies and procedures are implemented and that specific guidelines for daily operations are established and followed.

Documented accreditation also offers powerful evidence in the face of legal action against an agency, and it contributes to a swift and effective defense against frivolous lawsuits. Additionally, awareness of accredited status tends to increase the community's support for the agency as well as the professionalism and morale of the correctional staff.

While ACA has always included a review of the health care practices in its facility audits, specific standards for health care are a response to the dramatic changes in correctional health care during the last couple of decades. Emerging technologies and new threats from infectious diseases demand a greater depth of involvement in health care for accredited facilities.

During the presidency of Richard Stalder (1998-2000), ACA formed a Performance-Based Standards Committee to draft standards for health care. Chaired by Dr. Kenneth Moritsugu (now the acting U.S. surgeon general), along with then-Sheriff Charles Foti (now Louisiana's attorney general), Dr. Lester Wright, Dr. Michael Hegmann, Dr. Dianne Rechline, Dr. David Thomas, Dr. Harold Margolis and others, this committee sent the first full draft for performance-based health care standards to the Standards Committee.

Correctional populations have mushroomed during the past 20 years, and that growth has brought about new health care challenges. Diseases such as HIV infection, methicillin-resistant staphylococcus aureus (MRSA), hepatitis A, B and C, and tuberculosis are much more prevalent in prisons now than in years past, and they have a significantly greater impact on a correctional facility's operation. The female offender population, as well as the population of geriatric offenders, has increased, along with their demand for appropriate health care. In addition, with the deinstitutionalization of mental health patients, many of these troubled individuals end up in correctional systems, making correctional agencies responsible for their mental health treatment and care.

Providing adequate health care for corrections' growing and varied populations is an enormous undertaking and a

critical part of any agency's mission. ACA believes that an important way for facilities to demonstrate excellence in correctional practice is to demonstrate excellence with their health care services. That is why ACA is leading the way in health care accreditation with up-to-date standards that provide explicit guidance for responding to the latest health care demands.

Health care standards will do more than just show if adequate health care services are being provided in a particular facility. This process will help identify specific weaknesses and deficiencies in a facility's health care program and will let an agency know how its health care services are impacting its population.

While developing its health care standards, ACA recognized that health care practitioners would have to lead in the effort. It assembled some of the foremost medical experts to ensure that these standards, though designed for the correctional environment, were chiefly about health care. To update its health care standards, ACA formed a committee whose members show a high caliber of correctional and medical expertise. Members of the committee include: Elizabeth Gondles, Ph.D., president of the Institute for Criminal Justice Healthcare; Newton E. Kendig, M.D., medical director of the Health Services Division, Federal Bureau of Prisons (BOP), with assistance from Michele J. McDaniel and Anita Lockhart, also from the BOP; C.D. Menon, mental health administrator with the BOP; Arthur F. Beeler Jr., warden of the BOP's Federal Medical Center in Butner, N.C.; James LeBlanc, warden of the Dixon Correctional Institute in Jackson, La.; Lannette Linthicum, M.D., medical director of the Texas Department of Criminal Justice; M. Kay Northrup, R.N., warden of the Corrections Medical Center, Ohio Department of Rehabilitation and Correction; Richard Stalder, secretary of the Louisiana Department of Public Safety and Corrections; and Lester N. Wright, M.D., deputy commissioner and chief medical officer of the New York State Department of Correctional Services.

Why Revise Existing Health Care Standards?

When ACA releases its revised health care standards for adult correctional institutions, they will include a new edition of performance standards, outcome measures and expected practices. However, it is usually the outcome measures and expected practices that undergo the revisions. A performance standard is a statement that clearly defines an essential condition within a correctional agency that reflects the health care program's overall mission and purpose. Because performance standards are so fundamental, it is less likely that they will require frequent revision. In other words, the basic purpose of good health care in a correctional agency will not change.

Expected practices, on the other hand, are steps that health care practitioners believe a facility must take to achieve and maintain compliance with the performance standards. These activities represent the latest and best thinking in correctional health care, and they are developed from years of practical experience and observation. As conditions in correctional health care change, and as practitioners learn from further experience, expected practices and outcome

measures should evolve to reflect the growing body of medical knowledge and experience.

A pertinent example of such a change is in the outcome measures of the forthcoming revised *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions*. Performance Standard 1A states, "Offenders have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner." The stated goal of that performance standard ("Provide appropriate and necessary health services and care for offenders.") is a basic function for any correctional facility, and the outcome measures call for recording the number of offenders diagnosed with tuberculosis, hepatitis C, HIV infection and other diseases.

The new outcome measures for Performance Standard 1A reflect a relatively recent and growing concern about methicillin-resistant staphylococcus aureus (MRSA) among correctional practitioners in the field. A potentially serious bacterial skin infection, MRSA outbreaks have occurred in offender populations throughout the United States and can occur in correctional staff and their families. The outcome measures now call for recording data on the incidence of MRSA infection, as well as other diseases. This is an important and timely addition, as MRSA infection can disrupt correctional operations, can be costly to treat if not effectively managed, and can affect the morale and health of staff and offenders.

Performance-Based Standards And Juvenile Corrections

Juveniles have distinct personal and developmental needs, and ACA has always advocated for treatment separate from adult offenders. Its accreditation process reflects this philosophy with separate volumes of standards for juvenile facilities and programs. When ACA publishes *Performance-Based Standards for Correctional Health Care in Juvenile Facilities*, it will mark the first expansion of the performance-based approach into the area of juvenile accreditation.

The juvenile performance-based health care standards, like the adult standards, provide a model to ensure that correctional agencies deliver quality, comprehensive and continuous medical, dental and mental health services. In addition, the juvenile standards include expected practices that reflect consideration of the juvenile's age, promote early intervention and emphasize family involvement as an important part of the juvenile's continuity of care.

For example, both adult and juvenile standards require that health care services in a clinical setting are available at least five days a week. However, the standards for juveniles include the provision that a health care practitioner also be available at least once a week to respond to any specific health questions juveniles may have. Also, the standards point out that when juveniles receive care and treatment for chronic illnesses or conditions such as asthma, diabetes and other diseases, age-specific medical reference materials must be available.

In addition, the juvenile standards have specific expected practices on the management of pharmaceuticals for juveniles. Any psychotropic drugs that require parenteral administration must be prescribed by a health care practi-

tioner and according to an established treatment plan. The standards also specifically prohibit the use of stimulants, tranquilizers or psychotropic drugs on juveniles “for purposes of discipline, security control or for purposes of experimental research.” While the adult health care standards allow offenders to perform limited health care duties under staff supervision, the juvenile standards prohibit juveniles from working on any health care tasks in their facility.

While ACA was constructing these juvenile health care standards, it remained mindful that juveniles in custody usually have family in the community and that their families can be an important resource. The standards require that the parents, guardians or legal custodians of juveniles in custody are informed about the medical care the juveniles have access to or have received. Of course, in the case of serious injury, illness or death of a juvenile, the parent, guardian or legal custodian must be promptly notified. Whenever possible, the juvenile’s family is required to be involved in any chemical dependency treatment, aftercare and discharge planning.

As with the health care standards for adult facilities, ACA worked closely with health care practitioners to develop the juvenile standards. The following individuals made every effort to ensure that these standards balance the security needs of the facility with the developmental and health care needs of juveniles: Robert Hofacre, director of ambulatory services for the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute; Elizabeth Gondles, Ph.D.; Geno Natalucci-Persichetti, senior policy analyst for the Ohio Department of Rehabilitation and Correction; Debra DePrato, M.D., associate professor at the Louisiana State University Health Sciences Center; Howard R. Ross, supervisor for the Nashville Davidson County Juvenile Court; and Lester Wright, M.D.

A number of health care professionals from the Ohio Department of Youth Services also were involved in the review process and revision of the juvenile health care standards. These individuals included Nancy Cunningham, Psy.D., correctional health care bureau chief; John F. Bradley, M.D., medical director; Glenn Thomas, Ph.D., clinical services director; Joyce Bednarek Starr, substance abuse services administrator; Jackie Carter, medical programs administrator; Eleanor Kalfs, medical programs administrator; Carol Metz, health services administrator; Pat Sarosi, health services administrator; Pam Robbins, health services administrator; Karen Bryan, health services administrator; Anne Gilstrap, food service administrator; and Bonita J. Sweeney, senior administrator for accreditation and standards.

Extensive Preparation and Field Testing

The revised *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* and the new *Performance-Based Standards for Correctional Health Care in Juvenile Facilities* are the results of a tremendous amount of work with some of the best thinkers and practitioners in the field of correctional health. These projects are the distillation of decades of combined experience and observation about how correctional health care works best in adult and juvenile settings.

These health care standards were field tested successfully with volunteer agencies before being approved. The series of field tests were more than mere “fire drills.” Field test results were reviewed carefully, and further revisions were made to the standards based on information received from the test sites. This meticulous honing process has produced remarkably polished and practical standards manuals that present a model for efficient and effective health care delivery while reflecting the best interests of offenders, juveniles, correctional agencies and the community.

Performance-based health care standards are about continuous quality improvement; therefore, none of ACA’s standards manuals is ever truly a “finished product.” ACA looks forward to the continued expansion of the “outcome measure” approach to health care standards and encourages feedback from those in the field who use them.

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Health Care Standards And Outcome Measures

ACA’s health care standards are performance-based. An important difference between performance-based standards and traditional standards is the use of “outcome measures.” Instead of requiring that a list of certain activities be performed to demonstrate compliance, outcome measures describe the results of the required activities.

An essential condition that needs to be achieved and maintained is identified as a “performance standard.” Actions and activities that will achieve the condition described in the performance standard are called “expected practices.” Compliance is demonstrated based on the extent to which the condition described in the performance standard has been achieved. That extent is determined by quantifiable data in the outcome measures.

For example, giving vaccinations for a particular disease is an activity that should improve the health of inmates, and this improvement can be measured by the incidence of the disease among the inmate population. Recording the incidence of the disease in the inmate population is an outcome measure. So, giving vaccinations is an activity (expected practice) that should improve inmate health (performance standard), and this can be measured by the incidence of disease (outcome measure).

Because outcome measures use quantifiable information, they can be compared over time to indicate changes in the conditions that are sought. The first time an outcome is measured establishes a point of reference. Comparing the next outcome measure weeks or months later can identify progress or lack of progress toward a desired performance standard. Agencies using performance-based standards can improve by directing and managing their activities more precisely and by using outcome measures to continuously evaluate how close they are to their desired result.