

Standards Committee Meeting Minutes

137th Congress of Correction

***Marriott Downtown, Muehlebach Tower,
Kansas City, Missouri
August 10, 2007***

Members present:

*Harley G. Lappin, Chairperson, Washington D.C.
Lannette Linthicum, MD, Vice Chair, Texas
Patricia Caruso, Michigan
Jeffrey Beard, Pennsylvania
Robert Garvey, Massachusetts
George Owens, Ohio
Robert Hofacre, Ohio
Vicky Myers, Missouri
Ron Budzinski, Illinois
Daniel Craig, Iowa
Brad Livingston, Texas
Steve Gibson, Montana
David K. Haasenritter, Virginia
Robert Kennedy, New York
Joe R. Williams, New Mexico
John Cary Bittick, Georgia*

Members absent:

*Kathleen Dennehy, Massachusetts
Cheryln K. Townsend, Nevada*

Staff:

*Mark Flowers, Director, Standards and Accreditation
Jeffrey Crawford, ACA Staff
Cecil Patmon, ACA Staff
Christina Randolph, ACA Staff*

Welcoming Remarks:

Chairperson Lappin called the meeting to order at 7:30 a.m. The members of the Standards Committee and guests introduced themselves. Mr. Lappin gave a brief overview of the agenda. Mr. Lappin opened the floor for old business.

Old Business:

One issue that remained open from the Winter conference was the definition of "Training". In Tampa, the standards committee requested a comparison of the current and proposed definition of "Training" as presented by Tracy Reveal, Chairperson, Training Definition Sub-committee, Ohio Department of Rehabilitation & Correction, provided an update on the

definition of “Training”.

Proposed Definition of Training:

“An organized, planned, documented and evaluated/assessed activity designed to impart knowledge and skills to enhance job performance. Training is based on specific objectives, job related, from an appropriate source, of sufficient duration, relevant to organizational need and delivered to appropriate staff.”

Elements of Defendable Training:

1. Based upon specific objectives.

Performance objectives (intent of training)

Formal lesson plans or functional equivalent (content of training)

2. Must be job-related

Job analysis (new employee)

Need resulting from problem analysis (existing employee)

3. From an appropriate source

Qualified by credentials

Qualified by knowledge and/or skills

Qualified by performance

“Delivery Skills Qualified”

4. Of sufficient duration (quantity of training)

Hours – how long did it take to learn?

Must be reasonably related to the complexity/importance of the topic.

5. Where something relevant is learned (quality of training)

Student feedback

Student evaluation & proficiency testing

Improved performance on the job

Agency improvements

6. Appropriate staff were attending

Topics related to job tasks and/or performance problems

Attendance documented with name roster and title/positions of staff that perform tasks or share problems

When all of the previous 6 items are planned, implemented & documented – it equals defendable training.

Comment/Action: Approved

Standards Committee Meeting Convened:

Chairperson Lappin called the meeting to order and reminded the committee that the guest speakers were not currently available, but would be called upon to speak once they became available.

Issue: Approval of Standards Committee Meeting minutes from the Winter Conference in Tampa, Florida.

Comment/Action: Robert Garvey made a motion to approve the minutes.

David Haasenritter seconded the motion. The motion carried.

Issue: Mr. Lappin open the floor for comments:

Comments:

Mark Flowers, Director, Standards and Accreditation welcomed the standards committee to Kansas City on behalf of ACA and thanked them for their continued service and dedication. He mentioned the process used for accepting proposal and explained that 19 proposals were made at the Winter conference in Tampa compared to the 65 that had been submitted for Kansas City. He contributed the increase of proposals to a new system of submitting proposals the standards department is using, which involves an e-mail message that was sent to ACA members informing them that the web site was open for proposed changes. A second message was sent to ACA members letting them know the proposals were back on the web site and were open for comments. Both phases were open for approximately two weeks. This process seemed to solicit more ACA member involvement and will be used again for future conferences.

Robert J. Garvey, Chairperson, Commission on Accreditation for Corrections (CAC), gave an overview of the commission's activities and stated that 184 agencies would be appearing before the CAC panel hearings. Mr. Garvey stated that the CAC was looking forward to working with the Standards Committee. Mr. Garvey mentioned that the committee was very interested in the youthful offender standards proposals, because that is an issue that the commission struggles with every conference.

Proposed Standard Revisions:

Proposal: 2007-01 Revision: 4-ACRS-4C-10

Policies direct Comment/Actions to be taken by employees concerning offenders who have been diagnosed with HIV, including, at a minimum, the following:

When and under what conditions offenders are to be separated

Issues of confidentiality

Counseling and support services

Comment/Action: Tabled, Send back to the Health Care sub-committee for a recommendation and present at the Winter conference in Grapevine, Texas.

Proposal: 2007-19 Revision: ACI- 4-4061

A criminal record check is conducted on all new employees, contractors, and volunteers prior to their assuming duties to identify whether there are criminal convictions that have a specific relationship to job performance. This record will include comprehensive identifier information to be collected and run against law enforcement indices. If suspect information on matters with potential terrorism connections is returned on a desirable applicant, it is forwarded to the local Joint Terrorism Task Force (JTTF) or another like agency.

Comment/Action: Approved

Proposal: 2007-20 Revision: ACI-4-4089

Written policy, procedure and practice provide that correctional officers assigned to an emergency unit have at least one year of corrections and 40 hours of specialized training before undertaking their assignments. Other staff personnel must have at least one year of experience in their specialty within a correctional setting. The specialized training may be part of their first year training program. Officers and staff assigned to emergency units receive 40 hours of training annually, at least 16 of which are specifically related to emergency unit assignment.

Comment/Action: Approved

Proposal: 2007-21 Deletion: ACI-4-4114

There is a staff member who is responsible for operating a citizen involvement and volunteer service program for the benefit of inmates.

Comment/Action: Approved

Proposal: 2007-22 Revision: ACI 4-4115

Written policy and procedure specify who is responsible for operating a citizen involvement and volunteer service program and their lines of authority, responsibility, and accountability.

Comment/Action: Approved

Proposal: 2007-23 Revision: ACI- 4-4116

The screening and selection of volunteers permits and encourages recruitment from all cultural parts of the community that exclude rejection of volunteers due to age (except those under age 18), sex, race, ethnic origin, or religion.

Comment/Action: Denied

Proposal: 2007-24 Revision: ACI- 4-4129

The number of inmates does not exceed the maximum allowable inmate population as based on the Standards Compliant Bed Capacity formula.

Comment/Action: Tabled, The Standards Compliant Bed Capacity (SCBC) formula must be modified by the FBOP and presented again at the Winter 2007 conference in Grapevine, Texas.

Proposal: 2007-25 Revision: ACI- 4-4150

Noise levels in inmate housing units do not exceed 70 dBA (A Scale) in daytime and 45 dBA (A Scale) at night.

Comment/Action: Tabled, A sub-committee consisting of Ron Budzinski (Chair), Robert Kennedy, Joe Williams and a representative from the Bureau of Prisons will provide comments to the standards committee regarding acceptable noise levels at the Winter conference in Grapevine, Texas.

Proposal: 2007-26 Revision: ACI- 4-4186

Written policy, procedure, and practice require that the chief security officer or qualified designee conduct at least weekly inspections of all security devices noting the items needing repair or maintenance. The inspections are reported in writing to the warden/superintendent and/or chief security officer.

Comment/Action: Approved

Proposal: 2007-27 Revision: ACI-4-4202

Written policy, procedure, and practice provide that written reports are submitted to the warden/superintendent or designee no later than the conclusion of the tour of duty when any of the following occur: 1. Discharge of a firearm or other weapon 2. Use of chemical agents to control inmates 3. Use of force to control inmates.

Comment/Action: Denied

Proposal: 2007-28 Revision: ACI 4-4220

All institution personnel are trained in the implementation of written emergency plans. Work stoppage plans are communicated only to appropriated supervisory or other personnel directly involved in the implementation of those plans.

Comment/Action: Approved

Proposal: 2007-29 Revision: ACI-4-4132 -3-ALDF-3C-10

I propose that the standard 4-4235 be eliminated or to change the word “pre-hearing detention” to “segregation” and apply the definition of segregation as defined under section D: Special Management. The wording of standard 4-4235 could be inserted into standard 4-4249 and 3-ALDF-3D-01.

Comment/Action: Tabled, send back to proposer. The standards committee did not understand what the proposal was.

Proposal: 2007-30 Revision: ACI-4-4340

Written policy, procedure, and practice provide for the issue of suitable, clean bedding and linen, including two sheets, pillow and pillowcase, one mattress, not to exclude a mattress with integrated pillow, and sufficient blankets to provide comfort under existing temperature controls. There is provision for linen exchange, including towels, at least weekly. Blanket exchange must be available at least quarterly.

Comment/Action: Approved

Proposal: 2007-31 Revision: Standards Supplement 4-4360

1) Dental screening conducted by health care staff upon arrival at any facility 2) Dental examination by a dentist within 14 days of admission to system, unless completed within the last six months. 3) Preventive care is available for those incarcerated more than 12 months. 4) A defined charting system is used that identifies the oral health condition and specifies the priorities for treatment by category 5) Consultation and referral to dental specialists, including oral surgeons, when necessary

Comment/Action: Denied

Proposal: 2007-32 Revision: ACI- 4-4360

Preventative care by licensed dentists or dental hygienists, when requested by offender, diagnostic x-rays are to be taken if necessary.

Comment/Action: Denied

Proposal: 2007-33 Revision: ACI- 4-4428, 4-4432, 4-4481, 4-4482

Add the following interpretation to standards 4-4428, 4-4432, 4-4481 and 4-4482: This standard is applicable to all facilities. For reception and diagnostic centers, this standard only applies as follows: 1. To reception and diagnostic centers with an average offender length of stay of 90 days or longer. 2. To reception and diagnostic centers with a cadre of offenders who are expected to serve more than 90 days of confinement within the facility or for those sentenced offenders awaiting transfer to another facility whose stay exceeds 90 days.

Comment: Tabled, Resubmit using the proper format.

Proposal: 2007-34 Revision: ACI 4-4482

The education and experience of the recreation program supervisor are taken into consideration by the appointing authority in determining appointment to the position. These include education, correctional experience, training in recreation and/or leisure activities and the ability to supervise the program. In institutions with more than 100 inmates, the position is full-time.

Comment/Action: Approved

Proposal: 2007-35 Revision: ACI 4-4513

One full-time qualified chaplain is assigned to facilities per every 300 inmates. In facilities with less than 300 inmates, a qualified volunteer may be used to ensure adequate religious programming is available.

Comment/Action: Denied

Proposal: 2007-36 Revision: 4-ALDF-1A-19

A ventilation system supplies at least 15 cubic feet per minute of circulated air per occupant with a minimum of five cubic feet per minute of outside air. Toilet rooms and cells with toilets have no less than four air changes per hour unless state or local codes require a different number of air changes. Air quantities are documented by a qualified technician not less than once per accreditation cycle.

Comment: Make changes in the other manuals.

Comment/Action: Approved

Proposal: 2007-37 Deletion: 4-ALDF-2A-37

Confinement of juveniles under the age of 18 is prohibited. Delete standard due to the fact that many states mandate that juveniles that are adjudicated adults will be housed in adult local detention facilities.

Comment/Action: Tabled update in Texas January 2008, A sub-committee consisting of committee members Steve Gibson , Chuck Seidleman, Cheryl Townsend and a FBOP Legal representative was selected to evaluate this proposal and provide feedback to the standards committee in January 2008 at the ACA Winter conference.

Proposal: 2007-38 Revision: 4-ALDF-2A-37

Confinement of juveniles under the age of 18 is prohibited, unless required by state statute and only then after a hearing in which a judge has determined the juvenile will be tried as an adult.

Comment/Action: Tabled, A sub-committee was selected to evaluate this proposal and provide feedback to the standards committee in January 2008 at the ACA Winter conference.

Proposal: 2007-39 Revision: 4-ALDF-2A-37

Confinement of a person under the age of twenty-one, or as defined in the local jurisdiction as under the age of majority is prohibited.

Comment/Action: Tabled, A sub-committee was selected to evaluate this proposal and provide feedback to the standards committee in January 2008 at the ACA Winter conference.

Proposal: 2007-40 Revision: 4-ALDF-2A-37

Confinement of juveniles as defined by local/ state jurisdiction is prohibited.

Comment/Action: Tabled, A sub-committee was selected to evaluate this proposal and provide feedback to the standards committee in January 2008 at the ACA Winter conference.

Proposal: 2007-41 Revision: 4-ALDF-2A-38

If youthful offenders are housed in the facility, they are housed in a specialized unit for youthful offenders except when: •violent, predatory youthful offender poses an undue risk of harm to others within the specialized unit, or •a qualified medical or mental-health specialist documents that the youthful offender would benefit from placement outside the unit A written statement is prepared describing the specific reasons for housing a youthful offender outside the specialized unit and a case- management plan specifying what behaviors need to be modified and how the youthful offender may return to the unit. The statement of reasons and case-management plan must be approved by the facility administrator or his/her designee. Cases are reviewed at least quarterly by the case manager, the administrator or his or her designee, and the youthful offender to determine whether a youthful offender should be returned to the specialized unit. (New Construction, renovation, addition only)

Comment/Action: Denied

Proposal: 2007-42 Revision: 4-ALDF-2A-39

Direct supervision is employed in the specialized unit to ensure the safety and security of youthful offenders. (New construction, renovation, addition)

Comment/Action: Denied

Proposal: 2007-43 Revision: 4-ALDF-2A-42

Youthful offenders in the specialized unit for youthful inmates have no more than incidental sight or sound contact with adult inmates from outside the unit in living, program, dining, or other common areas of the facility. Any other sight or sound contact is minimized, brief, and in conformance with applicable legal requirements (New construction, renovation, addition)

Comment/Action: Denied

Proposal: 2007-44 Revision: 4-ALDF-2A-54

Staff assigned to work directly with inmates in special management units are selected based on criteria that includes: • completion of probationary period • experience • suitability for this population Staff is closely supervised and their performance is documented at least annually. There are provisions for rotation to other duties.

Comment/Action: Approved

Proposal: 2007-45 Revision: 4-ALDF-4B-09

Inmates have access to operable showers with temperature-controlled hot and cold running water, at a minimum ratio of one shower for every 20 inmates, unless national or state building or health codes specify a different ratio. Water for showers is thermostatically controlled to temperatures ranging from 100 degrees to 120 degrees Fahrenheit to ensure the safety of inmates and to promote hygienic practices.

Comment/Action: Denied

Proposal: 2007-46 Revision: 4-ALDF-4C-30

Inmates who are referred as a result of the mental health screening will receive a mental health appraisal by a qualified mental health person within 14 days of that screening. Inmates who are referred as a result of staff referral will receive a mental health appraisal by a qualified mental health person within 14 days of the date of referral. If there is documented evidence of a mental health appraisal within the previous 90 days, a new mental health appraisal is not required, except as determined by the designated mental health authority. Mental health examinations include, but are not limited to: * assessment of current mental status and condition, *assessment of current suicidal potential and person-specific circumstances that increase suicide potential. * assessment of violence potential and person-specific circumstances that increase violence potential, * review of available historical records of inpatient and outpatient psychiatric treatment, * review of history of treatment with psychotropic medication, * review of history of psychotherapy, psycho-educational groups, and classes or support groups, * review of history of drug and alcohol treatment, * review of educational history * review of history of sexual abuse-victimization and predatory behavior, *assessment of drug and alcohol abuse and/or addiction, * use of additional assessment tools, as indicated * referral to treatment, as indicated, * development and implementation of a treatment plan, including recommendations concerning housing, job assignment, and program participation.

Comment/Action: Denied

Proposal: 2007-47 Deletion: 4-ALDF-5C-07

The standard, if not deleted, could be modified to require those inmates serving out their sentences at the local detention facility to be required to work if not assigned to programs. The current standard as written is based towards a state correction system where inmates of the same classification level are housed and serving out their entire sentence.

Comment/Action: Tabled, Send to the Core Jail standards sub-committee and obtain a recommendation. Present at the Winter conference in Grapevine, Texas.

Proposal: 2007-48 Revision: 4-ALDF-7B-03

A criminal record check is conducted on all new employees, contractors, and volunteers prior to their assuming duties to identify whether there are criminal convictions that have a specific relationship to job performance. This record will include comprehensive identifier

information to be collected and run against law enforcement indices. If suspect information on matters with potential terrorism connections is returned on a desirable applicant, it is forwarded to the local Joint Terrorism Task Force (JTTF) or another like agency.

Comment/Action: Approved

Proposal: 2007-49 Deletion: 4-ACRS-1C-03

Revision: 4-ACRS-1C-09

There is a written evacuation plan to be used in the event of a fire. The plan is certified by an independent qualified agency or individual trained in the application of national fire safety codes. The plan is reviewed annually, updated if necessary and reissued to the local fire jurisdiction. The plan includes the following:

- location of building/room floor plan
- use of exit signs and directional arrows that are easily seen and read
- location of publicly posted plan
- at least quarterly drills in all facility locations, and on every shift, including administrative areas

Comment/Action: Approved to delete 4-ACRS-1C-03, The bullet from 4-ACRS-1C-03 was added to 4-ACRS-1C-09.

Proposal: 2007-50 Revision: 4-ACRS-7D-33

Procedures specify to the offender how the amount of offender fees will be determined, and when and how it will be collected and recorded. If the program is provided by a contractor, the contractor will provide the contracting agency, at least monthly, with an accounting of fees received, including the amount paid and the payer.

Comment/Action: Approved

Proposal: 2007-51 Revision: APPFS-3-3004

Field facilities are located in areas that are optimally accessible to offenders' places of residence and employment, to transportation networks, and to other community agencies.

Comment/Action: Denied

Proposal: 2007-52 Revision: PPM 3-3020

Policies such as the offender grievance process is provided to the offender but is not provided prior to implementation. Recommend deleting the last part of this standard

requiring "when appropriate, to probationers/parolees prior to implementation.

Comment/Action: Denied

Proposal: 2007-53 Revision: PPM 3-3064

Salary levels and employee benefits are not established by this agency. Recommend the standard require demonstration of efforts the agency makes to recruit, train, and maintain good staff since salary and benefits are beyond our control.

Comment/Action: Denied

Proposal: 2007-54 Revision: PPM 3-3087

Recommend "psychological examination" be replaced with "mental health screening" since the medical examination could include a mental health screening. If the doctor recommends a more intensive psychological evaluation after the mental health screening, this would be required of the applicant.

Comment/Action: No Action Taken, This is already published in the 2006 supplement

Proposal: 2007-55 Revision: APPFS-3130

Written policy, procedure, and practice govern classification and supervision of offenders in order to safeguard the community and meet the program needs of the offender. Offenders should be placed in the appropriate supervision category within 45 days to the initial interview. Reclassification should occur at six-month evaluation periods or as events occur that impact the programming designed for successful completion of probation, and be recorded and justified in the chronological record.

Comment/Action: Tabled, Return to proposer for clarification.

Proposal: 2007-56 Revision: PPM 3-3132

The field officer instructs the offender on the order of supervision and makes the appropriate referrals for treatment, public service work, or other resources in order to comply with conditions imposed. The officer provides the offender with a copy of the order of supervision. The officer discusses other resources, such as employment or educational needs, with the offender as needed in order to assist the offender during the supervision period and documents this in case notes.

Comment/Action: Denied

Proposal: 2007-57 Revision: PPM 3-3136

Delete this standard as it is very similar to 3-3132. If it is not deleted, recommend it be reworded to reflect that the officer is responsible for providing the offender a copy of the order of supervision once he/she is instructed by the officer and that the officer will refer the offender to whatever resources or referrals are needed to complete the conditions of supervision imposed by the sentencing or releasing authority.

Comment/Action: Denied

Proposal: 2007-58 Revision: PPM 3-3138

The conditions of supervision are reviewed with the offender on an as-needed basis in order to monitor compliance. Appropriate referrals are made during the course of supervision in order to ensure compliance with conditions of supervision. These reviews and referrals are documented in case notes.

Comment/Action: Denied

Proposal: 2007-59 Revision: APPFS 3-3139

Written policy, procedure, and practice governing community supervision provide for review of levels of supervision at least every six months, or as events occur that impact the programming designed for successful completion of probation, with prompt reclassification, where warranted.

Comment/Action: Denied

Proposal: 2007-60 Revision: PPM 3-3144

Revise to acknowledge that a closing summary includes information entered in the database which summarizes events and performance of an offender while on supervision.

Comment/Action: Denied

Proposal: 2007-61 Revision: PPM 3-3153

The agency maintains a file of those agencies providing financial assistance to offenders from available community resources.

Comment/Action: Approved

Proposal: 2007-62 Revision: PPM 3-3174

Clarification is needed on what is meant by “detention” warrant. It is recommended that this be re-worded to reflect that if authorized, the probation officer will conduct a warrant less arrest when the offender’s presence in the community would present an unreasonable risk to the public or individual safety.

Comment/Action: Denied

Proposal: 2007-63 Revision: 1-ABC-2C-02

Except for a 90 day program, dayrooms with space for varied offender activities are situated immediately adjacent to the offender sleeping areas. Dayrooms provide a minimum of 35 square feet of space per offender (exclusive of lavatories, showers, and toilets) for the maximum number of offenders who use the dayroom at one time, and no dayroom encompasses less than 100 square feet of space (exclusive of lavatories, showers, and toilets).

Comment/Action: Denied

Proposal: 2007-64 Revision: 1-ABC-5C-03

Except for 90 day programs, dayrooms provide sufficient seating and writing surfaces. Dayroom furnishings are consistent with the custody level of the offenders assigned.

Comment/Action: Denied

Proposal: 2007-65 Deletion: 1-ABC-2C-08-1

Request deletion of this standard, because As described in the boot camp manual, the program is based on a short, intensive, and extremely harsh program that gives structure to the lives of offenders. As described in standard 1-ABC-4E-19, the boot camp programs involve varying degrees of strenuous and prolonged physical activities and the offender must be physically fit to participate in the program. An offender who cannot perform basic life functions would not qualify for this program.

Comment/Action: Denied

Proposal: 2007-66 Deletion: 1-ABC-2C-08-2

Request deletion of this standard, because as described in the boot camp manual, the program is based on a short, intensive, and extremely harsh program that gives structure to the lives of offenders. As described in standard 1-ABC-4E-19, the boot camp programs involve varying degrees of strenuous and prolonged physical activities and the offender

must be physically fit to participate in the program. An offender who cannot perform self-care and personal hygiene care would not qualify for this program

Comment/Action: Denied

Proposal: 2007-67 Revision: 1-ABC-4E-25

Except for a 90 day program, written policy and procedure require that dental care is provided to each inmate under the direction and supervision of a dentist, licensed in the state, as follows: * dental screening within fourteen days of admission unless completed within the last six months, conducted on initial intake with instruction on dental hygiene * dental examination by a dentist within twelve months, supported by e-rays, if necessary. * treatment of dental pain, sedative fillings, extractions of non-restorable teeth, gross debridement of symptomatic areas, and repair of partials and dentures for those inmates with less than twelve-months detention * treatment plan with x-rays for those inmates who request care with more than twelve-months detention.

Comment/Action: Denied

Proposal: 2007-68 Revision: 1-ABC-4E-26

Except for 90 day programs, written policy, procedure, and practice designate the conditions for periodic health examinations for offenders.

Comment/Action: Denied

Proposal: 2007-69 Revision: 1-ABC-4G-04

Except for a 90 day program, where statutes permit, written policy, procedure, and practice allow for offenders' participation in employment, restitution, or school release programs.

Comment/Action: Denied

Proposal: 2007-70 Revision: 1-ABC-5A-01

Except for 90 day programs, the facility maintains a written plan for full-time work and/or program assignments for all offenders in general population.

Comment/Action: Denied

Proposal: 2007-71 Revision: 1-ABC-5B-11

Except for 90 day programs, written policy, procedure, and practice provide that the educational program allows for flexible scheduling that permits offenders to enter at any

time and to proceed at their own learning pace.

Comment/Action: Denied

Proposal: 2007-72 Revision: 1-ABC-5C-01

Except for a 90 day program, written policy, procedure, and practice provide for a recreational program that includes leisure-time activities and outdoor exercise.

Comment/Action: Denied

Proposal: 2007-73 Revision: 1-ABC-5C-02

Except for a 90 day program, written policy, procedure, and practice provide that the recreation program is supervised by a qualified person who has a minimum of a bachelor's degree in recreation or leisure services or the equivalent in combined education and experience. In facilities with more than 100 offenders this position is full time.

Comment/Action: Denied

Proposal: 2007-74 Revision: 1-ABC-5C-03

Except for a 90 day program, written policy, procedure, and practice provide that facilities and equipment suitable for the planned leisure activities are available in proportion to the offender population and are maintained in good condition.

Comment/Action: Denied

Proposal: 2007-75 Revision: 1-ABC-5D-16

Facility staff provides information to visitors regarding transportation to the facility and facilitates transportation between the facility and nearby public transit facilities.

Comment/Action: Approved

Proposal: 2007-76 Revision: 1-TC-4A-17

If possible, programs should be divided into housing units of no more than 64 program members, except where existing facility design does not allow it. In such cases, programs must ensure that group activities are managed in a manner that meets the intent of the 64 participant maximum.

Comment/Action: Denied

Proposal: 2007-77 Revision: 1-CO-1D-02

Written policy, procedure, and practice specify training and staff development requirements for all employees. This training shall include, the following at a minimum:

- fire and emergency procedures*
- safety procedures*
- interpersonal relations*
- communication skills*
- sexual harassment.*

The sophistication level and amount of training should be based on the employee's need to know and their job assignment.

Comment: Organizations are encouraged to train staff on agency operations.

Comment/Action: Approved

Proposal: 2007-78 Revision: 2-CO-5E-01

2-CO-5E-01 Revised August 2004. *Written agency policy provides for religious programming for inmates/juveniles/residents, including: · Program coordination and supervision; · Opportunities to practice one's faith individually and corporately as authorized; · Possession of authorized religious symbols and/or items essential for faith practice obtained from appropriate community sources. · Availability of religious program information to offenders; · Access to approved publications related to religious beliefs and practices; · The observance of authorized religious diets, holy day ceremonies, work restrictions, and authorized communal sacramental rites (providing such rites do not conflict with existing procedures/policies or jeopardize the security and orderly running of the facility); · Distribution of resources among faith groups authorized to meet, commensurate with their representation within the population, to include the use of religious facilities and equipment; · Accessibility by staff chaplains to all areas of the facility; · Clergy/spiritual advisor visitation to occur through established visiting procedures; · Use of community resources; to include the use of religious volunteers, consistent with the safety and security of the facility.*

Comment/Action: Tabled, Send back to proposer for clarification.

Proposal: 2007-79 Revision: 3-JTS-3A-16-1

Add language that allows this standard to be not-applicable when four/five-point restraints are not authorized or prohibited by appropriate statutory authority.

Comment/Action: Denied

Proposal: 2007-80 Revision: 3-JTS-4C-26

Dental hygiene "instruction" within 14 days of admission.

Comment/Action: Denied

Proposal: 2007-81 Revision: 3-JTS-4C-26

Policies prohibit the use of restraints on pregnant prisoners when they are being transported to give birth, giving birth and after they have just given birth.

Comment/Action: Tabled, update in Grapevine, Texas in January 2008

Proposal: 2007-82 New Standard

For 90 day programs only, written policy, procedure, and practice provide that the program will include a component for suitable facilities and equipment for planned leisure and outdoor exercise activities that is approved by the program administrator. Comment: Recreational activities should be structured into the 90 day program that includes the yard, library, and the auditorium.

Comment/Action: Denied

Proposal: 2007-83 New Standard

*For 90 day programs only, written policy and procedure require that dental care is provided to each inmate under the direction and supervision of a dentist, licensed in the state, as follows: * dental screening within fourteen days of admission unless completed within the last six months, conducted on initial intake with instruction on dental hygiene * treatment of dental pain, sedative fillings, extractions of non-restorable teeth, gross debridement of symptomatic areas, and repair of partials and dentures for those inmates with less than twelve-months detention.*

Comment/Action: Denied

Proposal: 2007-84 New Standard

For 90 day programs only, written policy, procedure, and practice provide that the 90 day program include an educational program component that allows the offenders to proceed at their own learning pace.

Comment/Action: Denied

Summary of 65 Proposals:

15 Proposals were Approved
35 Proposals were Denied
14 Proposals were Tabled
01 Proposals had No Comment/Action Taken

Guest Appearances

RADM Newton E. Kendig Assistant Director, Health Services Division, Federal Bureau of Prisons, Washington, DC

Dr. Kendig provided oral testimony and answered questions about the updated Health Care Outcome Measures worksheet, Technical Guide and Definitions.

ACA Health Care Outcome Measure Technical Guidance

1A (1) (NEW) The number of offenders diagnosed with a MRSA infection within the past twelve (12) months divided by the average daily population.

Purpose: Methicillin-resistant *Staphylococcus aureus*, (MRSA) infections are readily transmitted from person to person within congregate settings such as jails and prisons. Outbreaks of MRSA infections among offender populations have occurred throughout the United States. Although most MRSA infections can be effectively treated with incision and drainage or antibiotics, serious life threatening infections requiring hospitalization may develop particularly if the cases are not diagnosed. Furthermore, MRSA infections occur in correctional staff and their families. This measure estimates the incidence of MRSA infections in a given facility over time. This calculation is important to CEOs because MRSA infections can disrupt correctional operations, can be costly to treat if not effectively managed, and can affect the morale and health of correctional workers and offender populations. This may be a useful indicator to determine if appropriate hygiene practices are used.

Methodology: A continuous manual or automated method should be established for tracking all offenders diagnosed with MRSA infections within the institution or during infirmary or community hospitalization that ensures ongoing reporting to the CEO. The tracking of MRSA and other skin infections can be facilitated by referring all bacterial culture results to a single infection control officer and notifying the officer of all clinically evaluated skin infections. Skin and soft tissue infections empirically treated as MRSA should also be tracked as a component of this outcome measure. Periodic bacterial cultures should be obtained in correctional settings where MRSA infections are chronically suspected and empirically treated to both confirm that MRSA infections are an ongoing problem and to assess the resistant patterns of the isolates. A designated health care authority should notify the CEO of any increases in MRSA cases or suspected outbreaks within the facility and ensure that multi-disciplinary infection control meetings identify potential interventions to reduce the incidence of MRSA in the facility.

Outcome Measure Calculation

MRSA bacteria are a type of “*staph*” bacterium that are resistant to beta-lactam antibiotics, including: penicillin, ampicillin, amoxicillin, augmentin, methicillin, oxacillin, dicloxacillin, cephalosporins, carbapenems (e.g., imipenem), and the monobactams (e.g., aztreonam).

Numerator

Assess offenders in the facility during a set 12-month reporting period (Recommend ending the reporting period at the end of the calendar year.)

1. Include offenders with new positive MRSA cultures from blood, sterile body fluids, and abscesses.
2. Include offenders with new positive MRSA cultures from purulent drainage of skin or soft tissue

infection (avoid contacting external skin when culturing drainage).

3. Include new empiric (clinically diagnosed) MRSA infections within a facility with ongoing, previously confirmed MRSA infections.

4. Include recurrent infections that occur in a single offender as separate MRSA cases.

5. Consider concurrent infections at multiple sites in one offender as one infection.

6. Include both community-associated and nosocomial (hospital-acquired) cases.

7. Exclude inmates with MRSA colonization without evidence of infection.

8. Exclude inmates diagnosed with MRSA but housed in another correctional system, community-based facility, or home detention.

9. Exclude inmates who may have been initially diagnosed while housed at another correctional facility, but still may be on active treatment or observation.

Denominator

Average daily population during the 12-month reporting period.

Limitations: The measure is a detection rate that provides an approximated incidence of MRSA infections within a given facility. It does not take into account the total number of offenders who move through the facility during a given year since the average daily population is used as the denominator. Therefore, a facility with a large turnover of the offender population may have a skewed increase in the incidence of reported MRSA infections compared to a facility with a similar average daily population but has much lower offender turnover. Because not all skin and soft tissue infections are cultured and some cases resolve without being clinically detected or reported, the number of MRSA infections reported in this measure is only an estimate. Empirically diagnosed skin and soft tissue infections, however, serve as a proxy for MRSA infections because of the widespread prevalence of this pathogen nationwide. Distinguishing between MRSA infections acquired within the correctional setting versus the hospital or elsewhere in the community is difficult, therefore, MRSA cases detected within a specific facility may or may not represent transmission within the correctional setting.

Resources

http://www.cdc.gov/ncidod/dhqp/ar_mrsa_mrsa.html

http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca.html

1A (2) Number of offenders diagnosed with active tuberculosis in the past twelve (12) months divided by the average daily population.

Purpose: The measure approximates the incidence of active tuberculosis disease (TBD) among offenders in a facility during an established reporting period and assumes real time reporting of active TB cases to the CEO. Pulmonary TB is a contagious airborne disease that can easily spread in congregate settings, such as jails and prisons, and threaten correctional workers and offenders alike. Readily identifying TB cases and determining the incidence of TBD among the offender population helps the CEO assess the risk of TB transmission within the facility and allocate resources for containing this public health threat.

Methodology: A continuous manual or automated method should be established for tracking all offenders diagnosed with active TBD within the institution or during infirmary or community hospitalizations that permit real time reporting to the CEO by a designated health care authority. A log of active TBD cases should be maintained. Additionally, all TB cases must be reported to local and State authorities in accordance with applicable laws and regulations. The designated health care authority should ensure that each TB case is effectively treated, contained, and monitored in accordance with CDC guidelines. Contact investigations shall be conducted within the institutions for potentially contagious TB cases in order to prevent or contain TB outbreaks.

Outcome Measure Calculation:***Numerator***

Include offenders in the facility diagnosed with TBD during the 12-month reporting period. (Recommend ending reporting period at the end of the calendar year.)

1. Include all offenders diagnosed by a qualified health care practitioner with newly diagnosed TBD by a positive culture for *M. tuberculosis*, whether pulmonary or extrapulmonary.
2. Include all offenders with pathologic evidence of TBD, e.g., caseating granulomas, even if cultures are unobtainable or negative.
3. Include all offenders who have clinical and radiographic evidence of TBD who are empirically treated for TBD and clinically and radiographically improve even though TB cultures are negative.
4. Exclude offenders on continuing treatment for previously diagnosed TBD during other reporting periods or diagnosed prior to arrival at the facility.
5. Exclude inmates diagnosed and/or treated for LTBI (Latent Tuberculosis Infection).
6. Exclude inmates diagnosed with TBD but housed in another correctional system, community-based facility, or home detention.

Denominator

Average daily population during the 12-month reporting period.

Limitations: This measure is an approximated incidence of TBD within a given facility/system. It does not take into account the total number of offenders who move through the facility/system during a given year since average daily population is used as the denominator. Therefore, a facility with a large turnover of the offender population may have a skewed increase in TB incidence compared to a facility with a similar average daily population but has much lower offender turnover.

Resources:

1. http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/maj_guide.htm
2. <http://www.cdc.gov/nchstp/tb/pubs/dtbefax.htm>

1A (3) Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months divided by the number of offenders administered tests for TB infection in the past twelve (12) months as part of periodic or clinically-based testing, but not intake screening.

Purpose: The measure estimates the incidence of newly acquired TB infections among offenders within a given facility. The detection of airborne TB transmission within the facility is critically important for CEOs since TB is a serious, but treatable, disease that can affect correctional staff and inmates and can spread unabated if not detected and controlled.

Methodology: A continuous manual or automated method should be established for tracking all offenders who newly acquire LTBI within the facility that permits ongoing reporting to the CEO. Policies and procedures must be established to ensure that periodic (e.g., annual) and clinically-indicated screening for TB infection (e.g., contact investigations) are conducted in accordance with CDC guidance. Newly acquired TB infections within a facility should be rare, carefully documented, and thoroughly investigated by the designated health care authority and infection control committee. Offenders who are new converters (i.e., are recently infected) must be high priority candidates for treatment of LTBI.

Outcome Measure Calculation***Numerator***

Include all offenders with newly acquired TB infections diagnosed in the facility during the 12-month reporting period. (Recommend ending reporting period at the end of the calendar year.)

1. Include offenders with a newly positive blood test for TB infection (e.g., QuantiFERON) while

incarcerated in the facility, i.e., not an intake screening test.

2. Include offenders with a newly positive tuberculosis skin test (TST) while incarcerated in the facility, i.e., not an intake screening test. These offenders will have had previously documented negative TSTs but now have a TST that has increased by 10 millimeters. They are considered new converters.

3. Exclude offenders who have a new TST that is greater than or equal to 10 millimeters, but the increase from the previous test was less than 10 millimeters (e.g., TST increases from 7 mm to 12 mm). Consider these offenders as previously infected, therefore are not new converters, yet they should still be considered candidates for LTBI treatment.

4. Exclude all offenders with a past positive screening test for TB infection.

5. Exclude all offenders with accepted negative documentation for LTBI on intake, but were not retested and confirmed as negative within the last 12 months and now have a positive screening test for tuberculosis infection.

Denominator

Number of offenders administered annual or clinically-indicated screening tests for TB infection. Exclude offenders with positive tuberculosis screening tests conducted at intake during the reporting period.

Limitations: This may produce a higher estimate of new conversions as differentiating between boosted test and new conversions is difficult if 2 step TSTs are not done. These boosted reactions may otherwise be included. Furthermore, this measure does not assess the number of offenders who were not screened for newly acquired TB infection but should have been based on facility policy or clinical indications.

Resources:

1. http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/maj_guide.htm
2. <http://www.cdc.gov/nchstp/tb/pubs/dtbefax.htm>

1A (4) Number of offenders who completed treatment for latent tuberculosis infection in the past twelve (12) months divided by the number of offenders treated for latent tuberculosis infection in the past twelve (12) months.

Purpose: The measure estimates the proportion of offenders who complete treatment for LTBI. Effectively treating LTBI should reduce the incidence of TBD and associated outbreaks within the facility. Measuring LTBI treatment success helps the CEO assess the effectiveness of this important TB control strategy.

Methodology: Within the first month of the 12-month reporting period, establish a cohort of inmates who are either on or are starting treatment for LTBI. All data collected for the reporting period will be based on the outcomes of this cohort.

Accurately assessing LTBI treatment requires a careful clinical evaluation of treatment candidates and prescribed regimens as recommended by the CDC. Administration by directly observed therapy is recommended

- Isoniazid (INH)/6-9 months: 180 - 270 doses of a daily regimen, or 52 - 76 doses of twice weekly dosing, has been completed (NOTE: 6 months of therapy is suboptimal, but still has significant treatment efficacy so is considered a successful treatment regimen for the purpose of this outcome measure); or
- Rifampin (RIF)/4 months: 120 doses of a daily regimen, has been completed.

The designated health care authority should report to the CEO the proportion of offenders who successfully complete treatment for LTBI on an annual basis and pursue strategies to improve adherence and LTBI completion rates as appropriate.

Outcome Measure Calculation

Numerator

Identify within the first month of the reporting period a cohort of all offenders on LTBI treatment to be tracked within the 12 month reporting period (Recommend ending the reporting period at the end of the calendar year.)

1. Include offenders who started treatment for LTBI during the cohort identification period and completed an adequate treatment course in the facility during the 12-month reporting period.
2. Include offenders who arrived on treatment for LTBI, whether new admissions or transfers, during the cohort identification period and then completed adequate therapy during the 12-month reporting period.
3. Exclude inmates that have either started or arrived to the facility on treatment, but are outside of the first month cohort identification period.
4. Exclude offenders that have discontinued treatment for any reason.
5. Exclude offenders who were started on treatment but transferred to another facility, inmates that might have died, or were released prior to completion.
6. Exclude offenders completing LTBI treatment but housed in another correctional system, community-based facility, or home detention.

Denominator

The denominator is the total number of offenders in the facility who were appropriately prescribed treatment for LTBI or were on a treatment regimen during the cohort identification period (the first month of the reporting period) that remain within the facility. These inmates would have the opportunity to complete therapy within the following 11 months of the reporting period and, therefore, have the 9-month window to complete therapy.

Limitations: This measure does not take into account the number of offenders in the facility who are candidates for LTBI treatment, but are not identified or offered therapy. This measure does not specify the reasons for why treatment was discontinued.

Resources:

http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/maj_guide.htm

<http://www.cdc.gov/nchstp/tb/pubs/dtbefax.htm>

1A (5) Number of offenders diagnosed with Hepatitis C viral infection at a given point in time divided by the total offender population at that time.

Purpose: The measure estimates a point prevalence of chronic hepatitis C viral infection diagnosed in the offender population within a given facility. CEOs can better manage their health care budgets and better assess health care delivery needs by an annual measurement of offenders with hepatitis C. These cases often require significant resources and can be a risk management concern for a correctional system if not effectively and consistently managed.

Methodology: Hepatitis C viral infection is diagnosed with the detection of anti-HCV by immunoassay (EIA) or chemiluminescence immunoassay (CIA). A secondary test documenting viremia is not required for the purposes of this outcome measure. Tracking of chronic hepatitis C cases can be operationalized by requiring reporting of positive laboratory tests via electronic or manual methods through a single point of contact. The designated health care authority should report the annual point prevalence of hepatitis C viral infection to the CEO. It will important to report the facility's routine testing protocols or criteria for determining testing the need for HCV testing.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation:***Numerator***

Include all offenders who are diagnosed with chronic hepatitis C infection a given point of time.

1. Include all offenders within the facility with a current laboratory test indicative of hepatitis C viral infection whether or not they have received antiviral treatment.
2. Exclude inmates diagnosed with chronic hepatitis C infection but housed in another correctional system, community-based facility, or home detention.
3. Exclude inmates with suspected acute hepatitis C viral infection who are currently under evaluation for clearance of their infection (i.e., viremia).

Denominator

The total offender population in the facility at the time the number of offenders with hepatitis C infection was counted.

Limitations: Diagnosed hepatitis C cases may not represent the true number of offenders infected with HCV, since not all offenders may have been tested.

Resources:

<http://www.cdc.gov/ncidod/diseases/hepatitis/resource/pub.htm>

http://www.cdc.gov/nchstp/od/cccwg/ID_Hepatitis.htm

1A (6) Number of offenders diagnosed with HIV infection at a given point in time divided by the total offender population at that time.

Purpose: The measure estimates a point prevalence of diagnosed HIV infection among an offender population within a given facility. CEOs can better manage their health care budgets and better assess health care delivery needs by an annual measurement of offenders with HIV infection. These cases often require significant resources and can be a risk management concern for a correctional system if not effectively managed.

Methodology: HIV infection is diagnosed with a positive anti-HIV enzyme immunoassay (EIA), with a confirmatory test, e.g., Western blot (WB) or an immunofluorescence antibody test (IFA), or positive result or report of a detectable quantity on any of the following HIV virologic (nonantibody) tests:

- HIV detected through a FDA-approved nucleic acid test
- HIV p24 antigen test, including neutralization assay
- HIV isolation (viral culture).

Tracking offenders diagnosed with HIV infection requires a manual or automated method for collecting these data. If automated methods are unavailable, establishing a single point of contact to receive/review laboratory diagnostic information and chronic care enrollee information can facilitate data collection. The designated health care authority should report the annual point prevalence of HIV infection to the CEO.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation***Numerator***

1. Include all offenders in the facility who are diagnosed with HIV infection at a given point of time.
2. Exclude inmates diagnosed with HIV infection but housed in another correctional system, community-based facility, or home detention.

Denominator

Total offender population in the facility at the point in time the offenders with HIV infection were counted.

Limitations: The number of offenders diagnosed with HIV infection may not represent the total number of offenders infected, since not all offenders may have been tested.

Resources:

<http://www.cdc.gov/hiv/>

<http://www.cdc.gov/hiv/resources/guidelines/index.htm>

1A (7) Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time divided by the total number of offenders diagnosed with HIV infection at that time.

Purpose: The measure estimates the proportion of offenders with HIV infection who are receiving treatment with antiviral therapy at a given point in time. Antiretroviral therapy is indicated for a subset of persons diagnosed with HIV infection and is proven to reduce hospitalization and deaths from AIDS when appropriately prescribed and administered. CEOs can better manage their HIV programs, including budgetary needs, by an annual assessment of affected offenders who are receiving treatment.

Methodology: Tracking offenders with HIV infection who are receiving effective antiviral therapy requires monitoring pharmacy or medical records through automated or manual methods. The indications for antiretroviral therapy and recommended drug regimens are determined by community standards that constantly evolve and are frequently updated by the United States Public Health Service (USPHS). Therefore, this outcome measure is not constructed to determine the percentage of offenders with HIV infection who are appropriately prescribed therapy. The designated health care authority, however, should establish a method for reviewing antiretroviral prescribing practices, and improving patient care, as appropriate. The designated health care authority should report the annual point prevalence of HIV-treated offenders to the CEO and establish a method for assessing whether treatment is being provided in accordance with USPHS guidelines and other relevant evidence based guidelines.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation

Numerator

1. Include all offenders who are being treated with antiretroviral therapy at a given point of time.
2. Exclude offenders with HIV infection on antiretroviral therapy who are housed in another correctional facility, community-based facility, or home detention.

Denominator

The total number of offenders diagnosed with HIV infection housed in the facility at the time that the treated offenders were counted.

Limitations: This measure does not assess whether or not the specific antiretroviral therapies are medically appropriate or warranted. The measure also does not take into account offenders who may be candidates for treatment who are currently being evaluated or awaiting release.

Resources:

<http://www.cdc.gov/hiv/topics/treatment/index.htm#treatment>

<http://www.aidsinfo.nih.gov>

1A (8) Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less than 50 cps/ml divided by the total number of treated offenders with HIV infection that were reviewed.

Purpose: This measure assesses how well offenders with HIV infection are medically managed.

Poorly treated HIV infection may progress to the acquired immunodeficiency syndrome (AIDS) and its associated complications. The measure is important to CEOs from a risk management, security, and fiscal perspective, since well managed offenders with HIV infection are less likely to transmit infection, require outside medical trips for related complications, or suffer a sentinel event such as a preventable injury or death.

Methodology: This measure requires tracking viral loads for offenders with HIV infection under treatment with medications. Testing is done by an ultra-sensitive nucleic acid test that is capable of detecting HIV in the blood at < 50 cps/ml. Monitoring HIV viral loads can most efficiently be achieved by automated methods or separately documenting readings at each chronic care evaluation as a reportable outcome measure. Otherwise, assessing treatment response in among offenders with HIV infection requires retrospective chart reviews, which is very time consuming.

If not all evaluations of treated offenders with HIV infection can be reviewed, then a random subset of offenders under treatment for at least 6 months should be selected for analysis. If the total population is less than 10 offenders, then report data on all inmates. If the study population is greater than 10, report either 25% of affected offenders or 10 offenders, whichever number is greater. If a subset of the population is used, a random sample is vital. In selecting this random sample, ensure there are offender cases among all providers to monitor treatment variations.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation

Numerator

1. Include, on a given date, the number of offenders from the selected sample with HIV infection who have been under treatment for at least 6 months and have a viral load less than 50 cps/mL on their most recent evaluation. If not all offenders with HIV infection are selected for review, then a random subset should be evaluated (see above).
2. Exclude offenders who have been under treatment for HIV infection for less than 6 months within the facility.
3. Exclude offenders with HIV infection who are housed in other correctional systems, community-based facilities, or home detention.

Denominator

Include all offenders in the review sample with HIV infection on antiretroviral therapy for at least 6 months who were reviewed on the given date. (The denominator should be at least 10 unless there were fewer than 10 offenders with HIV infection in the facility who warranted evaluation.)

Limitations: The reported outcome measurements do not account for offenders with HIV infection who were prescribed effective treatment, but who were not adherent to their regimen and did not meet therapeutic targets. Furthermore, successful treatment for HIV infection, e.g., maximal viral suppression, is in large part related to the degree of viral resistance present at the time treatment is initiated. This outcome measurement does not take into consideration whether or not individual offenders were not successfully treated because of inherent viral resistance present at the time of incarceration.

If a subset is used to report this measure, then some margin of error will be included.

Resources:

<http://aidsinfo.nih.gov/> (Adult and adolescent guidelines)

1A (9) Number of offenders diagnosed with an Axis I disorder (excluding sole diagnosis of substance abuse) at a given point in time divided by the total offender population at that time.

Purpose: The measure estimates a point prevalence of serious mental illness diagnosed in the offender population within a given facility. CEOs can better manage their health care budgets and better assess health care delivery needs by an annual assessment of mentally ill offenders who often require significant resources and can be a risk management concern for a correctional system if not effectively and consistently managed.

Methodology: Axis I disorders, excluding substance abuse as a sole diagnosis, are defined by the most current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association. Axis I disorders do not include personality disorders. Tracking offenders with serious mental illness requires a manual or automated method for collecting this information. If automated methods are unavailable, establishing a single point of contact for whenever offenders with mental illness are assigned to chronic care clinics can facilitate data collection. A process for assessing and improving the validity of the diagnostic information should also be established.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation

Numerator

1. Include all offenders who are diagnosed with an Axis I mental health disorder at a given point of time.
2. Exclude offenders with Axis I mental health disorders but housed in another correctional system, community-based facility, or home detention.

Denominator

The total number of offenders in the facility at the time the offenders with Axis I mental health disorders were counted.

Limitations: The number of diagnosed offenders with Axis I mental health disorders may not represent the true number of offenders with serious mental illness since affected offenders may be undetected. Further, calculation of this measure at one point in time each year under-represents the complexity of mental health issues for high-turnover facilities.

Resources:

<http://www.nimh.nih.gov>

1A (10) Number of offender admissions to off-site hospitals in the past twelve (12) months divided by the average daily population.

Purpose: This measure estimates the annual rate at which offenders are admitted to off-site hospitals. CEOs should monitor offender hospitalization rates since this is a relevant measure for monitoring current and future security risks, medical costs, and the adequacy of preventive and ambulatory care within the correctional setting.

Methodology: The designated health care authority should ensure that all offender off-site hospitalizations are monitored on a daily basis to ensure the adequacy of health care delivery and minimize the length of stay as medically feasible. An automated or manual method should be established to track the number of off-site hospitalizations, including length of stay whenever possible. The designated health care authority should annually report the offender hospitalization rate to the CEO. Unnecessary or preventable hospitalizations should be identified by the health care authority and related health care delivery concerns addressed.

Outcome Measure Calculation:***Numerator***

1. Include all offenders admitted to an outside hospital for any reason within the 12-month reporting period, including those offenders still hospitalized at the end of the reporting period. (Recommend ending reporting period at the end of the calendar year.)
2. Count multiple admissions separately, for any individual offender if these admissions occurred in the reporting period.
3. Exclude offenders who are admitted to hospitals for same day procedures, including ambulatory surgery and observation for less than 24 hours.
4. Exclude inmates admitted to DOC operated hospitals as a result of an intra-system transfer.
5. Exclude inmates admitted to outside hospitals directly from other correctional systems, community-based facilities, or home detention.

Denominator

Average daily population for the 12-month reporting period.

Limitations: The measure does not account for the significant variations in on-site correctional health care services, or the variations in community hospital capabilities and discharge criteria. The measure is only an approximated calculation of the facility's hospitalization rate. It does not take into account the total number of offenders who move through the facility during a given year since average daily population is used as the denominator. Therefore, a facility with a large population turnover may have a skewed increase in their rate of hospitalizations compared to a facility with a similar average daily population but has much lower offender turnover.

1A (11) Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months divided by the average daily population in the past twelve (12) months.

Purpose: The measure estimates the annual rate of off-site emergency visits within a given facility. CEOs and health care authority should regularly assess the extent of emergency transfers of offenders outside the facility in order to monitor potential security risks, medical costs, and the adequacy of preventive and ambulatory care within the correctional setting.

Methodology: The designated health care authority should ensure that all off-site offender emergency visits are evaluated to assess the quality of emergency care provided to the offender prior to transfer, identify any potential lapses in providing ambulatory care, and ensure that adequate follow-up is provided upon return to the facility. The designated health care authority should annually report the rate of off-site emergency services to the CEO.

Outcome Measure Calculation:***Numerator***

1. Include all offenders sent to an off-site emergency care facility for any unscheduled reason within the 12-month reporting period. (Recommend ending reporting period at the end of the calendar year.)
2. Count multiple emergency care visits separately, for any individual inmate if these visits occurred within the 12-month reporting period; except as referred from one emergency department to another.
4. Exclude inmates treated onsite or at other DOC operated facilities as a result of an intra-system transfer.
3. Exclude inmates sent to emergency care facilities directly from other correctional systems, community-based facilities, or home detention.

Denominator

1. Average daily population for the 12-month reporting period.

Limitations: The measure does not account for inherent variances in the morbidities of offender populations in different facilities or variations in on-site correctional health care services. This

outcome measure could also be influenced by the practitioner's skills and capabilities. The measure is only an approximated calculation of the facility's rate of off-site emergency visits. It does not take into account the total number of offenders who move through the facility during a given year since average daily population is used as the denominator. Therefore, a facility with a large population turnover may have a skewed increase in their rate of off-site emergency visits compared to a facility with a similar average daily population but has much lower offender turnover.

1A (12) Number of offender specialty consults completed during the past twelve (12) months divided by the number of specialty consults (on-site or off-site) ordered by primary health care practitioners in the past twelve (12) months.

Purpose: Measures the access that offenders have to specialty consults ordered by primary care practitioners. Measures the rate at which institution resources are utilized to obtain specialty consultations. These data may be an indicator for the CEO and the health authority of whether it is feasible and cost effective to provide specialty service in-house.

Methodology A consult is a patient evaluation as requested by a primary care practitioner and approved by a utilization review process and/or by health care authority. This must be approved within the reporting period.

Outcome Measure Calculation

Numerator

1. A specialty consult included an approved referral and completed evaluation by a medical specialist (e.g., surgeon, dermatologist, nephrologists, pulmonary specialist, orthopedic specialist, cardiologist, obstetrician, or gynecologist) within the reporting period. (Recommend ending the reporting period at the end of the calendar year.)

2. Count all approved on site, off site, or electronic telemedicine specialty consults for medical conditions ordered by a primary care practitioner. Do not include subsequent pre- or post- procedure follow ups ordered by the specialists.

3. The consult may occur off or onsite or via a telemedicine process as the medical specialist may make periodic rounds to the facility so the consult may occur in the facility.

Denominator

Count all requested evaluations ordered for the offender and while the offender remained in the facility which were approved by the utilization review process and/or reviewed by the health care authority within the reporting period.

Limitations

The number of consults completed will not address the appropriateness of the need for specialty services in the event of a suboptimal utilization process. Further, it does not refer to the skill set of in house physicians or the availability of community services

1A (13) Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mm Hg/ > 90 mm Hg divided by the total number of offenders with hypertension who were reviewed.

Purpose: This measure assesses hypertensive offenders whose hypertension is poorly controlled. Inadequately controlled hypertension can lead to end-stage disease such as heart failure, stroke, and kidney failure. The measure is important to CEOs from a risk management, security, and fiscal perspective, since poorly controlled offenders with hypertension are more likely to require outside medical trips for related complications, costly inpatient care, and are more likely to suffer a sentinel event such as a preventable injury or death.

Methodology: This measure requires tracking blood pressure readings of offenders who are treated with medication for hypertension. Monitoring blood pressure readings can most efficiently be achieved by automated methods or separately documenting blood pressure readings at each chronic care evaluation as a reportable outcome measure. Otherwise, assessing the control of hypertension among affected offender populations requires retrospective chart reviews, which is very time-consuming.

If not all evaluations of treated hypertensive offenders can be reviewed, then a random subset of offenders under treatment for at least 6 months should be selected for analysis. If the total population is less than 30 offenders, then report data on all inmates. If the study population is greater than 30, report either 25% of affected offenders or 30 offenders, whichever number is greater. If a subset of the population is used, a random sample is vital. In selecting this random sample, ensure there are offender cases among all providers to monitor treatment variations.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation

Numerator

1. Include, at a given date, the number of offenders with hypertension who have been under treatment for at least 6 months and have a blood pressure reading of > 140/90 mm Hg on the most recent evaluation. If not all hypertensive offenders are selected for review, then a random subset should be evaluated (see above).
2. Exclude offenders who have been treated for hypertension for less than 6 months within the facility.
3. Exclude offenders with hypertension who are housed in other correctional systems, community-based facilities, or home detention.

Denominator

Include all offenders in the review sample with hypertension under treatment for at least 6 months who were reviewed on the given date. (The denominator should be at least 30 unless there were fewer than 30 offenders with hypertension who warranted evaluation.)

Limitations: This measure does not reflect optimal hypertension control. The outcome measurement also does not account for offenders prescribed effective treatments who are not adherent to therapy and, therefore, do not meet therapeutic goals.

If a subset is used to report this measure, then some margin of error will be included.

Resources:

<http://www.nhlbi.nih.gov/guidelines/hypertension>

1A (14) Number of selected diabetic offenders at a given point in time who are under treatment for at least six (6) months with a hemoglobin A1C level measuring greater than nine (9) percent divided by the total number of diabetic offenders who were reviewed.

Purpose: This measure assesses diabetic offenders whose diabetes is poorly controlled. Inadequately controlled diabetes can lead to end stage diseases such as blindness, neuropathy, and kidney failure. The measure is important to CEOs from a risk management, security, and fiscal perspective, since poorly controlled offenders with diabetes are more likely to require outside medical trips for related complications and are more likely to suffer a sentinel event such as a preventable injury or death.

Methodology: This measure requires tracking hemoglobin A1C readings of diabetic offenders who

are treated with medication for their diabetes. Monitoring hemoglobin A1C readings can most efficiently be achieved by automated methods or separately documenting readings at each chronic care evaluation as a reportable outcome measure. Otherwise, assessing the control of diabetes among affected offender populations requires retrospective chart reviews, which is very time-consuming.

If not all evaluations of treated diabetic offenders can be reviewed, then a random subset of offenders under treatment for at least 6 months should be selected for analysis. If the total population is less than 30 offenders, then report data on all inmates. If the study population is greater than 30, report either 25% of affected offenders or 30 offenders, whichever number is greater. If a subset of the population is used, a random sample is vital. In selecting this random sample, ensure there are offender cases among all providers to monitor treatment variations.

(Recommend selecting the midpoint of a calendar year to be the data reporting point. It is highly suggested at all facilities within a correctional system use the same reporting date for system wide data aggregation capability.)

Outcome Measure Calculation:

Numerator

1. Include, at a given date, the number of offenders from the selected sample with diabetes who have been under treatment for at least 6 months and have a hemoglobin A1C reading of >9% on the most recent A1C. If not all diabetic offenders are selected for review, then a random subset should be evaluated (see above).
2. Exclude offenders with diabetes who have been under treatment for less than 6 months within the given facility.
3. Exclude offenders with diabetes who are housed in other correctional systems, community-based facilities, or home detention.

Denominator

Include all offenders in the review sample with diabetes under treatment for at least 6 months who were reviewed on the given date. (The denominator should be at least 30 unless there were fewer than 30 offenders with diabetes in the facility who warranted evaluation.)

Limitations: This measure does not reflect optimal diabetic control. The reported outcomes also do not account for offenders prescribed effective treatments who are not adherent to therapy and therefore do not meet therapeutic goals.

If a subset is used to report this measure, then some margin of error will be included.

Resources:

<http://www.diabetes.org/for-health-professionals-and-scientists/cpr.jsp>

1A (15) The number of completed dental treatment plans within the past twelve (12) months divided by the average daily population during the reporting period.

Purpose: Inmates present with an array of oral health needs ranging from periodontal disease, caries, and edentulism. If not addressed, incipient conditions can progress into acute disease which is often non-restorable and inmates can be left in a state of poor masticatory function. Costly litigation has focused on the inability to manage and address identified dental conditions.

This calculation measures an inmate's access to continuous routine care resulting in the completion of planned treatment. By tracking completed treatment plans, the CEO and health care authority can assess the availability of dental resources and improve the inmate's access to routine dental care at the facility. This measures a program's ability to provide comprehensive dental care.

Methodology: A continuous manual or automated method should be established for tracking all offenders that ensures ongoing reporting to the CEO. Data should be maintained by the provider showing that planned care has been completed. Emphasis is placed on the completion of planned care as opposed to the development of a treatment plan. Daily and monthly statistical reports should provide the number of inmates whose care has been completed for the reporting period.

Outcome Measure Calculation

Numerator

1) Include inmates that have a completed treatment plan during the reporting period and as determined by the facility's dentist. A completed treatment plan requires that a documented individual treatment plan (ITP) with radiographs has been developed for the inmate and according to the ITP all oral hygiene appointments, tooth restorations, extractions of non-restorable teeth, and tooth replacements (as determined by the DOC guidelines) have been performed in their entirety. (Recommend ending reporting period at the end of the calendar year.)

2) Exclude inmates for which routine or emergency care was rendered but require continued dental appointments to restore dental health.

Denominator

Average daily population during the 12-month reporting period.

Limitation: The measure is a rate of completed dental treatment plans within a given facility. It does not take into account the total number of offenders who move through the facility during a given year since average daily population is used as the denominator. Therefore, a facility with a large turnover of the offender population may have a skewed increase dental completion rate (depending on the amount of care required for completion) compared to a facility with a similar average daily population but has much lower offender turnover. Further, since the ability to complete dental treatment plans would typically require many appointments (and are therefore time consuming), the reported completion rate does not imply that all treatment was rendered at the reporting facility.

Conversely, processing centers with high turnover populations may have comparatively lower rates if that facility has an emergency-only dental mission.

Low rates of completed dental treatment plans will not distinguish between causes such as the length of time required to complete a dental case, the number or complexity of procedures required for completion, or even the lack of dental resources available to provide routine care.

2A (1)(NEW) Number of health care staff with lapsed licensure or certification during a twelve (12) month period divided by the number of licensed or certified staff during a twelve (12) month period.

Purpose: The measure assesses the degree to which the facility ensures that all licensed or certified staff maintain their ability to practice their profession in accordance with State regulations. The CEO should ensure that health care staff are qualified to deliver medical services to minimize the delivery of substandard medical care to the offender population and prevent associated medical-legal risks.

Methodology: The health care authority must ensure that systems are in place to regularly monitor all personnel files of health care staff that require licensure or certification to practice their profession. This system must validate that all providers who must possess a current, valid, and unrestricted licenses have done so. Any provider who cannot produce a current, valid, and unrestricted license for verification is considered to have a lapsed license. Lapsed licensure includes change to inactive status, non-renewal, expiration, suspension, or revocation and also includes anyone whose license lapsed in the reporting period even if it was subsequently reinstated. Lapsed certifications apply only to those professions where certification is required by the governing State.

Health care staff should be prohibited from delivering patient care if they are no longer licensed or certified when such qualification is required.

Outcome Measure Calculation

Numerator

1. Include any health care staff for whom licensure or certification is required that worked during the reporting period that have lapsed their licensure or certification within the reporting period. This would include in-house contractors as well as facility employees. (Recommend ending the reporting period at the end of the calendar year.)
2. Include all staff with lapses during their term of employment even if they are no longer working at the institution at the end of the reporting period.
3. Exclude health care staff who can achieve certifications for their profession, but work in a profession where certification is not required to practice within the given State.
4. Exclude staff who do not have current licensure due to state administrative errors during the renewal process. (Staff must be able to demonstrate they fulfilled their obligation to the requirements for licensure.)

Denominator

Include any health care staff, in-house contractors as well as facility employees, requiring licensure or certification who were working in the facility during the reporting period.

Limitations: This would not address the cause of lapsed licensure, the length of time the practitioner was without a valid license, or the impact of this on the provision of health care in the facility.

Resources:

State licensing boards

2A (2) Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job divided by the number of new health care staff during the twelve (12) month period.

Purpose: The measure assesses the degree to which the facility ensures that new health care staff receive orientation training prior to performing their job duties. CEOs should ensure that orientation to duty assignments are routinely provided since properly trained staff are safer and more productive workers.

Methodology: The orientation of health care staff should be both correctional and clinically - focused. The orientation program should include definitive learning objectives, a delineated course content, and sufficient hours to provide adequate training. Optimally, the training should include an assessment of acquired knowledge and skills prior to duty assignment.

Outcome Measure Calculation

Numerator

All new health care staff in the reporting period that completed the required orientation training prior to performing any routine job-specific duties. (Recommend ending the reporting period at the end of the calendar year.)

Denominator

All new health care staff in the reporting period.

Limitations: This is not an indicator of the adequacy of orientation training, participant learning, or the relevancy of its content.

2A (3) Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months divided by the number of employees.

Purpose: The purpose of this measure is to estimate the annual incidence of occupational exposures

to blood or other potentially infectious material within the facility. Surveillance of work-related injuries is important for the CEO to maintain a safe work environment for correctional workers and is required by federal regulations.

Methodology: Each CEO must ensure that a system is in place to document all occupational exposures to blood or other potentially infectious material, including injuries from sharp devices, in accordance with OSHA standards. Sharps include, but are not limited to needles, scalpels, dental instruments, utensils, knives, homemade weapons and tattoo devices. Health care, safety, and security authorities should assess occupational exposures to blood or other potentially infectious material, as applicable to their disciplines, and amend policies and operational procedures as warranted reducing future exposures within the facility.

Outcome Measure Calculation

Numerator

1. Include the number of incidents where occupational exposures to blood or other potentially infectious material among correctional employees and contract staff have occurred during the reporting period. (Recommend ending the reporting period at the end of the calendar year.) Exposures include any percutaneous (injuries that occur when the skin is penetrated by a contaminated sharp object) or mucous membrane (inside the eyes, nose, or mouth), exposures to potentially infectious body fluids that can spread bloodborne pathogens, e.g., blood, fluids that contain visible blood, semen, vaginal secretions, and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.
2. Include exposures of potentially infectious body fluids to compromised skin.
3. Count recurrent exposures during separate incidents to a single employee separately.
4. Exclude contacts to human body substances that are not considered exposures to bloodborne pathogens, e.g., contact with saliva, urine, feces, sputum, sweat, tears, or vomitus, not visibly contaminated with blood.
5. Exclude contacts of potentially infectious body to intact skin.
6. Exclude percutaneous contacts from a sterile sharp object.
7. Exclude volunteer and inmate exposures, even though these exposures also warrant emergency evaluation.

Denominator

The number of correctional employees and contract staff (those employed for greater than 20 hours weekly) in the facility at the end of the reporting period.

Limitations: The measure is limited by discrepancies in defining occupational exposures to blood or other potentially infectious material and the potential for under reporting of occupational exposures by correctional staff. This number may be skewed by the turnover rate of employees and contract staff within the reporting period.

Resources:

1. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>
2. <http://www.osha.gov/SLTC/healthcarefacilities/standards.html>

2A (4) (NEW) The number of direct care staff (employees and contractors) with a conversion of a TB test that indicates newly acquired TB infection in the past twelve (12) months divided by the number of direct care staff tested for TB infection in the past twelve (12) months during periodic or clinically indicated evaluations.

Purpose: The measure estimates the incidence of newly acquired TB infections among direct care staff within a given facility. The detection of airborne TB transmission within the facility is critically important for CEOs since TB is a serious, but treatable, disease that can affect correctional staff and inmates and can spread unabated if not detected and controlled.

Methodology: Newly acquired TB infections among direct care staff (employees and contract staff that work greater than 20 hours per week) should be assessed through periodic (e.g., annual) and clinically indicated tuberculosis screening tests. Suspected new TB infections among direct care correctional staff should be rare, carefully documented and thoroughly investigated by the clinical authority and infection control committee. Since correctional staff may be exposed to TBD in the community, evidence of new TB infections among direct care staff may not reflect transmission within the prison setting.

Outcome Measure Calculation

Numerator

1. Include direct care staff, including contract staff, with a newly positive blood test for TB infection obtained via periodic or clinically indicated testing, i.e., not upon initial hire. (Recommend ending the reporting period at the end of the calendar year.)
2. Include direct care staff with a newly positive TST in the reporting period obtained via periodic or clinically indicated testing, i.e., not upon initial hire. Staff who had previously documented negative TSTs but now have a TST that has increased by at least 10 millimeters are considered to be new converters.
3. Exclude all direct care staff with a past positive screening test for TB infection.

Denominator

The number of direct care employees and contract staff that work greater than 20 hours per week screened for tuberculosis infection during the past 12 months through periodic (e.g., annual testing) and clinically indicated testing (e.g., contact investigations).

Limitations: This may produce a higher estimate of new conversions as differentiating between boosted test and new conversions is difficult if 2 step TSTs are not done. These boosted reactions may otherwise be included. Periodic testing for TBI may not be mandatory nor conducted in all jurisdictions.

Resources:

1. http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/maj_guide.htm
2. <http://www.cdc.gov/nchstp/tb/pubs/dtbefax.htm>

3A (1) Number of offender grievances related to health care services found in favor of the offender in the past twelve (12) months divided by the number of evaluated offender grievances related to health care services in the past twelve (12) months.

Purpose: The measure assesses offender grievances that have been sustained concerning the delivery of health care services within a facility during a given year. The CEO should monitor the grievance process and assess whether or not offender complaints related to the delivery of health care services are warranted in order to improve offender health care, reduce unnecessary health costs, and reduce future medical-legal risks.

Methodology: All facilities should have an offender grievance procedure that is tracked through manual or automated systems. The designated health care authority should investigate all sustained offender grievances related to medical care to ensure that justified complaints are adequately addressed.

Outcome Measure Calculation

Numerator

1. Include all offender grievances sustained during the 12-month reporting period related to the delivery of health care services. (Recommend ending the reporting period at the end of the calendar year.)
2. Exclude all offender grievances/complaints related to health care delivery in other correctional systems, community-based facilities, or home detention.

Denominator

The number of offender grievances related to health care delivery that were formally submitted in writing at the local facility level and completely reviewed during the 12-month reporting period. Count repeated grievances on the same issue by the same offender as only one grievance.

Limitations: The measure is greatly limited by the differences in thresholds for “sustaining” offender grievances between facilities and systems.

3A (2) Number of offender grievances related to safety or sanitation sustained during a twelve (12) month period divided by the number of evaluated offender grievances related to safety or sanitation during a twelve (12) month period.

Purpose: The measure assesses offender grievances that are granted within a given facility regarding safety and sanitation concerns. By regularly evaluating safety and sanitation concerns the CEO can ensure a healthier and safer correctional environment.

Methodology: All facilities should have an offender grievance procedure that is monitored through manual or automated systems. Safety and sanitation issues include, but are not limited to occupational health, hand hygiene programs, environmental protection, pest management, fire safety, and chemical abatement. CEOs should regularly assess offender grievances that are sustained regarding safety or sanitation, since these matters not only directly affect offenders, but just as much the health and safety of correctional workers and the immediate community.

Outcome Measure Calculation

Numerator

1. Include all offender grievances granted during the 12-month reporting period related to safety and sanitation. (Recommend ending the reporting period at the end of the calendar year.)
2. Exclude all offender grievances/complaints related to safety or sanitation for offenders housed in other correctional facilities/systems, community-based facilities, or home detention.

Denominator

The number of offender grievances regarding issues of safety or sanitation that were formally submitted in writing at the local facility level and completely reviewed during the 12-month reporting period. Count repeated grievances on the same sanitation issue by the same offender as only one grievance.

Limitations: The measure is greatly limited by the differences in thresholds for “granting” offender grievances between facilities and systems.

3A (3) Number of adjudicated offender lawsuits related to the delivery of health care found in favor of the offender in the past twelve (12) months divided by the number of offender adjudicated lawsuits related to healthcare delivery in the past twelve (12) months.

Purpose: This outcome measure defines the rate of favorable legal outcomes for offenders on health care issues within a facility. This indicator cannot be used without reviewing other data concerning the provision of health care within a facility, but when used in concert with other indicators, may indicate possible systemic problems.

Methodology: The numerator will include all lawsuits that were filed by or in behalf of offenders that relate to health care delivery at the facility. Health care delivery will encompass those services provided by the facility or on behalf of the facility while the inmate was under this correctional authority. It shall include cases for any medical or mental health claim.

Outcome Measure Calculation

Numerator

1. Include all health care lawsuits that were complete in being adjudicated within the reporting period and were found in favor of the offender. (Recommend ending the reporting period at the end of the calendar year.)
2. Include lawsuits settled in favor of the plaintiff in lieu of trial.
3. Include cases won by the offender on appeal.

Denominator

1. All health care lawsuits filed by inmates or in behalf of inmates that had been adjudicated or settled in the reporting period.

Limitations: This will not differentiate between the varying degrees of severity of the underlying failures in health care delivery (e.g., inappropriate surgery versus failure to allow soft shoes without adverse clinical consequences). This does not differentiate between settled for merit versus administrative reasons. However, it is important to capture all these instances in as much as they represent actual instances of adverse actions against the organization.

4A (1) Number of problems identified by quality assurance program that were corrected during a twelve (12) month period divided by the number of problems identified by quality assurance program during a twelve (12) month period.

Purpose: This indicator establishes a rate of resolved health care problems as identified by a quality assurance program and as certified by the facility leadership. The number of issues corrected during a twelve month period reveals how vigilant institution and health care leadership is in correcting found deficiencies. Upon examination, if a number of issues identified were not resolved, it would indicate a lack of leadership, resources or both.

Methodology: The quality assurance department or function conducts a periodic assessment of the number of process outcome or systemic health care deficiencies identified as important for the delivery of health care services. This assessment is to be conducted at least once a year and indicates the beginning of the reporting year. Findings from these reviews are further assessed and prioritized through a deliberative process by facility leadership. Problems certified through this process will be monitored for completion during the reporting period. The quality assurance department shall compare the number of issues found against those corrected.

Outcome measure calculation

Numerator

1. Include the number of problems determined to be resolved by the quality assurance department and certified by facility leadership
2. Include only those problems which could be completed within the reporting period. (Recommend ending the reporting period at the end of the calendar year.)

Denominator

1. Include the number of problems found through a formal assessment process and certified by facility leadership within the reporting period.
2. Include only those problems which could be completed within the reporting period.

4A (2) (NEW) Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period.

Purpose: This measure requires the assessment and reporting of certain adverse outcomes to the CEO. By identifying and evaluating health care risk management issues, the CEO can implement policies and procedures to reduce the incidence of adverse outcomes in the future, improve offender care, reduce unnecessary health care costs, and avoid litigation. The health care authority, designated by the CEO, is responsible for the surveillance for high-risk processes and outcomes, analysis of these events, and recommending corrective actions to the CEO.

Methodology: The measure requires identifying high-risk events and adverse health outcomes, analyzing the occurrences for root cause, and implementing corrective actions to prevent recurrences. These events are defined as the omission or commission of diagnostics, procedures, or treatments that result in the risk of or actual serious physical or psychological injury, especially injury resulting in permanent loss of function or limb or offender death. Examples include treatment administered to the wrong patient, failure to diagnose a serious medical condition despite available objective evidence, or delay in delivering health care that results in preventable complications.

Outcome Measure Calculation

Numerator

(Recommend ending the reporting period at the end of the calendar year.)

1. Include the number of omissions or commissions of diagnostic tests, procedures, or treatments that result in serious physical or psychological injury producing permanent loss of function.
2. Include the number of omissions or commissions of diagnostic tests, procedures, or treatments that result in serious physical injury producing permanent loss of limb or organ.
3. Include omissions or commissions in health care delivery related to offender suicides or suicide attempts which are examined in psychological reconstructions or mortality review processes that result in the death or serious physical or psychological injury of the offender.
4. Include omissions or commissions in health care delivery related to offender deaths which are examined in mortality review processes.
5. Include all serious medication errors as defined and counted in a separate outcome measure.

This measure is the total number of healthcare risk management omissions and commissions for the given year, not a rate.

Limitations: The measure does not determine whether or not all high risk events and adverse outcomes are identified within the facility and that staff have the skills to analyze the events and synthesize the necessary preventive actions. The measure also does not account for the tremendous variance in the number of health care encounters in a given facility dependent upon the offender general population and turnover.

4A (3) Number of offender suicide attempts in the past twelve (12) months divided by the average daily population.

Purpose: The measure estimates the annual rate of offender suicide attempts in a facility. CEOs should monitor the rate of offender suicide attempts in their facilities since offender suicides are a major risk management concern and are, at times, preventable. By tracking and evaluating serious offender suicide attempts the CEO and health care authority can improve the facility's suicide prevention program.

Methodology: A continuous manual or automated method should be established for tracking all offenders in the facility who attempt suicide that permits ongoing reporting to the CEO. Incident report forms documenting suicide attempts should be reviewed by health care staff. A qualified mental health professional should determine whether or not a single event is classified as a suicidal attempt versus a "gesture" or "accident." Each facility should develop a mechanism for a formal review of the suicide prevention program to address risk management concerns and reduce future suicide attempts.

Outcome Measure Calculation

Numerator

1. Include all offenders who attempt suicide and are placed on suicide precautions (do we want it tighter to be "direct observations"?) during a 12-month reporting period. (Recommend ending the reporting period at the end of the calendar year.) Suicide attempts are offender actions intended to

cause their own death as determined on a case by case basis by a mental health professional.

2. Include all offenders who seriously harm themselves even if the self-inflicted incident was potentially a “gesture” and not an attempt in the mind of the offender (e.g., swallowing a razor blade with intestinal trauma requiring abdominal surgery).

3. Exclude offenders who commit self-injuries that are deemed suicidal gestures (i.e., not true attempts) by the designated mental health professional (e.g., superficial self-inflicted scratches and cuts not requiring suturing).

4. Exclude offenders who attempt suicide but are housed in other correctional systems, community-based facilities, or home detention.

Denominator

Average daily offender population during the 12-month reporting period.

Limitations: The measure is only an approximated rate of suicide attempts within a given facility. It does not take into account the total number of offenders who move through the facility during a given year since average daily population is used as the denominator. Therefore, a facility with a large turnover of the offender population may have a skewed increase in their suicide attempt rate compared to a facility with a similar average daily population but has much lower offender turnover. Furthermore, the accuracy of this measure is limited by the difficulty in differentiating suicidal attempts from suicidal gestures, even by qualified mental health professionals.

4A (4) Number of offender suicides in the past twelve (12) months divided by the average daily population.

Purpose: The measure estimates the proportion of offenders who annually commit suicide in the facility and assumes the immediate reporting of all apparent suicides to the CEO. CEOs should review each offender suicide to identify interventions that may reduce the risk of future suicides among the offender population. Annual suicide measurements give the CEO a barometer to assess the effectiveness of the facility’s suicide prevention program.

Methodology: A reporting method should be established to ensure that all apparent suicides are immediately reported to the CEO or designated official. The CEO should establish a method for making a final determination if an offender’s death is classified as a suicide, using autopsy findings (if available), the clinical assessments provided by the designated health care authority, and any relevant investigations. An automated or manual tracking system should be maintained to document all offender suicides over time. A designated health care authority should ensure that all offender suicides undergo a careful evaluation. Potential concerns (when identified) and recommended interventions for preventing future offender suicides should be forwarded to the CEO for review.

Outcome Measure Calculation

Numerator

1. The numerator is the number of offender suicides within the past 12 months. (Recommend ending the reporting period at the end of the calendar year.)

2. Exclude offenders who commit suicide while housed in other correctional systems, community-based facilities, or home detention.

Denominator

The denominator is the average daily population of the facility during the 12-month reporting period.

Limitations: The measure is only an approximated rate of offender suicides within the facility. It does not take into account the total number of offenders who move through the facility during a given year since average daily population is used as the denominator. Therefore, a facility with a large population turnover may have a skewed increase in their annual suicide rate compared to a facility with a similar average daily population but has much lower offender turnover. Furthermore, certain offender deaths may be difficult to accurately classify as suicides versus accidents, e.g., certain drug overdoses.

4A (5) Number of unexpected natural deaths in the past twelve (12) months divided by the total number of deaths in the same reporting period.

Purpose: The measure estimates the proportion of unexpected natural deaths among the offender population within a given facility. CEOs should monitor the rate of unexpected offender deaths in the facility since a subset of these deaths may be preventable. Furthermore, a multi-disciplinary review of these deaths may detect risk management or health care delivery concerns that if addressed, could reduce further offender morbidity and decrease future health care costs, e.g., community hospitalizations.

Methodology: The CEO should establish a method for making a final determination if an offender's death is classified as unexpected using autopsy findings (if available), the clinical assessments provided by the designated health care authority, and any relevant investigations. An automated or manual tracking system should be maintained to document all unexpected natural deaths over time. A designated health care authority should ensure that all unexpected natural deaths undergo a thorough evaluation. Potential concerns (when identified) and recommended interventions for preventing future unexpected natural deaths should be forwarded to the CEO for review.

Outcome Measure Calculation:

Numerator

1. Include all medically unexpected deaths during the 12-month reporting period. (Recommend ending the reporting period at the end of the calendar year.) Medically unexpected deaths are those that occur suddenly without any clinical warning (i.e., sudden death) and are not as a result of a previously diagnosed medical condition(s) that is life threatening, e.g., certain cancers, AIDs, congestive heart failure, kidney or liver failure, and geriatric co-morbidities. Offenders with terminal medical conditions, however, can die “unexpectedly” from other causes and should be included in the numerator. Additionally, “medically unexpected deaths” include offenders who succumb despite well managed chronic conditions, e.g., an offender with an acute MI with a history of well-controlled hypertension.
2. Include offender deaths from injuries.
3. Exclude offender deaths from suicide, homicide or executions.
4. Exclude any offender deaths occurring in other correctional systems, community-based facilities, or home detention at the time of their death.

Denominator

Number of offender deaths in the 12-month reporting period

Limitations: The measure is a calculation of the rate of unexpected offender deaths within the facility. The total number of deaths might be skewed from correctional facility to facility, since it does not take into account the total number of offenders who move through a facility within a given year.

4A (6) Number of serious medication errors in the past twelve (12) months.

Purpose: This measure requires the cumulative reporting of the most serious medication errors to the CEO. Medication dispensing, prescribing, distribution, and administration errors are a serious risk management issue in any health care system and can be the source of preventable hospitalizations and litigation. All CEOs should require medication error reporting for their health care delivery system. A “no fault” approach to medication error reporting should be adopted with the exception of gross negligence by the health care provider. A “no fault” approach has been proven to increase the reporting of medication errors and secondarily improve the medication delivery system. By tracking serious medication errors, the CEO can determine how health care policies and operations can be improved to reduce the incidence of future medication errors.

Methodology: Each CEO should establish a policy that requires the reporting of serious medication errors to the health care authority. In turn, the health care authority should provide a summary of medication errors to the CEO during the past year. The report should assess risk management issues that require attention to improve the medication delivery system within the facility.

Outcome Measure Calculation:

1. Count the number of medication errors that caused temporary offender harm (i.e., complication which is completely reversible) and required the need for treatment or intervention. An example might be prescribing despite a known drug allergy to that class of agents.
2. Count the number of medication errors that caused the offender harm and resulted in initial or prolonged hospitalization.
3. Count the number of medication errors that resulted in permanent offender harm (i.e., life long treatment or irreversible sequelae as a direct result of the error).
4. Count the number of medication errors that resulted in a near death event.
5. Count the number of medication errors that resulted in an offender's death.

This measure is the total number of serious medication errors for the year, not a rate.

Limitations: This measure does not determine whether or not all serious medication errors are identified within the facility and that staff have the skills to analyze these errors and synthesize the necessary corrective actions. The measure also does not account for the tremendous variance in the number of medications prescribed, dispensed, and administered within a given facility dependent on the offender census, morbidity, clinician prescribing practices, and population turnover.

Name _____		of _____		Facility _____	
Date _____					
		Number of Months Data Collected _____			
		Health Care Outcome Measure Worksheet		Appendix A	
		Health Care Outcomes			
Standard	Outcome Measure	Numerator/Denominator	Value	Calculate O.M	
1A	(1)	Number of offenders diagnosed with a MRSA infection within the past twelve (12) months			
	divided by	The average daily population			
	(2)	Number of offenders diagnosed with active tuberculosis in the past twelve (12) months			
	divided by	Average daily population.			
	(3)	Number of offenders who are new converters on a TB test that indicates newly acquired TB infection in the past twelve (12) months			
	divided by	Number of offenders administered tests for TB infection in the past twelve (12) months as part of periodic or clinically-based testing, but not intake screening.			
	(4)	Number of offenders who completed treatment for latent tuberculosis infection in the past twelve (12) months			
	divided by	Number of offenders treated for latent tuberculosis infection in the past twelve (12) months.			
	(5)	Number of offenders diagnosed with Hepatitis C viral infection at a given point in time			
	divided by	Total offender population at that time.			
	(6)	Number of offenders diagnosed with HIV infection at a given point in time			
	divided by	Total offender population at that time.			
	(7)	Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART) at a given point in time			
	divided by	Total number of offenders diagnosed with HIV infection at that time.			
	(8)	Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less than 50 cps/ml			
	divided by	Total number of treated offenders with HIV infection that were reviewed.			
	(9)	Number of offenders diagnosed with an Axis I disorder (excluding sole diagnosis of substance abuse) at a given point in time			
	divided by	Total offender population at that time.			
	(10)	Number of offender admissions to off-site hospitals in the past twelve (12) months			
	divided by	Average daily population.			

	(11)	Number of offenders transported off-site for treatment of emergency health conditions in the past twelve (12) months		
	divided by	Average daily population in the past twelve (12) months.		
	(12)	Number of offender specialty consults completed during the past twelve (12) months		
	divided by	Number of specialty consults (on-site or off-site) ordered by primary health care practitioners the past twelve (12) months.		
	(13)	Number of selected hypertensive offenders at a given point in time with a B/P reading > 140 mmHg/ >90 mm Hg		
	divided by	Total number of offenders with hypertension who were reviewed.		
Name _____ of _____ Facility _____ Date _____				
		Number	of	Months
Collected _____		Data		
	(14)	Number of selected diabetic offenders at a given point in time who are under treatment for atleast six months with a hemoglobin A1C level measuring greater than 9 percent		
	divided by	Total number of diabetic offenders who were reviewed.		
	(15)	The number of completed dental treatment plans within the past twelve (12) months		
	divided by	the average daily population during the reporting period.		
2A	(1)	Number of health care staff with lapsed licensure or certification during a twelve (12) month period		
	divided by	Number of licensed or certified staff during a twelve (12) month period.		
	(2)	Number of new health care staff during a twelve (12) month period that completed orientation training prior to undertaking their job		
	divided by	Number of new health care staff during the twelve (12) month period.		
	(3)	Number of occupational exposures to blood or other potentially infectious materials in the past twelve (12) months		
	divided by	Number of employees.		
	(4)	Number of direct care staff (employees and contractors) with a conversion of a TB test that indicates newly acquired TB infection in the past twelve (12) months		
	divided by	Number of direct care staff tested for TB infection in the past twelve (12) months during periodic clinically indicated evaluations.		
3A	(1)	Number of offender grievances related to health care services found in favor of the offender in the past twelve (12) months		
	divided by	Number of evaluated offender grievances related to health care services in the past twelve (12) months.		
	(2)	Number of offender grievances related to safety or sanitation sustained during a twelve (12) month period		
	divided by	Number of evaluated offender grievances related to safety or sanitation during a twelve (12) month period.		
	(3)	Number of adjudicated offender lawsuits related to the delivery of health care found in favor of the offender in the past twelve (12) months		
	divided by	Number of offender adjudicated lawsuits related to healthcare delivery in the past twelve (12) months		

4A	(1)	Number of problems identified by quality assurance program that were corrected during a twelve (12) month period		
	divided by	Number of problems identified by quality assurance program during a twelve (12) month period		
	(2)	Number of high-risk events or adverse outcomes identified by the quality assurance program during a twelve (12) month period.		
	(3)	Number of offender suicide attempts in the past twelve (12) months		
	divided by	Average daily population		
	(4)	Number of offender suicides in the past twelve (12) months		
	divided by	Average daily population		
	(5)	Number of unexpected natural deaths in the past twelve (12) months		
	divided by	Total number of deaths in the same reporting period.		
	(6)	Number of serious medication errors in the past twelve (12) months		
5A	None			
6A	None			
7A	None			
7B	None			
7C	None			

DEFINITIONS

Correctional Complex: A correctional complex is more than one facility managed by the same jurisdiction located within close geographic proximity where services are shared or consolidated.

Dental Screen: A system of structured inquiry and observation by a dentist, dental hygienist, dental assistant, qualified health care professional or health trained personnel of newly arrived offenders to determine whether a dental referral or immediate medical attention is needed.

Direct Care Staff: Any staff member who routinely has direct contact with the inmate population.

Emergency Care: Care of an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call. Emergency care shall be provided to the resident population by the medical director, physician, or other staff, local ambulance services, and/or outside hospital emergency departments.

Health Care Staff: Clinical and administrative personnel assigned to the health care unit.

Health Care Practitioner: Health care practitioners are clinicians who are trained to diagnose and treat patients, e.g., physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners and physician assistants.

Health Appraisal: A review of health care screenings and the collection of other health care data by a qualified health care professional that includes consultation with a health care practitioner.

Health Record: Separate records of medical examinations and diagnoses maintained by the responsible physician.

Health Screen: A structured inquiry and observation of newly arrived offenders to ascertain their health condition, to identify those who pose a health or safety threat to themselves or risk to others and to identify offenders who require a prompt referral or immediate medical attention.

Health Trained Personnel: Correctional officers or other correctional personnel who are trained and are appropriately supervised to carry out specific duties with regard to the administration of health care.

Infirmery: Health observation and care under the admission of a health care practitioner and supervision of a qualified health care professional housed in a separate area from other general housing areas.

Inter System: Transfers from one distinct correctional system to another.

Intra System: Transfers from facility to facility within the correctional system.

Medication Dispensing: The process of placing one or more doses of medication into a container then labeling it to indicate the name of the patient, the contents of the container, the dosing regimen and other necessary information by health care staff member as authorized by the jurisdiction.

Mental Health Care Practitioner: Mental health care practitioner is a clinician who is trained to diagnose and treat mental illness, e. g., physicians and psychologists.

Qualified Mental Health Care Professionals: Staff who perform clinical duties for mentally ill, e.g., physicians, psychologists, nurses, and social workers in accordance with each health care

professional=s scope of training and applicable licensing, certification and regulatory requirements.

Qualified Health Care Professionals: Staff who perform clinical duties, e.g., health care practitioners, nurses, social workers, emergency medical technicians in accordance with each health care professional=s scope of training and applicable licensing, certification, and regulatory requirements.

Comment/Action: Approved

*Colonel David Parrish, Hillsborough County Sheriff's Office
Tampa, Florida*

Col Parrish provided oral testimony and answered questions on the ALDF Core Standards.

Comment/Action: The "Core" standards were approved for field testing after they are returned to the original ALDF language. The results of the field test and the final version of proposed standards will be presented at the 138th Congress of Correction meeting in August 2008.

Closing Comments

Issue: Meeting Adjournment

Comment/Action: Robert Garvey made a motion to adjourn.

Patricia Caruso seconded the motion. The motion carried.

Chairperson Lappin thanked the committee for their hard work and diligence. The meeting was adjourned at 11:48 a.m.