

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES



ADMINISTRATION MANUAL

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Dates Reviewed:	

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All Policies and Procedures will be reviewed, at a minimum, annually by Office of Inmate Health Services Staff

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATION MANUAL

Chapter 1
CQI

Section 1
ADMINISTRATION

- I. Policy: To facilitate continuous improvement of quality health care being provided to all inmates located within the health care facilities of DPSCS, it is the policy of the Department of Public Safety to comply with all applicable Federal, State and Local laws and health services standards for the purpose of ensuring provision of quality health care to inmates.

- II. Procedure:
 - A. The DPSCS Quality Improvement Program shall be designed, maintained, and implemented within the Office of Treatment Services. Its focus will be on the assessment and monitoring of all health care activities, functions, and standards including, but not limited to, clinical practice, education, contract compliance and administration for comprehensive healthcare including Medical, Mental, Dental, Utilization Management and Pharmacy processes.
 - 1. The Continuous Quality Improvement program monitoring shall include, but not be limited to, the following areas of the Division of Correction health care delivery system:
 - a) Physician services
 - b) Nursing services
 - c) Pharmaceutical services
 - d) Rehabilitation services
 - e) Dental services
 - f) Dietary services
 - g) Radiology services

- h) Mental health services
- i) Quality Improvement Program/Discipline
- j) Emergency services
- k) Laboratory services
- l) Infection Control
- m) Health services contracts
- n) Medical record services
- o) Environmental Health and Safety
- p) Social Services
- q) Telemedicine
- r) Electronic Patient Medical Record

B. Responsibility and authority for the administration of the Continuous Quality Improvement (CQI) program lies with the DPSCS Office of Treatment Services. The Medical Director, Director of the Office of Inmate Health Services (OIHS) of the Office of treatment Services, and the Agency Contract Operations Manager (ACOM) in conjunction with the Director of CQI and Infection Control and staff will work together to assure the process. The DPSCS Medical Director shall chair a quarterly OIHS CQI meeting that will provide oversight for:

1. Scheduling, supervising and implementing quality improvement evaluations as approved by Office of Treatment Services
2. Reviewing reports of the contractor's quality improvement program, trending, monitoring activities.
3. Approving changes in activities, functions and/or standards emanating from monitoring activities as appropriate.
4. Submitting reports to the Office of Inmate Health Services (OHIS), Director of Treatment Services, Quality Improvement Program authority, site administrators and wardens, findings of deficient

standards and/or regulations. Referrals to the licensing boards of nurses, midlevel providers, physicians, dentists, mental health staff etc.

- C. The DPSCS CQI committee will convene with representative vendors quarterly.
- D. The contractor's quality improvement committee will submit minutes, trend data summaries, risk management issues, pharmacy, dental, mental health etc. to the DPSCS CQI Committee monthly.
- E. The Service area CQI committees will evaluate and review regional findings, develop and submit a corrective action plan to the ACOM and DPSCS CQI committee to investigate and review for effectiveness in altering outcomes.
- F. The OIHS Quality Improvement Program staff's responsibility shall include, but not limited to:
 - 1. Representing the Office of Health Care Services at the contractor's regional quality improvement committee meetings, as appropriate.
 - 2. Developing and executing plans for the organization, direction and supervision of the Division's Health Care Services Quality Improvement Program, and for addressing programmatic issues in the improvement and reorganization of existing methods and procedures in the care and treatment of physically and mentally ill inmates.
 - 3. Submitting budgetary requests for various needs of the Quality Improvement Program to the Director of Office of Inmate Health Services.
 - 4. Scheduling and supervising a quality improvement audit calendar in collaboration with the Agency Contract Operations Healthcare Manager and DPSCS Medical Director.
 - 5. Conferring with the Director of Office of Inmate Health Services (OIHS) in the development of policies related to the administration of health services to inmates.
 - 6. Reviewing and analyzing the Office of Inmate Health Services Quality Improvement Program reports submitted to the regional site administrators and wardens concerning problems as well as the in-house

monitoring findings, and making periodic institutional visits and health services rounds with the health care providers as a quality improvement monitoring approach.

7. Reviewing quarterly summary reports concerning health services provided to inmates and health education received by contracted staff functioning at the health care facilities within the DPSCS to highlight adverse trends or sentinel events for review by the DPSCS Medical Director
 8. Conducting the health services contractual audits periodically in the field with the ACOMs.
 9. Supervising Health Care Services Quality Improvement Program staff.
 10. Developing, coordinating, and implementing the Quality Improvement Program tools to be utilized by the staff in monitoring the delivery of health services in the correctional health care facilities.
 11. Preparing reports for submission to the Director of Inmate Health Services regarding the findings of the ACOMs and the Quality Improvement Program staff.
 12. Coordinating the problem identification process with the vendor Quality Improvement staff, utilized in monitoring the quality of health care provided in the correctional health care facilities.
 13. Comparing various data obtained during monitoring of the provision of health services by the contractor. This shall be done in collaboration with the ACOM and the DPSCS Medical Director.
 14. Reviewing the contractor's Quality Improvement Programs for approval.
 15. Comparing institutional quality improvement staff audit findings with the findings of the Office of Inmate Health Services Quality Improvement staff.
 16. Performing other duties as assigned.
- G. There will be a Quality Improvement Program Committee composed of an interdisciplinary team of DPSCS employees including, at a

minimum:

1. Director of the OIHS Quality Improvement Program
2. ACOM Supervisor
3. Quality Improvement field coordinators /ACOMs
4. DPSCS Chief Medical Officer
5. DPSCS Dental Consultants
6. Director of Office of Inmate Health Care
7. Other designated personnel as required such as the Director of Mental Health
8. Representative of Office of Treatment Services

H. The Quality Improvement Program Committee shall:

1. Assist in generating and coordinating ideas for monitoring activities to prevent duplication, assist in identifying potential interdisciplinary studies and facilitate as well as coordinate monitoring activities.
2. Design effective mechanism for identification and prioritizing of problems, their assessment, resolution, and evaluation.
3. Assist in generating and coordinating ideas for monitoring activities.
4. Develop criteria for monitoring activities and utilize appropriate mechanism to aggregate data relevant to practice and performance so that patterns are ascertainable.
5. Make recommendations, as appropriate, for corrective action in activities, functions, and/or standards to the Quality Improvement Program Administrator.
6. Establish an annual study calendar in response to organizational goals, including specific issues and responsible person (s).
7. Review educational opportunities relevant to quality improvement and quality control.

8. Evaluate annually and assist in the modification of, as necessary, the Office of Health Care Services program's plans to ensure integration, coordination, confidentiality and effectiveness of the Quality Improvement Program.
 9. Re-study death reviews, serious incident reports (SIR), etc.
- I. The Quality Improvement Program Committee shall have the authority to identify, investigate, and provide guidance to the responsible personnel regarding areas of non-compliance and corrective action and will:
1. Assist the Quality Improvement Program Staff in reviewing and approving or disapproving institutional plans of correction.
 2. Monitor inmates receiving health services and the professionals and paraprofessionals providing health services within the Division of Public Safety. Correction health care facilities shall be monitored according to predefined standards, structure, and process and performance outcome criteria. Emphasis shall be placed on known, potential or suspected problems relevant to:
 - a. Inmates and the quality of health services rendered;
 - b. Professionals and paraprofessionals and their practices; and
 - c. Other problems affecting the health care services provided which cannot be justified as appropriate under specific circumstances i.e. *sentinel events*.
 3. Provide problem assessment in order to identify and select deviations from the expected occurrence. To do this , the Quality Improvement Program staff shall validate the:
 - a. Existence of the problem;
 - b. Extent of the problem;

- c. Nature of the problem;
 - d. Complexity of the problem; and
 - e. Characteristic of the problem
 - f. Performance measures indicators where appropriate
 - g. Contract compliance issues
- J. Other methods to be utilized during assessment visits shall include:
- 1. Internal data sources, such as patient records, committee reports, staff interviews and inmate questionnaires; and
 - 2. External data sources, such as Federal, State and other regulatory agency reports, costs review commissions, and third payer reports, if applicable.
- K. Problems shall be selected for review when resolution will provide a positive impact on patient care and/ or professional practices.
- L. An entrance interview, as required, shall be held with the following staff members to state the purpose of a visit to a facility, as appropriate:
- 1. Agency Contract Operations Manager
 - 2. Private contractor /designees
 - 3. Warden or designee; and
 - 4. Site Administrator
- M. An exit interview shall be held with the following members to advise the institutional staff of the Division of Correction auditor findings, and will include at a minimum:
- 1. Agency Contract Operations Manager
 - 2. Private contractor /designees
 - 3. Warden or designee;
 - 4. Site Administrator; and

5. Quality Improvement Coordinator

N. The findings of the Quality Improvement Program staff's audit shall be sent to the following members of the involved institution:

1. Agency Contract Operations Manager
2. Quality Improvement Coordinator site
3. Site administrator

O. A copy of the report and plan of correction shall be sent to the:

1. Assistant Commissioner(s); and designee
2. Other sources chosen by the Office of Inmate HealthCare Services

P. A plan of corrective shall be developed and submitted for approval to the Quality Improvement Program Staff and the ACOM from the following institutional staff:

1. Warden/custody staff if applicable;
2. Contractor Site Administrator; medical director , director of nursing;
3. Quality Improvement Coordinator contractor; and
4. Other pertinent staff including Chief of Security if indicated.

Q. The plan of correction shall be submitted within the requested time frame, and the strategies to remedy problems shall describe:

1. All actions required;
2. Person(s) responsible for implementing each action; and
3. The time by which actions are to be completed.

R. The following actions shall be implemented during the CQI evaluation process:

1. A letter of approval or disapproval of the plan of corrections CAP) shall be sent from the ACOM

2. Approved CAP shall be sent to the Office of Inmate Health Services CQI Coordinator for review, and will include:
 - a. A re-audit schedule to be within 30 days of implementation of the corrective action and a review of the process resolution within 90 days to determine sustainability.
 - b. Person designated as the one who will be held accountable for the implementation and resolution of the problem.
 - c. An expected date of resolution.
 - d. A plan for sustainability i.e. ongoing updates for staff, recurrent in-services with pre and post tests.
3. Failure to produce an *approved* Corrective Action Plan regarding impaired processes to the ACOM may result in the ACOM requesting another plan within 10 working days or a request for damages.

III. References:

IV. Rescissions: DPSCS 130-700-001: Administration

V. Date Issued: July 15, 2007

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATION MANUAL

Chapter 1
CQI

Section 2
CQI REPORTS AND MEETINGS

IV. Policy: To facilitate continuous improvement of quality health care being provided to all inmates located within the health care facilities of DPSCS, it is the policy of the Department of Public Safety to comply with all applicable Federal, State and Local laws and health services standards for the purpose of ensuring provision of quality health care to inmates and to require certain reports related to that quality.

V. Procedure:

A. All vendors are required to submit in a timely fashion (defined by contractual agreement) the following reports:

Indicators	Eastern	Western	Jessup	Baltimore
ER				
Mortality				
MH Referrals				
Methadone				
HIV				
TB				
Hepatitis C				
Pregnancy				
Sentinel Events				
Assaults on Staff				
Inmates Assaults				
Injuries				
Grievances				
On Call				
Unplanned				

Readmissions				
Security Breeches				
Medication Errors				
Patient Clinical Case Conferences				

B. DPSCS will hold a meeting quarterly that will include a discussion of the findings from these reports as well as provide an update on processes and improvement initiatives taking place throughout the State.

1. DPSCS Quarterly CQI Meeting Attendees will include, but not be limited to:

a. Contractor Staff

- The Contractor State Medical Director
- The Contractor Medical Director Utilization Management
- The Contractor UM Administrator designee (initial then as requested)
- The Contractor State Infection Control RN
- The Contractor State Director of Nursing,
- *The Pharmacy Contractor Designee (initial then as requested)
- *The Contractor Dentist Director/Designee (initial then as requested)
- The Contractor Mental Health Director Designee
- *The Contractor EPHR/HMIS Manager (initial then as requested)
- The Contractor State Quality Improvement Manager
- Contractor VP or Regional Manager Designees

b. The Agency State Medical Director-

c. The Agency Contract Operations Health Care (ACOM) Manager

d. The CQI designated ACOM for the Service Delivery Area on the agenda (Non mandatory option for other ACOMs)

e. Agency Social Work Designee

f. Agency Director of Mental Health

- g. Agency Director OIHS, Director Administration Treatment Services, DOC Program
2. Representatives named above should be present if trend issues or Serious Incidents in their areas occurred. The initial meeting will serve as an introduction to format and objectives and how Action plan items would be managed.
 3. Fixed Agenda will include:
 - a. UM data/region/quarter, ER/Amb, Inpatient days, consultations/specialty/ Top DRGs
 - b. Risk Management, Serious Incidents, Assaults, Sentinel Events:
 - i. Infection Control stats, Hep C, MRSA, TB, HIV, Outbreaks, Contact isolation etc
 - ii. Deaths/region/quarter ICD 9 diagnosis/Dispositions 1-4
 - c. Review of trend data areas , Action Plans by specialty, Medical, Dental Infection Control
 - d. Audits for the quarter/ Performance Measures articulated in the proposal for each contractor will be reviewed /discussed and a projected schedule of monitoring of specific contracted services/focus
- C. Regional Meeting will be held monthly by the contracted vendors and reports of those meetings will be made in the following format:

**Monthly
Regional CQI Meeting**

Region _____ Date _____

DATE	ISSUE	Sites involved	ACTION TO BE TAKEN	PERSON RESPONSIBLE	DUE DATE	STATUS
	2.2.2.6.5.2.1 Review Total health Care operation areas of opportunity/contract (Attach report)					
	2.2.2.6.5.2.2 Audits conducted prior month list					
	2.2.2.6.5.5 ACOM issues (List areas)					
	2.2.2.6.5 Vendor Contract Issues 2.2.3 FCM/Mumby&Simmons 2.2.2. MHM 2.2.4 Correct RX 2.2.5 Wexford 2.2.1 CMS 2.2.6 EPHR					
	2.2.2.6.5.6 Incidents (list) 2.2.2.6.5.6.1 Deaths etc. Attach report					
	2.2.2.6.7 Grievances/Complaints # per month /site					
	2.2.2.6.5.6.10 Patient Case conference List DOC # initial name and issues/processes related to focus review					
	2.2.2.6.10 Risk management /Mortality Review					
	2.2.2.6.5.6.7 Lapses in protocol /procedure (list)					
	2.2.2.6.5.6.8 Infection Control					
	2.2.2.6.5.6.9 Security Breaches, Sharps, medication, keys					
	2.2.2.6.11.1 Pharmacy issues					

VI. References:

VII. Rescissions:

VIII. Date Issued: September 15, 2007

OFFICE OF TREATMENT SERVICES
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Chapter 1
CQI

Section 3
AUDIT REPORT FORMAT

- I. Policy: Periodic data collection utilizing Department of Public Safety and Corrections Systems (DPSCS) approved tools shall be reported on the standardized Audit Report (Appendix A) in order to document the medical contractor's compliance with contractual obligations and applicable policies and procedures. The uniformity of the audit report format will simplify the identification of outcomes of the resulting from audits and to readily see the recommendations being made for continuous quality in the DPSCS health care system.

- II. Procedure:
 - A. The Departmental Audit report will be prepared by Departmental staff using the attached DPSCS Audit Report form, including the completion of the worksheets developed by the Office of Inmate Health Services and calculations of compliance to the criteria.

 - B. Support documentation will include but will not be limited to:
 - 1. Worksheets (Excel based audit tools).
 - 2. Comments.
 - 3. Calculations portion of the Excel tools.

 - C. The Audit Report shall consist of an analysis of the audit findings and shall include recommendations for improvement, corrective action plans (CAP) if needed, and recommendations for the imposition of liquidated damages if needed. The form preparation includes the following:

Form Blank	Description for Completion
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1. Date prepared	Date of the audit.
2. Prepared by	Name and title of the person preparing the report with the office address of the preparer.
3. Audit Region/facility	Name of the region, name of the facility or multiple names of facilities if audit covers more than one facility.
4. Audit Subject	Name of audit tool used.
5. Audit period	Specify the time frames covered in the audit, for example: 7/1/2007-1/31/2010 or any time limiting factors used in selection audit sample.
6. Randomization criteria	Identify how the sample was selected and the number of records that were selected as well as the number of records that were audited.
7. Reason for audit/audit focus	Describe the source of the audit, such as whether it is a departmental directive (policy), a contractual issue, a routine audit per the audit calendar, a targeted audit resulting from an identified problem area, a follow up audit to a previous one that had adverse findings, etc. Identify the focus of the audit (MAR, Sick Call, Intake, etc.)
8. Materials audited	Describe the materials used in the audit such as logs, medical records, inmate interviews, etc.
9. Report distribution	List who will receive copies of the audit report, including DPSCS personnel and vendor personnel by name.
10. Summary	Provide a brief analysis of audit findings.
11. Recommendations	Note any specific recommendations for any aspect of the process, including CAP (with specific measurable outcomes). Recommendations may be as simple as "Continue to monitor compliance" in the event of a positive audit outcome.
12. Liquidated damages recommended or not	Describe any recommendations necessary for liquidated damages if needed followed by completion of the Excel Spreadsheet for the Review Board per policy. If none are assessed, state that in this blank.

D. The Audit Report must be maintained on-site in the Office of Inmate Health Services (OIHS) for reference and for any comparative studies for a period of not less than five years.

1. It will be filed in the auditor's office with attachments.
2. It will be distributed without attachments to:
 - a. The Director of the Office of Inmate Health Services
 - b. The Director for CQI/IDC of the OIHS
 - c. The Medical Director of Health Services (DPSCS)
 - d. The Regional Health Services Administrator (HSA) for the vendor.
 - e. The Regional Medical Director or Director for the appropriate vendor.
 - f. The Director for Quality issues for the appropriate vendor and, when applicable, the Infection Control Administrator for the audited vendor.

III. References:

IV. Rescissions: DPSCS 130-800-002 all issuances and versions

V. Issued: October 15, 2007

Appendix A

**State of Maryland
Department of Public Safety and Correctional Services
Office of Inmate Health Services**

AUDIT REPORT

Date Prepared: _____

Prepared By: _____
Name Title Office Location

Audit Region and Facility: _____
Region Facility/Facilities

Audit Subject: _____

Audit Period: _____

Randomization Criteria: _____

Reason for Audit/Audit Focus: _____

Materials Audited: _____

Summary: _____

Recommendations:

Liquidated Damages Recommended or Not:

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Chapter 2

NURSING PROTOCOL

- I. Policy: It is the policy of the Office of Inmate Health Service that the Contractor shall adhere to and maintain compliance with Current Consent Decrees, State laws and regulations, Maryland Commission on Correctional Standards, Departmental protocols and directives, and National Commission on Correctional health Care (NCCHC) Standards at BCDC and BCBIC.

- II. Procedure:
 - A. Contractors (medical, mental health, pharmacy, and case management) shall develop and implement protocols governing the practice of nursing staff for each of their respective areas.
 - B. Protocols must comply with the Maryland Nurse Practice Act and the Maryland Board of Nursing Standards.
 - C. If the protocols do not address particular conditions/complaints, substitution of other protocols shall not be used. If the protocols are not listed in the Inmate Health Services Manual, or if they require that a level other than a nurse perform the function, the inmate must be referred to a physician.
 - D. All nursing protocols must be reviewed and approved annually by the Office of Inmate Health Services (OHIS).
 - E. A copy of all nursing protocols shall be forwarded to OHIS for approval before being distributed to staff or placed in existing manuals.
 - F. The use of a nursing protocol, as with all nursing functions relating to patient care, must be documented in the inmate's medical record.

- III. References:
 - A. Title 10, department of Health and Mental Hygiene, Board of Examiners of Nurses.
 - B. Nurse Practice Act, Health Occupation Article, Title 8 Annotated Code of Maryland.

- IV. Rescissions: DPSCS 130-700-724 Office Of Treatment Services Manual Volume I: Nursing Protocol

- V. Date issued: July 15, 2007

OFFICE OF TREATMENT SERVICES
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Chapter 3
LICENSURE, CERTIFICATION AND CPR CERTIFICATION

- I. Policy: To establish policies and procedures governing possession of license, certification and credentials as required by federal, state and local laws and regulations, All health care professionals providing services to the inmates within the Maryland Department of Public Safety and Correctional Services will maintain valid licenses, certificates ,cooperative agreements, registrations, and credentials as required by all applicable federal, state and local laws.

- II. Procedure:
 - A. All licensed health care professionals (contractors and their staffs) shall possess the credentials, licenses and /or certificates required by law and regulation to provide the services required of an individual's profession.
 - 1. All employees shall maintain the proper training, licenses, certificates, cooperative agreements and registrations necessary to provide these services in Maryland as required by COMAR, licensing boards, contractual agreements and applicable job specific requirements.
 - 2. All licensure, certification and CPR certification shall be renewed on or before expiration dates and copies provided annually to the ACOM.
 - 3. Failure to renew and submit a copy of all licenses and/or certification may result in denial of entry into the institution to practice.

 - B. Contractors shall maintain credential folders for all health care providers they employ and for those employed by a subcontractor.
 - 1. Files will contain the items required for employees to perform their duties according to governing agencies of the State.
 - 3. The contractor shall maintain current policies and procedures that define the credentialing process in detail.

4. The contractor shall establish a written procedure to ensure that nursing personnel:
 - a. Have valid and current Maryland licenses and
 - b. Practice in accordance with the American Nurses Association standards for correctional facilities, and the Maryland Practice Act.
5. The contractor shall assemble and have accessible on site and available for review by DPSCS, credentialing information for medical doctors, dentists , pharmacists, physician assistants, and nurse practitioners etc. that includes (where applicable):
 - a. A signed application
 - b. Verification of education and training, work history
 - c. Professional references
 - d. Malpractice claims history
 - e. Results of a National Practitioner Data Bank Query
 - f. A copy of a current license to practice
 - g. Board or specialty certification
 - h. Evidence of review of health status
 - i. DEA and CDS certificate(s)
 - j. Lack of present illicit drug use
 - k. CPR certification
 - l. Criminal background check
6. Supervisors of medication technicians and medical assistants shall ensure certification, and that there is no deviation from the limitations and restrictions placed upon them.
7. Supervisors (site manager or director of nursing) shall ensure qualifications and certification of the medical records supervisor.

8. Supervisors shall ensure that credentials for radiology staff and special services staff, as applicable, are current and maintained in the institution.

C. The contractor shall provide the DPSCS with copies of all federal, state and local licenses, certificates, registrations, cooperative agreements, specialty board certifications or other notices of eligibility for certification, that are legally required for an employee or subcontractor:

1. Prior to the performance of any services under the contract, and
2. Within one month of the renewal date of the credential.

D. Before institutional identification is issued, a license and/or certification must be available to show security staff at the appropriate time.

- III. References:
- A. Title 10, DEPARTMENT OF HEALTH AND MENTAL HYGIENE Subtitle 27 BOARD OF NURSING Chapter 09 Standards of Practice for Registered Nurses Authority: Health Occupations Article.
 - B. Board of Physician Quality Assurance
 - C. Inmate Health Care Services project # Q0005057
- IV. Rescissions: DCD 130-100, Sect. 160 dated April 28, 1993
DPSCSD 130-700-720 Quality Improvement Program: Licensure, Certification, CPR
- V. Date Issued: July 15, 2007

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Chapter 4
CONTRACT MANAGEMENT PROCEDURE

Section 1
MONTHLY FACILITY SERVICES SCHEDULE

- I. Policy: There shall be a Monthly Facility Services Schedule (“MFSS”), approved by the Department, submitted by any Health Services Contractor providing services in DPSCS facilities. The MFSS shall comply with the Contractor’s Staffing and Services Plan, consistent with the scope of work defined by the contract. In accordance with its MFSS, the Contractor shall employ the number and types of personnel necessary to effectively provide the programs and services required by the Request for Proposal (RFP) in the Service Delivery Areas at the various facilities and locations in the facilities

- II. Procedure:
 - A. The MFSS and related documentation shall be submitted in a form and format as required by the Department.
 - B. The MFSS shall comply with the following requirements:
 - 1. Provide the full name and credential (e.g. PA, RN, etc) of every individual assigned to a position on the schedule for that month;
 - a. The Contractor may not place individuals in positions for which they are not qualified or for which they are not properly credentialed. The Contractor shall assure that personnel are qualified and licensed to perform assigned duties.
 - i. The Agency shall consider for approval qualified healthcare personnel to be employed on a PRN or temporary basis. The Contractor shall use only those pre-approved employees to staff vacant positions within the Service Delivery Area.

- ii. These personnel shall fill a specific position that has a defined position description approved by the Agency as described in the Contractor's Personnel Manual.
- 2. Provide the times and locations of all clinic services to be provided;
 - a. Clinic calendars shall list the type of clinic(s) at each institution and shall include, but not be limited to:
 - i. Chronic care clinics,
 - ii. Speciality clinics (e.g. Optometry, PT, surgical, Orthopedic, ID, etc).
 - b. As a legend insert, this calendar schedule will also include the daily on-call coverage by name, pager and phone numbers of each individual assigned.
- 3. Provide the time and locations of all training activities, and all administrative, clinical and management meetings;
- 4. Provide administrative responsibility assignment information (administrator on-call) and staffing coordinator assignment.
- 5. Be delivered to the ACOM supervisor not later than 10 days prior to the first day of the beginning of the service month addressed by the MFSS.

C. MFSS Adjustments

- 1. The Contractor may adjust the MFSS for any Provider upon verbal approval of the Agency Contract Operations Manager.
 - a. If the Agency Contract Operations Manager cannot be reached, the Agency Health Care Administrator; the Agency Medical Director or designee, or the Director of the Office of Inmate Health Care may act in the Agency Contract Operations Manager's place.
 - b. The verbal approval is not effective until confirmed by the Contractor in writing to the Agency within 10 workdays of the Agency's verbal approval, and the Agency approves the Contractor's written confirmation.
- D. The Contractor shall provide a staffing report by position, indicating position hours not properly filled, on the 10th day of the month following the month being reported.

- E. If requirements or conditions change, the Agency may direct minor variations to the MFSS. Otherwise, the Contractor shall provide whatever additional number and types of personnel as necessary to provide the services, without additional reimbursement.
- F. The Department shall complete a periodic review for comparison to contract specifics to include, but not limited to, the following:
 - 1. Appropriate credentials.
 - 2. Compared to Contractual specifications, the level of coverage by name/credential.
 - 3. Vacancies, number, credential and frequency.
 - 4. Following the review and advisement of recommended changes by the DPSCS ACOM, an acknowledgment memo (Appendix II) is generated for presentation with schedules to managing officers (wardens) for review and approval signature. The medical contractor shall provide to each managing officer (warden) the monthly staffing schedule for review and approval. This shall be returned to ACOM and copies, with schedules, will be disseminated to ACOM and the internal auditor at DPSCS.
- G. The hours worked by any individual shall correspond with the daily facility sign-in/sign-out logs.
- H. Sign-in/sign-out sheets shall be periodically reviewed by the Department

III. References:

IV. Rescissions: DPSCS 130-800-003 all issuances and versions

V. Issued: July 15, 2007

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

Chapter 4
CONTRACT MANAGEMENT PROCEDURE

Section 3
MEDICAL STAFF SIGN-IN/SIGN-OUT LOGS

- I. Policy All employees of the Department of Public Safety and Corrections Systems (DPSCS) medical contractors shall be required to make an entry on the sign-in/sign-out logs every time they enter or exit DPSCS.

- II. Procedure
 - A. The medical staff sign-in/sign-out log shall be used by medical staff only and the Correctional Officer (CO) on duty shall verify completeness of each medical staff by initialing each at the time it is made. Each log entry shall include:
 - 1. Correct time;
 - 2. Legible signature
 - 3. Specific Destination
 - B. If, through no fault of the CO, a log entry is incorrect, the CO will write the word "ERROR" in the initial box before writing his/her initials.
 - C. At no time shall any person sign-in/sign-out or enter a time in or out on the medical staff logs for any other medical staff person, for any reason.
 - D. All medical staff sign the log sheet designated for their position (e.g., "Doctor", "PA", "nurse", "other") and record in chronological order the time-in and time-out each time they enter and leave the facility for any reason. It is the responsibility of the medical staff to request the proper log sheet from the CO or report the problem to his/her supervisor if the CO fails to make proper log sheet available.

- E. All log entries shall be made in blue or black ink and:
1. All medical staff shall print and sign their names consistent with payroll names and signatures. The contractor shall provide medical staff payroll printed name and signature key to the regional health care administrator (and copies the Medical Internal Audit Unit [MIAU]).
 2. All signatures and time entries shall be legible.
 3. Military time shall be used to enter all sign-in/sign-out times. Examples:
 - a. 0800 = 8:00 AM
 - b. 1200 = Noon
 - c. 1900 = 7:00 PM
 - d. 2400 = Midnight
 - e. 0001 = 12:01 A.M. or one minute after midnight
- F. Any changes (e.g. a different time from the one first entered) to the log shall be corrected by drawing a single line through the error, and shall be initialed by both the affected medical provider and the CO on duty. The corrected signature, time or destination shall be re-entered on the same line directly above or next to the change. The CO will also initial the "CO initials" column, as normally required. It shall not be permissible to erase or otherwise cover up an entry.
- G. With the exception of temporary personnel, all medical staff shall show their Department approved IDs upon signing-in/signing-out. The identity of temporary medical staff who are issued a visitor's badge shall be confirmed by another form of Photo ID issued by the Motor Vehicle Administration and/or the medical contractor.
- H. In accordance with security regulations, all medical staff will strictly adhere to the sign-in/sign-out procedures and know that the CO will be monitoring the log and that the CO on duty shall not permit any medical staff to enter or leave the facility without correctly completing a log entry except in the case of a medical emergency, which shall be documented at the time of the exit or entrance of the individual(s)..
- I. All medical staff leaving the facility for another destination (including "off duty") shall clearly designate the destination on the log.

- J. All medical staff that work beyond 2400 hours shall not re-enter the sign-in time for the previous day's log entry when signing out on the log corresponding to the date that the employee actually left the institution. (For example, if a provider signs in before 2400 on the previous day's log, then left at 0800 the next day, he/she shall sign out on the log corresponding to the day he/she left.)

- K. The CO's responsibility to monitor the sign-in/sign-out procedures does not in any way release the medical contractor(s) from their responsibility to adhere to the sign-in/sign-out procedures required in this DPSCDS. Medical staff should remain aware that The CO will not "rubber-stamp" his/her initials without verifying the entries, and should not ask for such favors. If the CO finds out an entry was wrong but the medical staff has gone, the CO shall circle that entry and report it to the commander.

- L. Medical staff should be aware that the CO on duty at 2400 hours closes the log by replacing the previous log sheets with new log sheets. Log sheets are not closed before 2400 hours or prior to the closing of the post for any reason, and that:
 - 1. The CO who closes the log at the end of the day verifies that all log entries for the day have been completed. A single line is drawn (vertically, diagonally or horizontally) through all blank columns, boxes and/or rows and each line shall be initialed by the CO on duty.

 - 2. The CO who closes the log assures that all pages are in chronological order i.e., if there are two (2) pages of DOCTOR log sheets on 10/1/2008, they shall be numbered: Page 1 of 2, and Page 2 of 2,). The page numbers for DOCTOR, PHYSICIAN ASSISTANT, NURSE, or OTHER log sheets are never mixed together.

 - 4. The CO who closes the log at the end of the day secures the log sheets until they are turned over to the shift commander. (Medical staff needs to understand that the CO cannot re-open a sheet because the person "forgot to sign" or for any other reason)

 - 5. The shift commander on duty (between 2400 and 0800 hours) collects the log sheet(s) from the CO who closed the log sheet(s), signs and dates them, and secures the log sheet(s) until collected by the warden or warden's designee.

6. If there are days when no medical staff is on duty and log entries are not required, a log sheet shall be created. A line is drawn (either vertically, diagonally, or horizontally) through the entire sheet and initialed by the CO on duty and a brief note of "no" entries is required for that day. Exception may be granted to pre-release facilities where daily medical coverage is required to submit a memorandum (signed and dated by the warden or designee) stating the days no medical staff were on duty.
7. The shift commander and the warden or warden's designee sign and date each closed log sheet after it is collected to signify responsibility for the completed log entry (e.g. written the word "ERROR" next to his/her initials).
8. The original signed log sheet(s), including blank log sheets (or memorandum, as required) for days when no medical staff entered the institution, is submitted to the Medical Internal Audit Unit (MIAU) by the warden or warden's designee within 48 hours (or at the time frame approved by MIAU). The shift commander notifies the warden in writing (and copies the Medical Internal Audit Unit (MIAU) of any missing log sheet(s).

D. Other than to sign-in/sign-out, the medical contractor staff shall not be permitted access to original logs at any time for any reason. Copies of closed logs may, on special request by the medical contractor, be provided to that medical contractor with the approval of the warden or warden's designee before audits of such logs are completed for that month. MIAU shall be notified of such copies of closed logs provided to the contractor.

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| III. | References: | A. All Health Services Contracts for the Department of Public Safety and Correctional Services (DPSCS). |
| IV. | Rescissions: | DCD 130-800, Medical Sign-in/Sign-out Logs, May 1, 1999 |
| V. | Date Issued: | October 18, 2007 |

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATION MANUAL

Chapter 5
INMATE MEDICAL GRIEVANCE PROCEDURE

- I. Policy: All inmates will have access to a formal procedure for individual complaints against or about employees, officials, policies, or medical services provided through the DPSCS medical contracts. Inmates shall also be assured of written and timely responses to these complaints that are fair and reasonable.

- II. Procedure:
 - A. All staff having direct contact with inmates are to be informed of the complaint process available to inmates in order to facilitate timely implementation.
 1. It is the responsibility of the DPSCS Contractors to comply with all facility processes required to facilitate the inmates' rights of grievance regarding medical matters, and to assure that all staff are made aware of the process and the steps that must be followed its implementation.
 2. All staff will comply with any request to grieve in a timely manner
 - B. There are four (4) Grievance Procedure "Steps"
 1. To begin the process (Step 1), an inmate with a grievance or complaint against or about an employee, official, policy, medical, mental health, dental, service or dietary service of any DPSCS contractor may initiate a grievance by completing an "Inmate Grievance Form, Step 1" within 30 calendar days of the date on which the incident occurred or within 30 calendar days of the date the inmate first gained knowledge of the complaint.
 - a) The form should be submitted to the Inmate Grievance Coordinator (IGC) through the section Inmate Council Representative, the Section Officer or by depositing the form in one of the facility mail boxes. Inmates in the Women's Detention Center may also use one of the Grievance Boxes that are located next to the dorms.

- b) The IGC shall conduct a fact finding investigation of all grievances submitted, except those involving medical services. For medical services complaints, the IGC shall:
 - i. Copy the grievance form;
 - ii. Log it into a tracking system;
 - iii. Forward a copy of the grievance form to the Agency Contract Operations Manager (ACOM) within two days. When the ACOM receives the grievance, he/she is required to sign and date the form and give a copy to the IGC office indicating receipt of the grievance.
 - c) Upon receipt of the grievance form, the ACOM shall: copy; log; and forward the grievance form to the appropriate health care provider(s) by the next work day and will require a signature from the recipient.
 - d) Upon receipt of a medical grievance form, the health care provider shall: investigate the grievance; document findings; take appropriate action as indicated and forward a written response to the ACOM's Office within 5 working days.
 - e) The ACOM shall track the date of response from the health care provider(s) allowing no more than the stated 5 working days, review, copy; log and forward the response to the IGC before the end of the following work day and require a signature upon receipt by the IGC.
 - f) The IGC, upon receipt of the response from the health care provider, shall ensure that a copy of all related provider responses is forwarded to the resident within 2 working days as per the PDS Directive 180-1.
2. Grievance Procedure "Step II" allows an inmate who wishes to appeal the "Step I" decision. The Inmate Grievance Procedure (IGP) Committee may do so by completing a "Motion for Grievance Committee, Step II Form". The form must be submitted via the Inmate Grievance Box.
- a) The IGC will schedule the complaint to be reviewed by the IGP Committee at its next hearing. (Committee meetings are scheduled as needed.)
 - b) At the scheduled time and place for the hearing, the IGC shall convene the hearing. The hearing shall be conducted

in an informal manner, beginning with a presentation of the grievance by grievant, followed by the testimony of other parties and/or witnesses.

- c) The IGC shall allow committee members to question any of the parties or witnesses concerning their testimony and also allow the grievant or his/her representative to question the parties or witnesses.
 - d) Following the completion of the testimony, the IGC shall ask the grievant and his/her representative (if applicable), to leave the hearing room so that the IGP Committee can deliberate on the grievance and discuss possible solutions.
 - e) Following their discussion, the IGP Committee shall make a decision on a resolution of the grievance. The decision is to be made by a majority vote of the committee members.
 - f) If the decision of the IGP Committee is that the grievance is without merit, the inmate shall immediately return to the Hearing Room and be notified verbally of the committee's decision. A written explanation of the committee's decision shall be sent to the inmate within 5 working days of the hearing date.
 - g) If the IGP Committee finds that the grievance is meritorious, the inmate shall be immediately returned to the Hearing Room and receive verbal notification of the committee's decision. The committee's decision shall be sent in writing to the Warden with a recommendation for specific relief within 5 working days of the hearing date. The committee's recommendation is subject to the Warden's review and may be affirmed, reversed, or modified in writing, within 5 working days of receiving the committee's report.
3. Grievance Procedure "Step III" enables an inmate wishing to appeal the "Step II" decision to the Warden. S/he may do so by completing a "Motion to Appeal to the Warden, Step III Form" and submitting it to the IGC within 3 working days of the decision rendered in "Step II".
- a) The IGC shall deliver a copy of the appeal to the warden within 1 (one) working day of receiving the appeal, making all records of the Grievance (to date) available to the Warden.
 - b) The Warden shall review the grievances, the records and the decision (conducting any appropriate investigation) and will submit a written decision on the appeal (within 3 working

days of receiving the appeal) to the IGC, the grievant and parties to the grievance.

4. Grievance Procedure "Step IV" enables an inmate wishing to appeal the Step III decision to the Commissioner of the Division of Pretrial Detention and Services. S/he may do so by completing a "Motion to Appeal to the Commissioner, Step IV Form" (Appendix D) and forwarding it to the IGC within 3 working days of the inmate's receipt of the decision rendered in Step III.
 - a) The Commissioner shall direct the IGC to schedule a hearing and to inform the grievant and other parties to the grievance of the time, date and place for the hearing.
 - b) At the conclusion of the hearing the commissioner shall submit a written notice of the decision to the inmate and copies to the IGC, within 20 working days of the hearing. That decision shall be final. Any final decision from the Warden or the Commissioner which determines that the grievance is at least in part meritorious shall direct certain relief to be afforded to the inmate and shall direct the appropriate staff to provide the relief and to document compliance within 10 working days (if possible), or as may be otherwise specified in the decision.

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| III. | References: | PDSD 180-1 Inmate Grievances: Inmate Grievances Procedures |
| IV. | Rescissions: | None |
| V. | Date Issued: | July 15, 2007 |

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATION MANUAL

Chapter 6
MEDICAL RESEARCH

- I. Policy : To assure that inmates do not participate in medical, biomedical, chemical , behavioral or pharmaceutical, studies that do not have a direct or indirect health benefit to them or studies that do not follow existing state and federal regulations regarding inmates and research studies, any research, (biomedical, chemical or behavioral) using inmates as subjects, must be conducted in accordance with existing State and federal regulations and DPSCS application process for research proposals.
- II. Procedure:
- A. Any study shall require the written approval of the , Director of the Office of Inmate Health services/OIHS Medical/Mental Health Director, the Assistant Secretary of the Office of Treatment Services and approval of the DPSCS Research Committee.
- B. Researcher will request or obtain a DPSCS application for research and complete the following fields:

Researcher's Name	
Academic Title and Affiliation, if any	
Mailing Address	
Telephone Number	
Email Address	
Title of Research Study	
Main Research Hypothesis and Purpose of Study (why it will advance knowledge or practices in the criminal justice or related fields)	

Methodology(ies)	Timeline: Data Collection: Analysis: Confidentiality:
DPSCS Data or Cooperation Req'd	
Funding Source, if any	
Study Duration (incl est'd begin date)	
Publication Intentions	
Other Relevant Information	
Date	

- C. Researcher will mail or email the completed application, together with the Researcher's résumé or curriculum vitae, to the OIHS Director with a copy to the Medical Director and Mental Health Director if pertinent. If there are additional agencies involved please provide their memorandums' of agreement with the request.
- D. Additionally, the researcher will send the completed application to the Executive Director of the Office of Planning, Policy, Regulations and Statistics for DPSCS.

Richard A. Tamberrino, Executive Director (tel: 410-339-5066; fax 410-339-4227.)
Office of Planning, Policy, Regulations & Statistics
Department of Public Safety and Correctional Services
300 East Joppa Road, Suite 1000
Towson, Maryland 21286-3020
Email: Rtamberrino@dpscs.state.md.us

- E. Completed applications will be returned to the Researcher if all requested information is not provided on the application form. Allow at least 60 days after submission to receive a formal response from the Department.

F. Protecting the privacy of the research subjects is paramount. Any project found to be in violation of privacy and confidentiality as prescribed by DPSCS will be immediately discontinued.

III. References:

IV. Rescissions: DPSCS 130-17

V. Date Issued: September 15, 2007

POLICY / PROCEDURE: 130-

Reference: MCCS .02 L
 NCHC P-72
 ACA, HC-3A-09

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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATION MANUAL

Chapter 7

MEDICAL SERVICES LIABILITY FOR INMATES IN LEAVE OR
ESCAPE STATUS

- I. Policy : The Department of Public Safety and Correctional Services by (DPSCS) is financially responsible for any treatment of injury or illness sustained inmates while they are on unescorted family leave, work release, unescorted special leave, or in escape status.
- V. Procedure:
- A. Any inmate on leave status requiring medical care during that leave should be advised of DPSCS procedures for obtaining that care. A written instruction regarding what to do in case of medical need should be provided to an inmate before he begins any unescorted leave.
 - a. Emergency treatment shall be provided through the standard means for the community. Invoices shall be submitted to the DPSS Office of Inmate Health Services or to the SPSCS third party payment agent by the health care provider providing medical services to the inmate.
 - b. Non-emergency treatment shall be provided through the DPSCS medical contractor at the facility from which the inmate is on leave.
- VI. References:
- VII. Rescissions: DPSCS 130-28 (All Issuances)
- V. Date Issued: September 15, 2007

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATIVE MANUAL

Chapter 8
HOME DETENTION PROGRAM

- I. Policy Division of Correctional (DOC) inmates assigned to
The Home Detention Program shall have access to health care
consistent with good medical practice and in accordance with
established procedures.

- II. Procedure
 - A. Medical Records of all Home Detention candidates will be reviewed by
medical staff prior to inmate assignment to the Home Detention
Program. Assignment protocol will include the following:
 - 1. Inmates should be screened for acute or chronic medical
problems that would preclude employment which is required in
the Home Detention Program.
 - 2. Medical Clearance for Home Detention participation will be
verified by medical personnel through completion of the Home
Detention Medical Clearance Form (Appendix A) which shall be
forwarded by the Case Management Department to the medical
vendor for completion.
 - 3. The Home Detention Medical Clearance form shall be completed
by the medical vendor and returned to the Case Management
Department within three (3) working days.
 - a. Inmates with acute, unstable, medical problems
should not be cleared for participation in the Home
Detention Program.
 - b. Inmates with chronic, stable medical problems may
be cleared for participation in the Home Detention
Program unless they require prescribed medications
that are categorized in Group #1 (controlled) or

Group #2 (psychotropic) medication. (see the Pharmacy Manual for a list of these drugs).

- c. The frequency and duration of anticipated medical visits to the Home Detention Unit dispensary and/or subspecialty clinics must be clearly enumerated on the Home Detention Medical Clearance Form.
- B. Inmates enrolled in the Home Detention Program will have access to routine medical services at the DOC Home Detention Unit (HDU). The following services shall be provided at the Home Detention Unit dispensary.
1. Sick Call
 2. Medication Administration
 3. Chronic Care Clinics
 4. Periodic Medical Evaluation
 5. Infirmary Care
- C. Home Detention inmates required infirmary care shall be transferred to DOC or Baltimore City Detention Center infirmaries. Female DOC inmates shall be transferred to the Maryland Correctional Institution for Women (MCIW).
- D. Home Detention inmates requiring emergency services should contact the Unit Manager or his/her designee at the Home Detention Unit. The inmate will be referred to the HDU dispensary nurse or during non-operating hours to the HDU on-call medical provider will determine if emergency care is indicated and will direct the inmate to the appropriate health care facility and notify the HDU of the initiated action.
- E. Specialty services will be scheduled by the HDU dispensary. Specialty clinics for Home Detention inmates will be provided at BCDC, MCIW for female DOC inmates, and the Maryland Transitional Center for male DOC inmates or at a community hospital when indicated, but only upon referral from the HDU physician.
- F. Medical Records for inmates participating in the Home Detention Program shall be maintained at the Home Detention Unit in a confidential manner in accordance with DOC established procedures and applicable law and regulations.

- III. References:
 - A. DCD 100-520 through DCD 100-529:
Home Detention
 - B. Pharmacy Service Manual
- IV. Rescissions: DCD 130-100, Home Detention Program, Sept 11, 1992
- V. Date Issued: October 18, 2007

HOME DETENTION MEDICAL CLEARANCE FORM

Inmate Name	DOC#	Facility	Date
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The medical record of the above named inmate has been reviewed by medical staff for acute or chronic medical conditions or has prescriptive medications in Group 1 or Group 2 (as listed in the Pharmacy manual) that would preclude participation in the DOC Home Detention Program.

_____ The inmate is medically cleared for participation in the Home Detention Program.

_____ The inmate is medically cleared for participation in the Home Detention Program with the following limitations:

_____ The inmate is not medically cleared for participation in the Home Detention Program.

The following HDU Dispensary and sub-specialty clinic visits for the designated home detention time period are anticipated for this inmate while participating in the program:

The signature of the health care provider reviewing the medical record and completing this form is required:

Signature	Title	Date
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Printed Name	Date this form is due to Case Management
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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

ADMINISTRATIVE MANUAL

Chapter 9
CONTINUITY OF CARE

- I. Policy: Inmates leaving the Department of Public Safety and Corrections facilities will be provided with information and access to systems that will enable them to continue care received while incarcerated.

- II. Procedure:
 - A. By the 10th day of each month, the Nurse Manager in a facility will review the monthly summary of all mandatory releases sent from the Case Management office
 - 1) The Nurse Manager or designee will review the mandatory release summary with the Lead Pharmacy Nurse and identify all patients who are eligible to receive discharge medications by DPSCS guidelines.
 - 2) The pharmacy nurse shall generate a roster of the inmates who will require a 30 day supply of chronic care medications as well as the remaining doses of any short term antibiotics or drugs.
 - 3) A copy of the release list is faxed to the Regional Pharmacy vendor as well as to the medical records room.
 - 4) The Nurse Manager or designee will contact the Social Work Manager for all potential referrals.
 - 5) The Psychology department and the regional mental health contractor psychiatrist will also be notified if an inmate/patient is on psychiatric medications.
 - B. The Social Work manager will send a current monthly list of release planning at the beginning of each month.
 - C. The Nurse Manager will compare both lists and contact the Social Work Manager for any variances as well as medical records.

D. Fourteen days prior to the patients mandatory release date all of the following processes will have been addressed:

1. All after care follow-up will be reviewed prior to the medical release date.
 - a. Medications will be ordered by the physician for "mandatory release" on a specific date and for a specific length of time (not to exceed 30 day supply), including but not limited to medications equating a 30 day supply of psychotropic medications, up to a 30 day supply for HIV and PI medication.

No medications will be sent for INH/B6 or DEA controlled medications.
 - b. The treatment plan for M-2 status inmates (chronic but stable conditions) will be outlined on the continuation of care form along with a short medical summary.
 - c. The Social Work department will be contacted for patients, with stable chronic illnesses that require a referral to the community health care providers such as HIV, Dialysis , oncology , hospice etc.
2. The dispensary nurse will interview the patient. The following criteria will be met: no less than 24 hours prior to 24 hours prior to release:
 - a. The Continuity of Care form will be discussed with the patient and completed This will include details regarding ongoing treatment, medications, and general guidelines for continued care.
 - b. The nurse and the patient will sign, date, and time the form.
 - c. A copy of the information will be given to the patient along with any pending appointments scheduled. The name, phone number and location of clinical sites that manage conditions the inmate may have and information related to access to care should be given.
 - d. The original of the completed form will be returned to the Medical Records Dept for disposition.

- E. On the day of Mandatory Release the patient will receive a copy of the Continuity of Care form that includes the amount of medications (numbers of each pill or amount of liquids, or tubes for topicals, etc.) and how long these medications should last prior to the patient leaving the institution unless the inmate is released directly from court.
- F. If the patient is released directly by the court, every effort should be made to reach the inmate through mail and collaborations with community health organizations, outreach, case management, family, or any other means of contact available to the facility.

- III. References: DPSDS Directive 130-100-186
- IV. Rescissions: DPSDS Directive 130-100-186
- V. Date Issued: October 18, 2007