NATIONAL CRIMINAL JUSTICE EXECUTIVE TRAINING PROGRAM

HEALTH CARE IN CORRECTIONAL INSTITUTIONS

PARTICIPANT'S HANDBOOK

OFFICE OF DEVELOPMENT, TESTING,
AND DISSEMINATION
NATIONAL INSTITUTE OF LAW ENFORCEMENT
AND CRIMINAL JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
UNITED STATES DEPARTMENT OF JUSTICE

Office of Development, Testing, and Dissemination
National Institute of Law Enforcement and
Criminal Justice
Law Enforcement Assistance Administration
United States Department of Justice

HEALTH CARE IN CORRECTIONAL INSTITUTIONS

PARTICIPANT'S HANDBOOK

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NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE

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THE EXECUTIVE TRAINING PROGRAM
IN ADVANCED CRIMINAL JUSTICE PRACTICES

Introduction

The Executive Training Program in Advanced Criminal Justice Practices is a nationwide training effort that offers states and local jurisdictions the opportunity to learn about improved criminal justice procedures and put them into operation. The Executive Training Program is sponsored by the National Institute of Law Enforcement and Criminal Justice (NILECJ), the research center of the Law Enforcement Assistance Administration, United States Department of Justice.

The National Institute supports wide-ranging research in the many legal, sociological, psychological, and technological areas related to law enforcement and criminal justice. It also follows through with the essential steps of evaluating research and action projects and disseminating information on them to encourage early and widespread adoption.

The Executive Training Program is one of the Institute's priority efforts at transferring research results to actual application in police departments, courts, and correctional institutions across the country. In this program, top criminal justice administrators and other decisionmaking officials of courts, corrections, and police agencies in each state are selected to participate in workshops and other training activities held across the country. The aim of the Executive Training Program is to help states and local jurisdictions develop the capacity to use new procedures derived from research findings or designed and developed by the Institute's Office of Development, Testing, and Dissemination through its Exemplary Projects Program and Program Models publication series.

Goals

The primary goal of the Executive Training Program is to enable criminal justice executives and policyshapers to bring about adoption of improved court, corrections, and police practices identified or developed by the National Institute.

As LEAA's research, evaluation, and technology transfer arm, the Institute works to devise improved methods to control crime and strengthen the criminal justice system and to train law enforcement and criminal justice personnel to use these more promising approaches.

To introduce the new practices throughout the nation, the Institute's Executive Training Program:

- Informs influential policymakers about new practices and their potential for improving the criminal justice system, and
- Gives them the knowledge and skills needed to apply these methods in their jurisdictions.

Approach

Techniques that have been shown to work or that promise improved effectiveness or efficiency are presented to key criminal justice executives and decisionmaking officials in Training Workshops, Field Test Training, Follow-On Training, and Special National Workshops. Eight topics have been identified by the National Institute for training sessions that began in late 1976 for selected senior staff and officials of state and local agencies.

The Executive Training Program was designed, and is conducted and managed, by University Research Corporation (URC), a national training organization based in Washington, D.C. Some portions of the training are conducted under URC's supervision by consulting firms experienced in criminal justice training.

Program Activities

Three types of activities are being carried out under the program to facilitate the transfer of advanced practices to local jurisdictions.

1. Training Workshops

Eight Workshop series are being presented across the country. Each Workshop runs for about three days. It is devoted to one topic, and is open to 60 top criminal justice policymakers from throughout the geographical area of the Workshop presentation. At the first four Workshop series, participants learned new techniques for programs on:

- Managing Criminal Investigations
- Juror Usage and Management
- Prison Grievance Mechanisms
- Rape and Its Victims

Beginning in September 1977, Workshops are being presented around the country on:

- Managing Patrol Operations
- Developing Sentencing Guidelines
- Health Care in Correctional Institutions
- Victim/Witness Services

Nationally known experts assist in developing training and present portions of the Training Workshops. URC curriculum designers, trainers, and logistics, evaluation, and media staff are working with the National Institute, the criminal justice experts, and researchers from Exemplary Projects or Program Models to ensure clear presentation of concepts and appropriate guidelines for implementation. Participants receive individual program planning guides, self-instructional materials, handbooks, and manuals. Certificates, acknowledging the competence of participants to implement the new procedures, are awarded at the conclusion of training. In cases of special need, local training support may be provided after the participants begin the implementation process in their jurisdictions.

The training topics were selected from among the most promising models developed under NILECJ auspices, including models derived from:

- Research Results - Improved criminal justice practices identified through research findings.

- Exemplary Projects - Projects that show documented success in controlling specific crimes or that have demonstrated measurable improvement in criminal justice service.

- Program Models - Syntheses of the most advanced techniques, including operational guidelines, that can be followed in locales throughout the country.

Following each Training Workshop, up to six days of follow-on training are available, on a regional basis, to assist local agencies in direct application of skills learned in these executive training events.

2. Field Test Training

Each year, workshop topics may be selected for field testing in up to 10 jurisdictions. During 1976, "field test" sites were selected to implement projects in Managing Criminal Investigations and Juror Usage and Management.

The Executive Training Program will provide assistance to three Neighborhood Justice Center (NJC) test sites in Atlanta, Kansas City, and Los Angeles. A Neighborhood Justice Center is a community-based project that seeks to resolve conflicts between people who have a continuing relationship and who generally lack recourse to the courts. The Centers will recruit and train community people to apply the techniques of mediation and arbitration to disputes. ETP will be responsible for assisting these three project sites prepare grant applications; for conducting a seminar for the project staffs at the beginning of the test period; for providing 30 days of follow-on training assistance to each center during the start-up period; and for conducting NJC Directors' conferences during the course of the contract.

The field tests focus national attention on the new procedures and evaluate their effectiveness and transferability to other jurisdictions throughout the country. The communities selected are those considered most likely to be able to carry out model projects.

Representatives from the test sites, selected by specialists most familiar with the new procedures to be implemented, receive Field Test Training designed to:

- Prepare test site staff to operate or implement their projects,
- Identify needs for follow-on training, and
- Determine the most effective format for Training Workshops in the procedures.

Participants have clearly defined and specifically outlined implementation plans when they return to their jurisdictions. Each site also receives 30 days of follow-on training over an 18-month period. It is designed to provide ideas and recommendations for tailoring the program to local needs. The training helps local groups develop the capacity to solve their own problems and to share ideas and experiences with other field test projects.

3. Special National Workshops

Special National Workshops are the third part of the Executive Training Program. They are held for criminal justice policymakers on significant topics selected by the National Institute. The first Workshops focused on:

- Argersinger v. Hamlin - This 1972 U.S. Supreme Court decision, mandating that counsel be provided for all defendants who faced the possibility of incarceration, has had a major impact on the court system. The presentation focused on this decision and the problems associated with the delivery of legal counsel to indigent defendants.

- Update "77 - This Workshop brought mayors and county chairpersons from across the nation to Washington, D.C. to discuss the role of the local elected executives in planning and developing programs in law enforcement and criminal justice. LEAA/NILECJ Program Models, research findings, Exemplary Projects, and other resources were discussed as potential solutions to problems faced by these chief executives.

- Determinate Sentencing - A great deal of attention has recently been focused on the determinate or "fixed" sentence concept. This Workshop provided an in-depth analysis of this trend and its effect on both the judicial and correctional systems at the national and state levels. Current legislation and laws in California, Indiana, and Maine were discussed in detail together with related issues that affect police, prosecution, courts, and corrections.

Other Special National Workshops, in the planning stage, include: Stochastic Modeling (data analysis techniques for law enforcement planners and analysts); Plea Bargaining; Diversion; Mental Health in Corrections; and Update '78.

Recommendations for problem-solving are provided by criminal justice experts and others who have already dealt with these problems or whose theoretical and analytical contributions can be helpful in the implementation effort.

Results

The Office of Development, Testing, and Dissemination of the National Institute anticipates that the Executive Training Program will equip criminal justice executives to return to their communities with the knowledge and skills to improve delivery of criminal justice services and thus help to shape a safer environment. It also offers participants a personal benefit--the chance to enhance their own skills and career potential.

About ODTD

The Office of Development, Testing, and Dissemination (ODTD) is responsible for distilling research, transforming the theoretical into the practical, and identifying programs with measurable records of success that deserve widespread application. In selected instances, ODTD may also provide financial and technical assistance to adapt and test these practices in several communities. The result is that criminal justice professionals are given ready access to some of the best field test programs or those experimental approaches that exhibit good potential.

ODTD has developed a structured, organized system to bridge: (1) the operational gap between theory and practice; and (2) the communication gap between researchers and criminal justice personnel scattered across the country. ODTD's comprehensive program provides:

- Practical guidelines for model criminal justice programs;
- Training Workshops for criminal justice executives in selected model programs;
- Field tests of important new approaches in different environments;
- International criminal justice clearinghouse and reference services for the entire criminal justice community.

To perform these tasks, ODTD operates through three interdependent divisions--Model Program Development, Training and Testing, and Reference and Dissemination--whose functions serve as a systematic "thoroughfare" for identifying, documenting, and publicizing progress in the criminal justice field.

ABOUT THE AUTHORS

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Ms. Gluckstern, Ed.D., is a correctional specialist and psychologist at University Research Corporation and an adjunct faculty member in the Institute of Criminal Justice at the University of Maryland, where she teaches courses on the treatment of juvenile offenders and adults in the community. She is also a faculty member of the Psychology Department at Catholic University in Washington, D.C., and has supervised teachers of special education who are working with drop-out and delinquency prone adolescents. For the past four years, she has worked in collaboration with Berkshire County (Mass.) House of Corrections as Director of a project to develop management models for jails, and has recently been awarded a grant from the National Institute of Corrections to evaluate the Berkshire County project. She is co-author of four video-based training manuals in communications skills, as well as author of a number of articles in the field of corrections and psychology.

Margaret A. Neuse

Ms. Neuse, M.A., M.P.H. has worked for seven years in the health services delivery field. She received her Masters in Public Health from Tulane University's School of Public Health and Tropical Medicine with specialization in Family Health and Population studies. As a health educator and researcher, she worked in clinic programs in El Salvador, Haiti, and Louisiana. Since joining URC in 1974, she has provided training and technical assistance to international, state, and local health care programs in self-evaluation procedures to be used in the assessment and improvement of a variety of services: The services have included family planning, primary medical care, dental care, and health education. In addition to her work with health care programs and their administrators, she has also worked with correctional administrators and evaluators while providing training on management-oriented evaluation procedures for corrections, a workshop series conducted under a grant with ODTD/LEAA in 1975-76.

Jay K. Harness, M.D.

Dr. Jay K. Harness is currently the Director of the Office of Health Care of the Michigan Department of Corrections. He is also the founder of the Washtenaw County Jail Medical Facility in Ann Arbor, Michigan, and Prison Projects. Both programs, under the auspices of the University of Michigan Interns-Residents Association, use fully licensed and resident physicians from University Hospital to provide full-time medical care to inmates of the Washtenaw County Jail as well as some services to the State Prison of Southern Michigan at Jackson and the Detroit House of Corrections, women's

division, in Plymouth. Dr. Harness has served as a consultant to Michigan Governor William Milliken's Committee on Health Care in the Michigan State Correctional Institutions. Key to Health for a Padlocked Society was published as a result of his work on that committee. He is also a member of the AMA's Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions and a faculty member of the University of Michigan's Department of General Surgery.

Ralph W. Packard

Ralph W. Packard, M.S., has worked in corrections for eighteen years, starting as a line officer, with the last four years spent in developing a model for correctional change. He is currently Director of the Model Education Program at the Berkshire County House of Corrections which has developed in collaboration with the University of Massachusetts. In addition, he is responsible for the training of the correctional staff. He has lectured at the University of Alabama, University of Massachusetts, Berkshire Community College, Holyoke Community College, and Boston University. He has also presented a paper on Corrections Counseling for the past two years for the American Personnel and Guidance Association and the American Psychological Association and he is presently a principal investigator of a Pre-Release Center in Berkshire County funded through LEAA.

Cecil Patmon

Cecil Patmon, M.A., is a medical services administrator with the Department of Corrections in Illinois. His responsibilities are for the overall medical services administration, including budgeting, personnel policies, staffing, and training for local institutions. He also provides consultant services in program development and implementation for facility administrators. Previously he has worked in planning and implementing of new programs in the health service areas. As a public relations director for a hospital he has experience in fund-raising, community relations, and communications. Mr. Patmon has served as faculty advisor for the University Without Walls program in Chicago State University, and has been responsible for training high school dropouts for jobs in medical service delivery systems.

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HEALTH CARE IN CORRECTIONAL INSTITUTIONS

Workshop Agenda

DAY I

1:00 - 1:30 p.m.	Session 1:	Introductions and Overview of the Workshop
1:30 - 2:45 p.m.	Session 2:	The Health Care Delivery System in Corrections
2:45 - 3:00 p.m.	Break	
3:00 - 5:30 p.m.	Session 3:	Using Standards and Assessing Their Implications for Health Care Delivery in Corrections

DAY II

9:00 - 9:45 a.m.	Session 4:	Support Services Needed for Effective Health Care Delivery
9:45 - 11:00 a.m.	Session 5:	Implications of Using Standards for Personnel and Available Options
11:00 - 12:15 p.m.	Session 6:	Management of Health Care Delivery in Corrections
12:15 - 1:15 p.m.	Lunch	
1:15 - 2:30 p.m.	Session 7:	Review of the Health Care Delivery System: Service Delivery and Management--Changes Being Made, Options To Consider
2:30 - 2:45 p.m.	Break	
2:45 - 5:15 p.m.	Session 8:	Implementing Change in the Correctional Institution

DAY III

9:00 - 11:30 a.m.	Session 9:	Impacting on External Influences
11:30 - 12:30 p.m.	Session 10:	Developing Action Plans
12:30 - 1:00 p.m.	Session 11:	Wrap-up

Session 1

DAY I

1:00 - 1:30 p.m.

INTRODUCTIONS AND OVERVIEW OF THE WORKSHOP

Goals of the Session

At the end of the session, the participants will have a greater understanding of:

- The mandate and structure of NILECJ and the ETP Workshops
- The rationale for selecting Health Care in Correctional Institutions as a Workshop topic
- The development process used for the curriculum design
- The goals and objectives of the Workshop and the agenda
- The materials distributed at registration.

Rationale

The general purpose of the Workshop is to increase the awareness of state and local decisionmakers about the problems and needs that affect health care delivery in corrections. Both the experts in the field who served as consultants and the practitioners who responded to the needs assessment questionnaire indicated the importance of obtaining the support of decisionmakers if improvements in health services are to be implemented. The Workshop sessions will help them assess health care delivery, identify deficiencies, and suggest alternatives that may help meet those deficiencies. At the same time, attention will be given to the problems and issues that are unique to the delivery of health care in correctional settings.

HEALTH CARE IN CORRECTIONAL INSTITUTIONS

WORKSHOP GOALS

I. To increase participant's knowledge of issues relating to the delivery of adequate health services in corrections, including:

- Legal issues
- Proposed standards
- Needed services
- Approaches to delivery or management of services
- Access to and use of resources

II. To increase participant's knowledge and skills in assessing and planning for needed changes. Participants will be able to:

- Specify components of a health care delivery system
- Apply a process for assessing service delivery and management
- Apply strategies for implementing needed changes within both the correctional setting and the external environment

III. At the end of the workshop each participant will identify one change he or she plans to implement that will help to improve the delivery of health care in corrections.

THE NEEDS ASSESSMENT SURVEY

In order to develop a meaningful curriculum for the participants at the Training Workshops for Health Care in Correctional Institutions, a needs assessment survey was conducted. Administrators, specifically health care administrators in corrections, were interviewed by telephone. In addition, three state legislators who are interested in or involved with this aspect of corrections were interviewed. The findings are based on a sample of 37 respondents.

The main concerns reported by persons working the field are:

- Development and implementation of standards
- Court orders and rulings (legal implications)
- Alternative models for service delivery
- Alternative models for acquisition and use of resources.

These findings are also supported by two "mini-surveys" of different populations. We mailed a shorter version of the telephone survey questionnaire to sheriffs' departments. Ten offices responded. We also received 19 responses from participants (mostly corrections administrators) at an earlier Prison Grievance Mechanisms Workshop.

NEEDS ASSESSMENT FOR
DELIVERY OF HEALTH SERVICES IN CORRECTIONS

Summary of Data

Introduction

During the week of April 10, 1977, telephone interviews were conducted with professionals involved in the administration of health services in corrections on a state-wide basis. Twenty-eight officials from 24 states were contacted and interviewed. In addition, nine other persons returned questionnaires by mail. The data summarized below are based on 37 respondents from 28 states.

Professions of persons interviewed:

Corrections Administrator	9
Health Care Administrator (M.D.)	7
Health Care Administrator (Non-M.D.)	15
Legislator	3
Other	3
Total	37

Present Status of Health Care System

- Seven (or about one-fifth) of the respondents stated that their system was under a court order to improve care and more than one-third said that they are under a threat of suit or court order.

- Eight (approximately 25 percent) of those interviewed stated that their systems are not using any standards, and over 50 percent stated that standards for health care services have not been established for their systems.

Direct Services

- Half of the persons sampled stated that their systems do not have periodic re-assessment of inmate's health status.

- The survey respondents indicated that there are deficiencies in other services, such as health education.

- The majority of respondents said that their systems do have mental health services, but more than one-third of them felt that these services are inadequate.

Support Services

- The three areas involving support services that the respondents considered to be flawed are: (1) complete, uniform records system, (2) a system for uniform transmittal of information, and (3) a mechanism for insuring continuity of care.

Resources

- More than half of the persons interviewed indicated that there is a lack of sufficient facilities, personnel, and funds to meet health care needs.

Knowledge and Skills

- Most of the persons interviewed felt that they possessed at least adequate knowledge of most of the field as well as administrative skills.

- The three areas where one-third or more of the respondents felt that they did not have adequate knowledge are: (1) court orders and rulings, (2) alternative models for service delivery, and (3) alternative models for acquisition and use of resources.

- One-fourth of the respondents felt that they did not have adequate skills to develop a plan for improved health care delivery, to manage health services, and to facilitate change.

Responses to Open-Ended Questions

1. Question: Of the areas mentioned above, which do you think are most important for your job?

   The following areas are representative of the responses given:

   - Assessing and identifying deficiencies in the health care system;
   - Learning alternative models;
   - Developing an operational plan;
   - Managing services;
   - Monitoring; and,
   - Evaluating services.

2. Question: What do you think you need to know more about in order to improve the delivery of health care?

   The responses listed below are groupings of the actual answers:

   - Defining "adequate" medical care;
   - Developing formal standards and procedures;
   - Learning about alternative delivery systems (models);
   - Managing systems;
   - Knowing what is happening in the community in health care delivery, that is, locally as well as nationally.

3. Question: What do you perceive to be the greatest problems in the delivery of health care services in your system's institutions?

The responses concentrated on the following areas:

- Finances
- Recruitment and retention of qualified medical personnel--problems included:
  -- Salary structure and benefits;
  -- Use of paraprofessionals;
  -- Attitudinal bias against female medical professionals in male institutions;
  -- Differences in philosophy between medical and correctional staff; and,
  -- Delivery of appropriate health/medical services in a correctional setting, involving:
    - Consolidation of services for the whole system,
    - More extensive use of resources available in the community.

4. Question: What topics do you think should be addressed in a workshop on health services in corrections?

The respondents mentioned:

- Development and implementation of standards;
- Recruitment and retention of qualified personnel;
- Budgeting;
- Accreditation of health care facilities (By whom? What standards are appropriate?);
- Licensing/credentialing of paraprofessionals;
- Effective presentations to the legislature and local community to gain their support;
- Needs assessments for specific institutions;
- Planning in corrections and differentiation of corrections from other systems;
- Relative advantages and disadvantages of institutional versus community health care for inmates; and,
- Use of outside resources.

Mini-Surveys

1. Sheriffs' Departments

In order to determine whether there are any significant differences in how correctional administrators working on a state-wide level and those working in local jails perceive the needs of health care delivery, a questionnaire was sent to the local sheriffs' departments. Ten offices, representing departments in 10 different states, responded.

Two offices stated that their systems are under court order to improve care and another two stated that they are under a threat of court order. Two respondents also stated that they do not have standards or guidelines for health care delivery. Three respondents felt that their support services for health care are

inadequate and three indicated that the resources available for health care delivery are inadequate.

The respondents suggested the following topics for a workshop on health care delivery in corrections:

- Rights and responsibilities of corrections for health care delivery;
- Civil rights in reference to health care for offenders;
- Federal regulations on health care delivery in corrections;
- Medical management of special care categories;
- Mental health care;
- Communicable diseases and treatment in the correctional setting;
- Development of funding resources;
- Development of alternative resources;
- Use of inmates as paramedics; and,
- Interpersonal relations between medical and correctional staff.

2. Workshop Questionnaire

A short questionnaire was distributed to the participants at one of the Prison Grievance Mechanism Workshops. Nineteen persons working in the correctional setting responded to this questionnaire.

Four of these respondents stated that their present health program does not included dental and mental health care. Ten noted that their systems do not have standards or goals for health care delivery. And four indicated that their system is presently under a court order that affects the health care delivery systems they operate.

The respondents suggested the following issues for discussion at a workshop on health care delivery in corrections:

- Medical standards;
- Implications of court orders;
- Design plans;
- Goal setting techniques;
- Implementation of health care program;
- Relationships between inmates and medical staff;

- Methods of delivery;
- Alternative approaches;
- Resources for psychiatric services;
- Exposure to other systems; and,
- Techniques for solving problems relating to health care delivery.

Session 2

DAY I

1:30 - 2:45 p.m.

THE HEALTH CARE DELIVERY SYSTEM IN CORRECTIONS

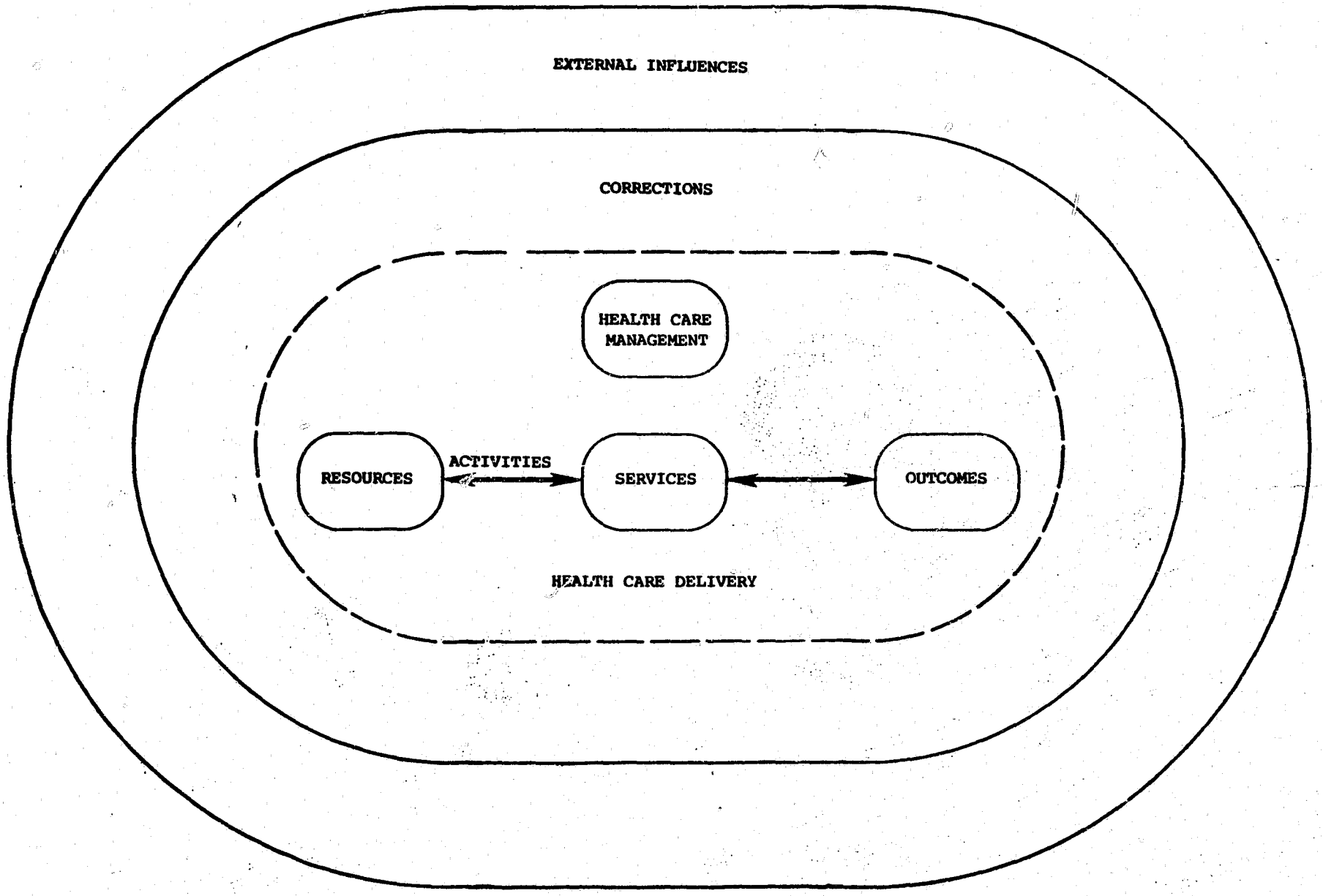
Goals of the Session

At the end of the session, participants will be able to identify:

- At least three components of the health care delivery system
- External factors which affect the health care delivery system in corrections
- At least three services that are part of the health care system
- At least three concerns of the courts which pertain to correctional health care
- At least three professional groups which have developed standards for health care in corrections
- At least one implication of the involvement of courts and professional groups in the future of correctional health services.

Rationale

Before proceeding into discussions of some of the specific problems that affect health care delivery in corrections, we must establish a common base of understanding so that Workshop participants can communicate with each other and with us in a meaningful way. For the purposes of this Workshop, such a common base will include information regarding what health care delivery means and what the impetus for change is. Forces for change have included the courts and professional organizations, such as the AMA, the APHA, and the ACA. They are now developing standards and exerting pressures aimed at improving inmate health care.


EXTERNAL INFLUENCES
CORRECTIONS
HEALTH CARE MANAGEMENT
RESOURCES
ACTIVITIES
SERVICES
OUTCOMES
HEALTH CARE DELIVERY

HEALTH CARE SERVICES

CHECKLIST

SERVICES	STATUS		
I. DIRECT SERVICES	Needed	Available	Comments
A. Ambulatory Care			
1. Primary Health Care Services			
a. Entrance screening**			
b. Entrance examinations**			
(1) Vital signs			
(2) Medical history			
(3) Physical exam			
(4) Laboratory work-up			
(5) Vision screening			
(6) Mental health exam**			
(7) Treatment plan			
(8) Referrals**			
c. Sick call - daily**			
(1) Diagnostic services--physical, lab as needed			
(2) Treatment plan			
(3) Prescription of drugs			
d. Over-the-counter (OTC) medication			

** Affected by provisions in various professional groups' proposed standards. See B. Jaye Anno's discussion in Chapter III of the Manual.

SERVICES	STATUS		
	Needed	Available	Comments
e. Segregation block visits			
(1) Diagnostic services			
(2) Treatment			
(3) Referrals			
2. Secondary Care Services			
a. Specialty clinics			
b. Follow-up acute and chronic care			
c. Physical therapy			
d. Referrals			
3. Emergency Care**			
a. First aid on-site			
b. Ambulance			
c. On-call coverage, 24-hour			
d. Referrals**			
B. Inpatient Care 1. Infirmary Care**			
a. Diagnostic services (e.g., lab, physical, X-ray)			
b. Minor acute care			
c. Convalescence			
d. Chronic care			
e. Isolation**			

SERVICES	STATUS		
	Needed	Available	Comments
2. Hospital Care**			
a. Major diagnostic			
b. Major acute care			
c. Major surgery			
d. Major medical care			
e. Major psychiatric care			
II. PREVENTIVE SERVICES			
A. Infection and Disease Control			
B. Sanitation Inspection			
C. Dietary Services			
D. Intake Physicals and Routine Screening			
E. Health Education			
F. Periodic Health Examinations (see Entrance Examination)			
III. SUPPORT SERVICES (for primary and secondary care)			
A. Medical Record**			
B. Pharmacy			
1. Formulary			
2. Medication distribution procedures**			
C. X-ray and Fluoroscopy			
D. Physical Therapy			
E. Occupational Therapy			
F. Orthopedic Appliance Laboratory			

HEALTH CARE SERVICES RESOURCES

CHECKLIST

RESOURCES	STATUS		
	Needed	Available	Comments
I. FACILITIES**			
A. Ambulatory Care Area			
1. Examining Rooms			
2. Treatment Rooms			
B. Infirmary			
C. Hospital			
D. Pharmacy			
E. Medical Records Storage			
II. EQUIPMENT AND SUPPLIES**			
III. PERSONNEL			
A. Administrative			
Health Care Administrator			
B. Medical			
Physician			
Physician Assistant (extender, MEDEX, etc.)			
Nurse practitioner			

**Affected by provisions in various professional groups' proposed standards. See B. Jaye Anno's discussion in Chapter III of the Manual.

RESOURCES	STATUS		
	Needed	Available	Comments
Emergency medical technician			
Nurse - Registered Nurse (R.N.)			
Licensed Practical Nurse (L.P.N.)			
Aide (orderly, attendant)			
C. Allied Health Personnel			
Medical technologist			
Laboratory technician			
Pharmacist			
Medical record librarian			
Medical records clerk			
Dietician			
Nutritionist			
Physical therapist			
Sanitarian			
D. Dental Care			
Dentist			
Dental hygienist			
Dental assistant			
E. Psychiatric Care			
Psychiatrist			
Psychologist			
Social worker (psychiatrist)			

SUPREME COURT INTERPRETATIONS OF THE EIGHTH AMENDMENT

HEALTH CARE IMPLICATIONS

AMENDMENT VIII. Excessive bail or fines and cruel punishment prohibited. Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

Health-Related Rulings on the Eighth Amendment

Punishments which are incompatible with the "evolving standards of decency that mark the progress of a maturing society" are repugnant to the Eighth Amendment.

Trop v. Dulles 356 U.S. 86, 101 (1958)

Punishments which "involve the unnecessary and wanton infliction of pain" violate the Eighth Amendment.

Gregg v. Georgia 96 S.Ct. 2909, 2925 (1976) (Plurality opinion)

Standard for Assessing Eighth Amendment Compliance

". . . deliberate indifference to the serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."

Estelle v. Gamble 97 S.Ct. 285, 291 (1976)

"This is true whether the 'deliberate indifference' is manifested by prison doctors. . . or by prison guards. . ."

Estelle v. Gamble, supra 291

EXAMPLES OF VIOLATION OF THE EIGHTH AMENDMENT

- Denial of treatment
- Failure to provide treatment prescribed
- Delay in providing treatment
- Inadequate treatment
- Expense of providing proper medical care is not an excuse for not providing it.

PROFESSIONAL ORGANIZATIONS INVOLVED IN SETTING STANDARDS

ACA - American Correctional Association
4321 Hartwick Road
College Park, Maryland 20740
phone: 301-864-1070

NSA - National Sheriffs' Association
1250 Connecticut Avenue
Suite 320
Washington, D.C. 20036
phone: 202-872-0422

NACCJSG - National Advisory Commission on
Criminal Justice Standards and Goals
633 Indiana Avenue, N.W.
Washington, D.C. 20531
phone: 202-376-3762

APHA - American Public Health Association
1015 18th Street, N.W.
Washington, D.C. 20036
phone: 202-467-5094

AMA - American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
phone: 312-751-6013

CAC - Commission on Accreditation for
Corrections
6110 Executive Boulevard
Rockville, Maryland 20850
phone: 301-770-3097

SCUCC - (National Conference of Commissioners
on Uniform State Laws)--Special
Committee on Uniform Corrections Code
645 North Michigan Avenue
Chicago, Illinois 60611
phone: 312-321-9710

"When clearly formulated and precisely stated in measurable terms, standards can serve as the basis for objective evaluation of programs as well as development of statutes and regulations relating to correctional services."

NACCJSG

A standard is a "principle with teeth."

PROBLEMS WITH PRESENT STANDARDS

1. Not comparable in content or format
2. No assistance given as to how standards can be met
3. Ambiguous language, subject to individual interpretations
4. Not measurable
5. Not equally applicable to small and large, short-term and long-term institutions
6. No mechanisms to enforce or measure compliance

FUTURE TRENDS: COURTS AND STANDARDS

1. Accreditation
2. Use of standards by courts
3. Legislation of standards

Standards ?

Minimum
vs.
Adequate
vs.
Quality & Quantity
vs.
Optimal

Session 3

DAY I

3:00 - 5:30 p.m.

USING STANDARDS AND ASSESSING THEIR IMPLICATIONS FOR HEALTH CARE DELIVERY IN CORRECTIONS

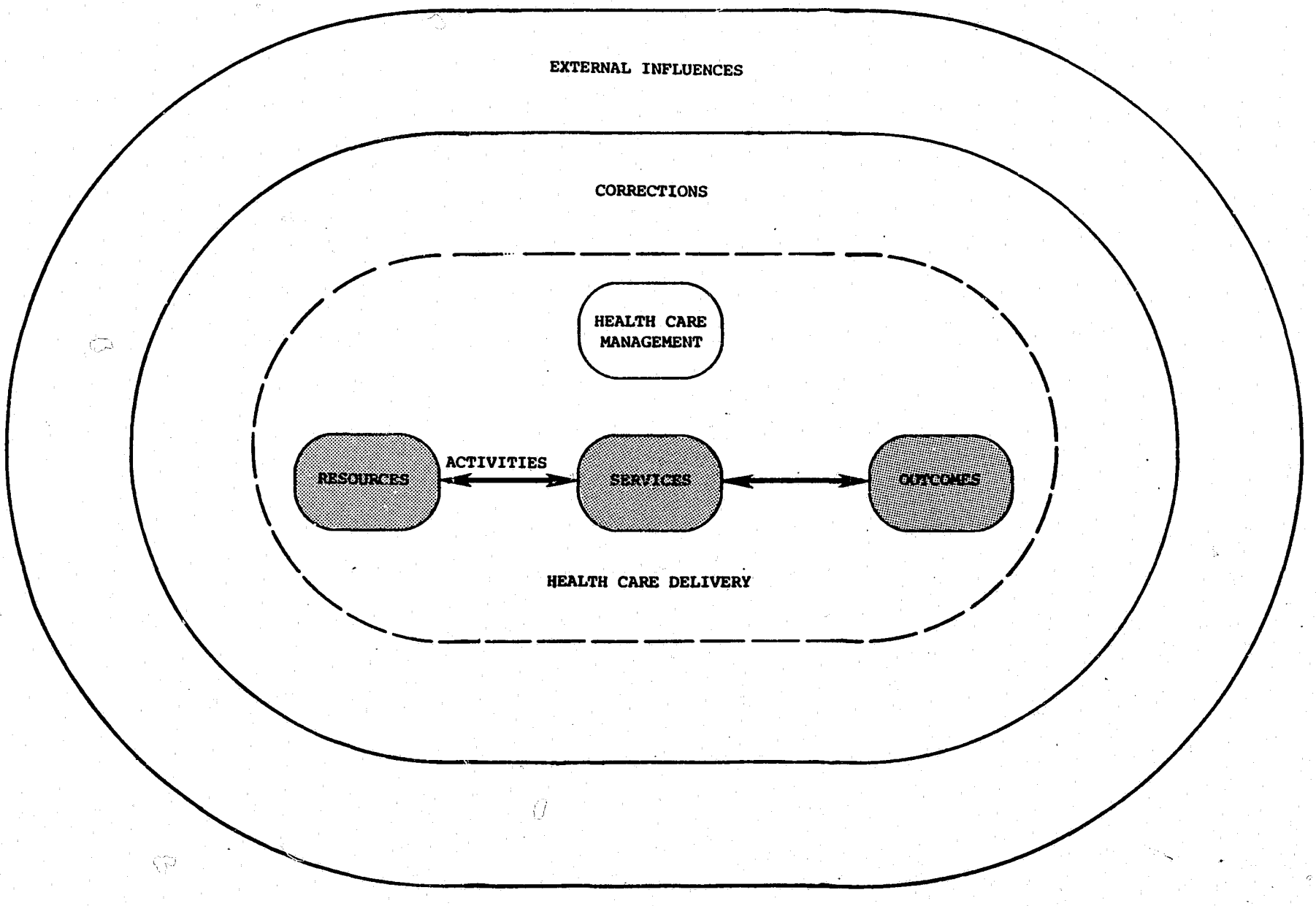
Goals of the Session

At the end of the session, the participants will be able to:

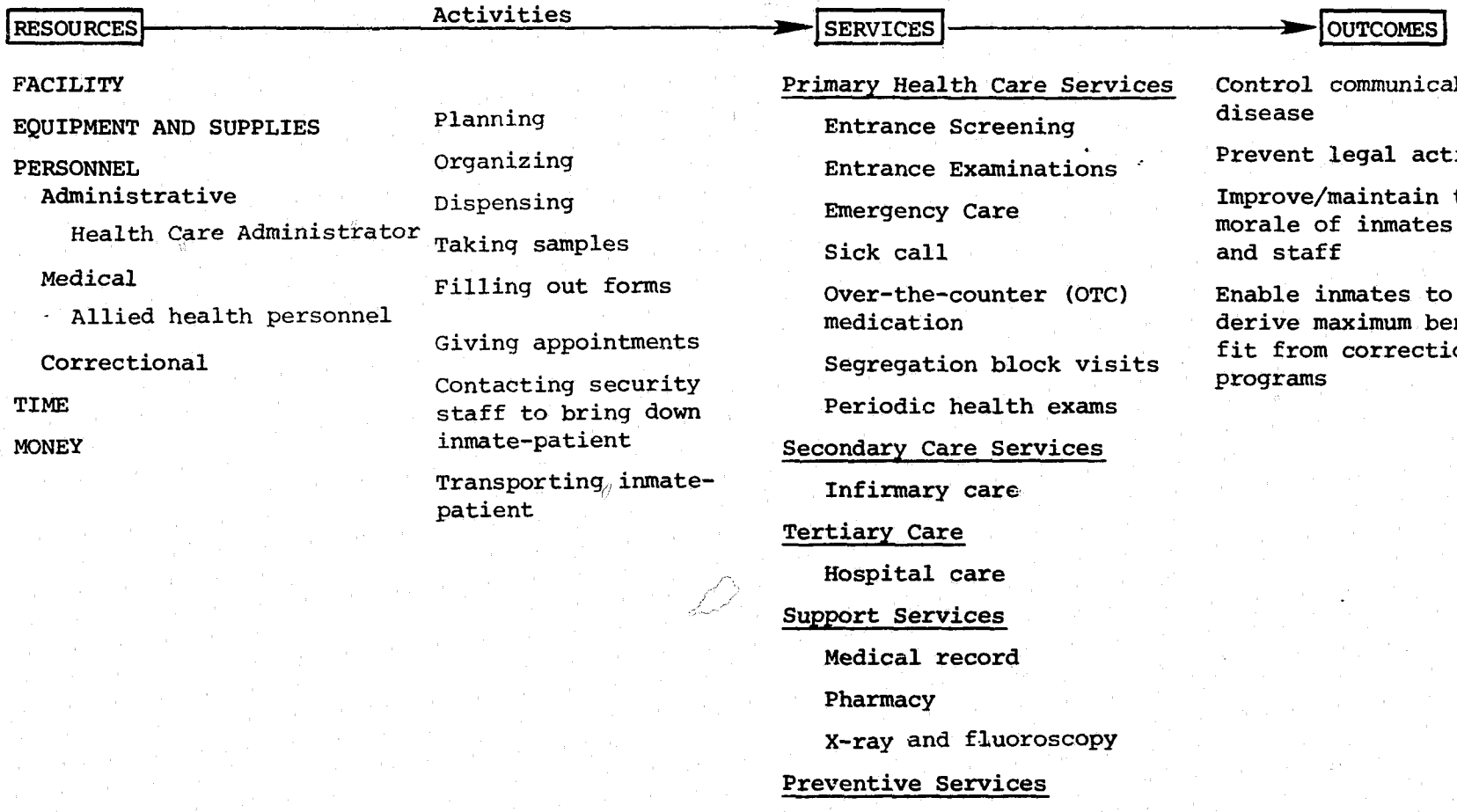
- Give examples of components of a health care delivery program;
- List the steps involved in systematically assessing the implications of standards for health care delivery;
- Given the use of a standard in the delivery of health services, identify the implications for resources (personnel);
- Identify implications of standards on resource needs and the changes in management and/or environmental factors (e.g., correctional and political environments and the community) they will effect in health care delivery.

Rationale

The process of setting and adapting standards for the correctional system or institution and identifying health care service needs are key issues in delivering health care in corrections--issues identified during the needs assessment phase. This session addresses these issues by providing an approach both for analyzing health care delivery and for assessing the available standards and their implications. Other issues which affect the delivery of services will also be discussed during the presentation and group work.

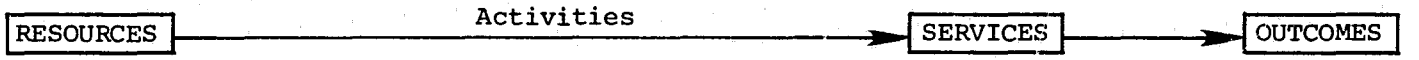

EXTERNAL INFLUENCES
CORRECTIONS
HEALTH CARE MANAGEMENT
RESOURCES
ACTIVITIES
SERVICES
OUTCOMES
HEALTH CARE DELIVERY

CORRECTIONAL HEALTH SERVICES: SYSTEMS FRAMEWORK



SYSTEMS FRAMEWORK EXERCISE

Take any health care program with which you are familiar, either as a provider of care or as a consumer. Starting with RESOURCES, identify the most important RESOURCES, ACTIVITIES, SERVICES, AND OUTCOMES of the program. If you have time, do the same for one other program with which you are familiar.



Program _____

Program _____

STEPS IN USING STANDARDS AND ASSESSING THEIR IMPLICATIONS

1. Check the relevance and consistency of the standard for achieving the outcomes of health care delivery for your institution(s).

2. Identify services covered by the standard; list range of services and identify number of services needed (in specific time period).

   Take into consideration at least the following:

   a. Court and legal requirements
   b. Professional opinion, to refine the range and quality of services
   c. Past experience
   d. Projections for future inmate populations
   e. Other, similar institutions' experience, to identify number of services needed.

3. Identify options available for delivering services and resources which might be used.

   Take into consideration at least the following:

   a. Experience of similar institutions, literature, expert opinions, and personal experience
   b. Any restrictions made in the standard
   c. Relevant legal and other restrictions
   d. All resources available.

   Check feasibility of each option listed.

4. Select the most appropriate option; calculate resources needed.

   Take into consideration at least the following:

   a. Ability of option to deliver the number, type, and timing of services needed
   b. Availability of resources for that option and feasibility of getting them
   c. Cost of option.

Session 4

DAY II

9:00 - 9:45 a.m.

SUPPORT SERVICES NEEDED FOR EFFECTIVE HEALTH CARE DELIVERY

Goals of the Session

At the end of the session, the participants will be able to:

- List at least two support services needed for the effective delivery of health services,
- Identify at least one option for delivery of support services so that appropriate standards are met,
- Identify at least one implication of standards for resources needed in the delivery of support services.

Rationale

To the non-medical staff, support services, such as medical records, laboratory, and pharmacy, may not seem to have particular importance. Yet, all those involved in the delivery of health care in corrections must understand the importance of these services for maintaining a high quality of care. They need to know what the services are, how they are affected by the correctional environment, the effects of inadequate support services, and how the implementation of standards for these services may affect resource needs.

NOTES

NOTES

SYSTEMS FRAMEWORK: APPLICATION TO STANDARD FOR PHARMACY (APHA)

RESOURCES	Activities	SERVICES	OUTCOMES
Pharmacists		OTC medications in commissary (should have specific rules for dispensing)	• To aid in diagnosis, prevention, management of many health problems
Secure storage area			
Physically separate pharmacy			
Health care personnel or Trained non-health care personnel	- - - - - - - - - - - -	Administration of all other (non-OTC) medication	
		Documentation of administration	
Legally authorized health care personnel	- - - - - - - - - - - -	Prescription of medication	

ELEMENTS OF THE PROBLEM-ORIENTED MEDICAL RECORD

1. Data Base
2. Problem List
3. Plan (for treatment)
4. Progress Notes
   - Subjective
   - Objective
   - Assessment
   - Plan

SYSTEMS FRAMEWORK: APPLICATION TO STANDARD FOR MEDICAL RECORD (APHA)

Health record--all inmates

Record should be

- "complete"
- "current"
- "accurate"
- "transferrable" (go with inmate)
- "confidential"
- "one unit"
- "standardized"
- "easily audited"

- Supports continuity of care
- Transfers information on health status from one health care provider to another
- Documents health care encounters and events

Session 5

DAY II

9:45 - 11:00 a.m.

IMPLICATIONS OF USING STANDARDS FOR PERSONNEL AND AVAILABLE OPTIONS

Goals of the Session

At the end of the session, the participants will be able to:

- Identify the implications of implementing a standard on personnel resources;
- Identify at least two options for recruiting and using personnel that will improve health care services.

Rationale

The problems of recruiting and retaining personnel plague most health care administrators and other correctional decisionmakers as well. This Session builds on the analytical framework provided in Session 3 by applying it to a particular case and assessing specifically the implications of using standards on staffing. The case study will be the mechanism not only for applying the framework but also for raising some of the key issues which arise in the area of personnel and related service delivery issues.

CASE STUDY 1

Introduction

You are the members of a multi-disciplinary task force charged by the warden of the Horizon Center Correctional Institution (HCCI) with the task of making recommendations to correct the deficiencies in the health services being delivered to inmates. The institution is under threat of a court order from Judge Hamilton if the health services are not improved.

Current Status of Problem

The Horizon Center Correctional Institution is a state institution for 2,000 male inmates located in the semi-rural county of Riverside. In a preliminary survey of health services, one of the major deficiencies cited was the lack of any physical examinations for incoming inmates. The team conducting the survey noted that this could permit the spread of communicable diseases among the inmates and the staff. The team has recommended that all inmates be examined within 48 hours of entering the institution following the American Public Health Association standards for the examination.

The Assignment

At this meeting of the task force, you are to develop recommendations to present to the warden regarding the staffing for the conduct of entrance examination. (You are to focus on personnel only, not the other resources needed.) The recommendations should include suggestions on:

- How many and what types of personnel
- How the new personnel might be recruited
- Expected cost for staffing.

To develop these recommendations, you should complete the worksheet, using information from the memorandum that follows and your own experience.

HCCI
Horizon Center Correctional Institution

MEMORANDUM

DATE: September 19, 1977

TO: Marcia Tempelhof, R.N., HCCI Health Assessment Task Force Liaison

FROM: Carolyn Lee, R.N.

SUBJECT: Study of resources and options regarding entrance examinations

I am sorry for the delay in submitting this report with the information you requested for the task force. However, it has been more difficult than I anticipated to pull all of the information together.

Incoming Inmates

The monthly data on incoming inmates for July 1976 to June 1977 for HCCI:

	HCCI
July 1976	55
August 1976	60
September 1976	70
October 1976	75
November 1976	70
December 1976	80
January 1977	75
February 1977	75
March 1977	85
April 1977	65
May 1977	60
June 1977	70
TOTAL	840

Average Number Incoming Inmates Per Month = 70

The Director of Records has informed us that in the coming year we will be receiving about the same numbers as last year.

Time Needed To Conduct Exams

After consulting with a number of doctors and clinics, the following seems to be the average amount of time needed to complete the different portions of the examination:

Vital signs (e.g., temperature, blood pressure, and pulse)	5 minutes
History taking	15 minutes
Physical exam (all systems)	20-30 minutes
Lab tests--taking samples analysis	This varies; I could not get a meaningful average; this would not be done in HCCI.
Vision testing	5-10 minutes
Mental health screening	This is done by the Division of Screening and Treatment.
Total time (in-house) per entering inmate	50-75 minutes

Who Should Conduct Exams

Under some circumstances (such as in a private physician's practice) the doctor would do all aspects of the entrance exam. However, the only part of the exam which requires physician's training is the physical exam; other trained medical personnel such as R.N.'s, L.P.N.'s, or physician assistants could take vital signs, draw blood samples, and take the history. This would make the processing of patients more efficient. Even inmates could be trained to do parts of the exam, such as the vision test.

Resources Available

As you know, we now have available for health care delivery the following personnel:

2 physicians, half-time	1 lab technician, half-time
2 R.N.'s, full-time	1 pharmacist, half-time
2 L.P.N.'s, full-time	2 inmates are responsible for janitorial and secretarial duties
1 nurse's aide, full-time	

The full-time work week is 40 hours. Those personnel who are employed part-time at HCCI state that they are giving as much of their time as they can to the institution. All are fully occupied by sick call, follow-up of problem patients, and taking care of the 10-bed infirmary for minor ailments. We are definitely going to need additional personnel if we are to conduct the entrance physicals.

I have done a general assessment of what other medical and health care resources might be available to us. The closest town, Greenhaven, is six miles away and has a population of about 10,000, and the entire county has a population of about 25,000. There are about 15 doctors, three or four practice pediatrics, and three practice obstetrics. There is a small 50-bed hospital, which all the doctors use. There is only one physician "group"--two internists, one pediatrician, one ob-gyn, and one surgeon, all of whom have offices in the same

building and refer to each other. Other medical resources include: the Red Cross, the Grey Ladies and Candy Stripers (volunteers who work at the hospital), the Lions Club (which offers free eye exams), the public health nurse, the school nurse, R.N.'s, L.P.N.'s, and other health care personnel who are not working, and several herbalists and palm-readers who offer cures for various ailments. We can also consider hiring and training people from the community.

In thinking about how we might staff for the delivery of the entrance exams, I reviewed some of the suggested approaches presented in an AMA pamphlet "Models for Health Care Delivery in Jails." I have listed below those which seem applicable for our institution:

Option 1: Contract with a group practice.

Option 2: Contract with the hospital to deliver the services.

Option 3: Hire just enough staff to add this service to those already available.

Option 4: Develop our own health maintenance type of organization or provide comprehensive services not only to our inmates but also, perhaps, to the local community and other correctional institutions.

Option 5: Use a nurse from the county health department (if one is available).

These are just some ideas; we will need to review them and consider others at our next meeting.

Wages and Salaries

I reviewed the typical wages/salaries of medical care personnel in this area:

Physicians	About $35/hour
Physician Assistants	About $8/hour
R.N.'s	About $8/hour
L.P.N.'s	About $5/hour
Nurses' Aides	About $3.50/hour
Lab Technicians	About $5/hour
Inmates	About $2/hour
Correctional Officers	About $6/hour

As you can see, the salaries of the health care personnel at the HCCI are slightly lower than in the community--averaging about a dollar or two difference.

STANDARD FOR THE ENTRANCE EXAMINATION*

The initial evaluation shall take place in an area that is conducive to the encounter. The patient shall be comfortable and clothed in garments suitable for the examination. The initial medical assessment shall include:

1. Measuring of the blood pressure, respiratory rate, temperature, and pulse.

2. Inquiry about:

   a. Headache, recent head injury and loss of consciousness;
   b. Use of prescribed medicines;
   c. Chronic health problems, such as heart disease, hypertension, seizure disorders, asthma, sickle cell disease, diabetes mellitus, and tuberculosis;
   d. Regular use of barbiturates, sedatives, opiates, alcohol, and non-prescribed drugs;
   e. Unusual bleeding or discharge;
   f. Recent fever or chills;
   g. Unusual pains and recent injury;
   h. Allergy to medication and other substances;
   i. Lacerations, bruises, abscesses, ulcers, and itchiness.

3. A visual inspection for signs of trauma, recent surgery, abscesses, open wounds, parenteral drug use, jaundice, pediculosis, and communicable disease.

4. Observation and evaluation of consciousness, awareness of surroundings and events, and appropriateness of personal interactions as well as height and weight and gross body composition.

5. Physical assessment of:

   a. Head-defects, contusions, lacerations, and dried blood;
   b. Ears-gross hearing loss, blood/discharge;
   c. Nose-blood and other discharges, recent injury;
   d. Eyes-bruises, jaundice, gross movements, pupil reactivity;
   e. Chest-labored or unusual breathing, penetrating wounds;
   f. Abdomen-tenderness, signs of blunt injury, surgical scars;
   g. Genitalia-discharge, lesions, lice;
   h. Extremities-sign of drug use, hyperpigmentation of anticubital fossae, abscesses, deformity, "tracks".

---

*Abstracted from Standards for Health Services in Correctional Institutions, American Public Health Association, Washington, D.C., 1976, pp. 3-8.

6. Implantation of tuberculosis skin test where not contra-indicated.**

7. Obtaining urine for the detection of glucose, ketones, blood protein and serum for serology.

The procedures necessary to complete the evaluation shall include:

1. Inquiry about:

   a. Prior significant illnesses and hospitalization;
   b. Familial and domiciliary diseases of significance such as diabetes mellitus, hypertension, tuberculosis, and hepatitis;
   c. Immunization status;
   d. Current symptoms and abnormalities in the nervous, gastro-intestinal, respiratory, auditory, integumentary, endocrine, cardiovascular, ophthalmic, musculosketal, and blood forming systems.

2. Physical inspection and examination of organs and structure of head, neck, chest, abdomen, genitalia, rectum, and extremities with particular emphasis and comment about the presence or absence of abnormalities suggested by the previously obtained history.

3. Mental health screening and evaluation which shall

   a. be conducted by a health worker sensitive to the crisis state in which the new prisoner is liable to be;
   b. include, as a minimum, the following elements of personal history: mental illness, mental health treatment, education, work, social, sexual, family, drug and alcohol use; and assessment of coping mechanisms and ego strengths; and any indication by the prisoner of a desire for help;
   c. be documented in writing in a standardized fashion;
   d. include explanation to the new prisoner of the mental health services available and procedure(s) for application.

4. Collective specimens for hepatitis screening, white blood cell count, hematocrit, and other indicated laboratory tests.

5. Vision testing with Snellen Chart and auditory testing with a reliable standard.

6. Immunization with Td in current needle users.

**Note: The importance of quickly diagnosing and treating venereal diseases and TB cannot be overemphasized. This is not only true for the inmate's protection, but also for the protection of all inmates, the staff, and the outside community.

WORKSHEET FOR USING STANDARDS AND ASSESSING THEIR IMPLICATIONS

1. Check relevance of standards and outcomes.

   Outcomes: To control and limit communicable disease within the institution.

   To identify current inmate health care problems.

   Relevant? - Yes

2. List services needed (or additional services needed) to achieve outcomes. Calculate volume of services (number of services needed in relevant time period, e.g., one examination per inmate per year, or 2,000 examinations).

Type Service	Number	Type Service	Number
Vital signs	840	Vision exams	840
Histories	840	Mental Health Exams	N/A
Physical Exam	840		
Lab tests	840		

3. List possible options for the delivery of service(s) (e.g., use of in-house resources, outside resources, staffing configurations, etc.).

OPTION A		OPTION B	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

OPTION C		OPTION D	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

Assess the feasibility of the options listed; omit those not feasible.

4. Identify most appropriate option and estimate costs.

Which option(s) would be the most effective in delivering the services?
Which option(s) would be the most feasible?
Which option(s) would be the least expensive?
Suggest approaches for the recruitment and retention of new personnel.

WORKSHEET FOR USING STANDARDS AND ASSESSING THEIR IMPLICATIONS

1. Check relevance of standard to outcomes.

   Outcome: _____

   _____

   Relevant? - _____

2. Identify services covered by standard list, range of services, and volume (number of services needed in relevant time period, e.g., one examination per inmate per year, or 2,000 examinations).

Type Service	Number	Type Service	Number

3. List possible options for the delivery of service(s) (e.g., use of in-house resources, outside resources, staffing configurations, etc.).

OPTION A		OPTION B	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

OPTION C		OPTION D	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

Assess the feasibility of the options listed; omit those not feasible.

4. Identify most appropriate option and estimate costs.

Which option(s) would be the most effective in delivering the services?
Which option(s) would be the most feasible?
Which option(s) would be the least expensive?
Suggest approaches for the recruitment and retention of new personnel.

CASE STUDY 2

CASE STUDY: EXCELSIOR COUNTY JAIL

Introduction

You are the members of a multi-disciplinary, community task force charged by the sheriff of Excelsior County, who is the chief law enforcement officer and responsible for operating the Excelsior County Jail (ECJ), with the task of making recommendations to correct the deficiencies in the health services delivered to the jail inmates. The sheriff is under pressure to upgrade the health services from the local medical society and Judge Grady who sits in the county court.

Current Status of the Problem

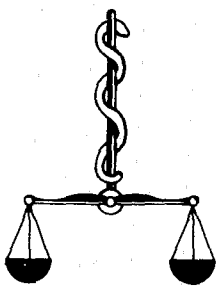
The Excelsior County Jail serves as a lock-up for the small police departments in the county that lack detention facilities. The facility also holds people awaiting trial in Superior Court, which is in session three times a year (May-June, August-September, and October-November); and those sentenced for a year or less. The average total daily census ranges between 70 and 80. In a preliminary survey of the health services and facility, the team noted that communicable diseases could be spread among the inmates and staff due to the lack of admissions screening, daily sick call, and procedures to respond to emergencies or illnesses which occur on weekends or non-sick call hours. The team has recommended that the jail provide these services, following the guidelines provided in LEAA's Prescriptive Package on correctional health care and the American Public Health Association report.

The Assignment

At this meeting of the task force, you are to develop recommendations to present to the sheriff regarding the staffing for the conduct of admissions screening, sick call, and 24-hour emergency coverage. (You are to focus on personnel only, not the other resources needed.) The recommendations should include suggestions on:

- How many and what types of personnel
- How the new personnel might be recruited
- Expected cost for staffing

To develop these recommendations, you should complete the worksheet, using the information collected and presented in the memorandum that follows and from your own experience in corrections and health services delivery.



Excelsior County Jail

MEMORANDUM

TO: John Prentiss, M.D. Task Force Liaison DATE: September 19, 1977

FROM: Bob Richardson, Methodist Deacon, Task Force Member

SUBJECT: Study of resources and options regarding staffing for health services for ECJ.

I am sorry for the delay in submitting this report with the information you requested for the task force. It has been a bit more difficult than I anticipated to pull all of the information together.

Inmate Numbers

The number of persons entering the jail is an approximation because people are sometimes brought in who spend such a short time that their incarceration is not recorded. The numbers below, therefore, include those who have probably spent a minimum of three hours in the jail. As you can see, I have separated out those who spend over a day from those who spend less than a day. I would think that this would make some difference for your determinations regarding health care services.

	July 1976	August 1976	Sept. 1976	Oct. 1976	Nov. 1976
less than 1 day	3	5	2	7	3
1 day or more (average 7 mos.)	81	74	66	94	61

	Dec. 1976	Jan. 1977	Feb. 1977	March 1977	April 1977
less than 1 day	4	9	12	5	4
1 day or more	49	53	63	56	92

	May 1977	June 1977	Totals	Average number per month
less than 1 day	8	2	64	5
1 day or more	98	89	876	73

There is no reason to suspect that the figures will change much in the coming year; they may go up a little, but not much.

Time Needed for Services (Screening, Sick Call, Emergencies)

As you suggested, I consulted a number of physicians to get an estimate of how long the screening would take. The following is an average of the times given:

Brief history: 3-5 minutes

Vital signs (temperature, BP, pulse): 3-5 minutes

Review of systems: 5 minutes

Total time per inmate: 11-15 minutes

For sick call, the same times would be needed per inmate.

Expected Numbers for Sick Call

You have collected data on incoming inmates from Jack Woods, and they would be those receiving screening. I checked with the jail in Carrolton and the medical staff say that approximately 10 percent of the inmates show up for sick call every day. Therefore, we can probably expect about seven or eight per day.

Resources Available

As you know, the medical resources currently available in the jail are rather limited. They have one physician who comes in twice a week for two hours to conduct sick call. He is also on-call for all medical emergencies, but he has an active practice on the outside, so sometimes another physician has to be called, or the hospital used for emergencies. The part-time physician also maintains the records, provides referrals for specialty care, and conducts immunization clinics.

The other jail employees include:

Sheriff

Deputy master

Shift supervisor

3 senior officers

Part-time director of education and treatment

Supervisor of work release

13 correctional line officers

The correctional staff maintain the sick call log and dispense all prescribed medication. They also provide all transportation and security at the hospital. While the community of Supreme, a town of 18,000, does not have a wealth of medical resources, there are the following:

Excelsior Medical Center--county hospital

Hawthorne Hospital--private

25 physicians covering all specialties

Civic groups, such as the Lions Club which offers free services, eye clinics, and the Red Cross

School nurse and two public health nurses.

There are also a number of trained nurses, R.N.'s and L.P.N.'s, and former medical technicians (U.S. Army) who are now living here but not working, at least not in their professions.

Options for Staffing

In order to provide screening, daily sick call, and improved emergency coverage we will need either to get new personnel or train others on the staff to conduct the screening. I have pulled the following suggestions for approaches to staffing from the AMA pamphlet "Models for Health Care Delivery in Jails." We will need to review them and adapt them or come up with our own at our next meeting.

Option 1. Jail A, a small facility, meets the medical care needs of the inmates by providing for access between the inmates and their personal physicians at the inmates' expense. Indigent inmates and those without a personal physician are being taken care of by contractual arrangement with a local community hospital. The care is rendered in the physicians' private offices or the local health agencies (hospital, laboratories, etc.). The jailers, through training from the physicians, are able to "screen" all incoming prisoners and provide a medical "triage" on all requests to see a doctor. (Triage means the sorting out and classifying of illnesses to determine priority of need and proper place of treatment.)

Option 2. Jail B contracts with a local physician to act as the medical officer. His duties include arranging for the provision of all medical care rendered within and without the institution and all dental care as needed. Basic primary care is delivered at the institution while all other care is usually delivered at a local hospital where the jail medical officer is on the staff.

Option 3. Jail C has contracted with a group practice, or public or private clinic, to provide 24-hour, seven-day-a-week emergency and acute medical services. The contract includes receiving screening, health data collection, and physical examination of every newly admitted inmate within 24 hours of arrival at the jail. The contract also provides that in-hospital or special services will be arranged by the contracted group or clinic when these services are needed.

Salaries

The average, current hourly rates for this area for the types of people discussed above are:

Physician	$25/hour
Physician Assistants	$8/hour
R.N.	$8/hour
L.P.N.	$5/hour
Medical Technician	$5/hour
Correctional Officer	$6/hour
Inmate	$2/hour

STANDARD FOR PERFORMANCE*

The Preliminary Screening for Admission

For his own protection, for the protection of other inmates, and for the protection of the correctional institution, a preliminary health evaluation should be made immediately upon the arrival of a new inmate--before he is permitted to enter the inmate population. As many as possible of the following points should be checked:

- Does the new arrival report pain, bleeding, or any other symptoms suggesting need for emergency service? Are there any visible signs of trauma or illness requiring immediate care?
- Does the new arrival have a fever, a sore throat, swollen glands, jaundice, or other evidence of an infection which might spread through the institution?
- Does his general appearance suggest the likelihood of head lice, body lice, pubic lice, or other parasites?
- Does he appear to be under the influence of alcohol, barbiturates, heroin, or any other drug? Is he exhibiting withdrawal signs, or at risk of developing them?
- Is he so excited or elated, so depressed and withdrawn, or so disoriented as to suggest the possibility of suicide or assault on others?
- Is he carrying medication, or does he report being on any medication which should be continuously administered or available--medication for arthritis, asthma, diabetes, seizure disorders, gastric or duodenal ulcer, heart disease, high blood pressure, psychiatric problems, etc.?
- Is he on a special diet for any of the above (or other) conditions?
- Has he recently been hospitalized or seen a physician for any illness?
- Is he allergic to any medications or other substances?
- Does he have an unusual, recently acquired headache?
- Has he fainted lately or has he had any recent head injury?

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*Brecher, Edward M. and Della Penna, Richard D., Prescriptive Package: Health Care in Correctional Institutions, National Institute of Law Enforcement and Criminal Justice, Washington, D.C., 1975, pp. 8-9.

A medical record folder should be prepared for each inmate on admission, and the pertinent findings of the screening examination, both positive and negative, should be the first entries in his permanent medical record.

The urgency of the preliminary screening varies from institution to institution and from inmate to inmate. It is most important in local detention facilities (jails) which receive most of their inmates directly off the street--and it is precisely in such institutions that screening on admission is most difficult and most likely to be neglected.

One purpose of the screening on admission is to identify very ill persons who should not be admitted at all but should be transferred at once to a hospital, mental hospital, or other facility. In some cases, the police officer, marshal, or deputy sheriff who brings the person to the institution may be instructed to take him instead to the other appropriate facility. If this is not possible, the correctional institution itself must promptly make the transfer instead of admitting the new arrival to the inmate population.

If the new arrival is moderately ill on admission, or if he is intoxicated, he should be sent to the institutions's infirmary rather than the general population. If he is in need of continuing medication, his medication should be taken from him but arrangements must be promptly made for dispensing appropriate doses through the institution's regular dispensing procedures. The purpose of the screening on admission, in short, is not merely to make a paper record but to see that the immediate health care needs uncovered in the course of the screening are promptly met. A substantial body of litigation arises out of failure to identify and promptly care for medical needs present at the time of admission.

The preliminary screening on admission need not be performed by a physician. Indeed, one of the major distinctions between horse-and-buggy medicine and the modern practice of medicine is the use of physician's assistants, nurse-practitioners, medical technical assistants (MTAs) and other "physical extenders" to perform duties which the physician does not have time for and which would otherwise not be performed at all--thus leaving the physician free for duties consonant with his level of skills and training.

The screening should always be performed by a member of the health care (not correctional) staff.

STANDARDS FOR PERFORMANCE*

1. REGULAR AMBULATORY CARE SERVICES (SICK CALL)

Principle: Every correctional institution should make provision for those persons treated on an ambulatory basis who have special health requirements such as limitations of activity. The disability due to illness generally occurs at a low threshold because of the highly structured and impersonal nature of institutional settings. Thus, there are many health problems which can be exacerbated by activity that is either too limited or too strenuous. Therefore, in making housing, duty or any activity assignments, on either a temporary or permanent basis, allowance for special health requirements should be made.

Public Health Rationale: The myriad health problems (some with and some without organic base) which arise must be evaluated and accurately treated as soon as they arise in order to prevent the unhappy sequelae from untended disease.

Satisfactory Compliance:

1. Each correctional institution shall demonstrate:
   a. That a regular ambulatory care schedule is provided;
   b. That a qualified provider of medical care or providers of medical care are in the institution during the scheduled period, and are providing medical services;
   c. That there exists a mechanism whereby inmates can seek health services directly without explicit or implicit obstruction. Health officials shall develop a means whereby inmates may continue to have full access to treatment even when the inmate is not in the general population for whatever reason.

2. The frequency and duration of ambulatory care services shall be determined by the size of the institution, and the particular health requirements of the population.

2. EMERGENCY SERVICES

Satisfactory Compliance:

1. Each correctional institution shall have a written plan for emergency procedures. The plan shall include the range of services available within the institution and shall be integrated with existing regional emergency medical care resources.

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*Standards for Health Services in Correctional Institutions, American Public Health Association, Washington, D.C., 1976, pp. 9-10 and 12-13.

2. All health staff persons shall be well trained in the provision of first aid and emergency care measures and cardiopulmonary resuscitation. In institutions where health staff is not available twenty-four hours a day, there shall always be on duty at least one correctional officer who has completed the equivalent to the primary American Red Cross First Aid course.

3. Emergency equipment and supplies consistent with the written emergency procedure and commensurate with the service capability of the institution shall be available and readily accessible. First aid supplies shall be located in all areas such as the kitchen and work areas where accidents are likely to occur.

4. Medical criteria alone shall dictate whether or not an inmate shall be transferred out of the facility to a civilian health center for emergency care. Security requirements shall not unreasonably delay the arrival or departure of emergency vehicles used in transfers.

5. Each institution shall include in its emergency procedures specific guidelines for transfer and provision for medical care in the event of fire, riot, or disaster.

WORKSHEET FOR USING STANDARDS AND ASSESSING THEIR IMPLICATIONS

1. Check relevance of the standard to the outcome.

Outcome: To control and limit communicable diseases within the institution--to prevent unnecessary illness among the staff and inmates

Relevant? - Yes

2. Identify services covered using the standard list and identifying the range of services and volume (number of services needed in relevant time period, e.g., one examination per inmate per year, or 2,000 examinations).

Type Service	Number	Type Service	Number
Screening Brief history	73/month	Emergency	?
Vital signs	73		
Review of systems-physical	73		
Sick Call	7-8/day		

3. List options for the delivery of service(s) (e.g., use of in-house resources, outside resources, staffing configurations, etc.).

OPTION A		OPTION B	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

OPTION C		OPTION D	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

Assess the feasibility of the options listed; omit those not feasible.

4. Identify the most appropriate option and estimate its costs.

   Which option(s) would be the most effective in delivering the services?
   Which option(s) would be the most feasible?
   Which option(s) would be the least expensive?
   Suggest approaches for the recruitment and retention of new personnel.

WORKSHEET FOR USING STANDARDS AND ASSESSING THEIR IMPLICATIONS

1. Check relevance of standard to outcomes.

Outcome: _____

_____

Relevant?- _____

_____

2. Identify services covered using the standard list and identifying the range of services and volume (number of services needed in relevant time period, e.g., one examination per inmate per year, or 2,000 examinations).

Type Service	Number	Type Service	Number

3. List possible options for the delivery of service(s) (e.g., use of in-house resources, outside resources, staffing configurations, etc.).

OPTION A		OPTION B	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

OPTION C		OPTION D	
Staff Person	Services to be Provided	Staff Person	Services to be Provided

Assess the feasibility of the options listed; omit those not feasible.

4. Identify the most appropriate option and estimate its costs.

Which option(s) would be the most effective in delivering the services?
Which option(s) would be the most feasible?
Which option(s) would be the least expensive?
Suggest approaches for the recruitment and retention of new personnel.

Session 6

DAY II

11:00 a.m. - 12:15 p.m.

MANAGEMENT OF HEALTH CARE DELIVERY OF CORRECTIONS

Goals of the Session

At the end of the session, the participants will be able to:

- Identify two or three of the types of decisions that need to be made in managing the implementation of health care standards in corrections;
- Identify the knowledge and skills and the actors who are needed to make appropriate management decisions regarding correctional health care standards;
- Identify the roles, responsibilities, and the appropriate communication networks needed to ensure that decisions are made effectively, particularly those decisions identified above;
- Identify at least one change that they would make in the management decisionmaking process for health care services in their institution or system. (Optional)

Rationale

Experts and practitioners have expressed concern about the management of health care in corrections and particularly the implementation of standards. They have asked how they can ensure that the most effective decisions regarding standards are made given the frequently competing interests in the correctional environment. All decisionmakers who affect health care delivery in corrections, not just the health administrators, need to have a common understanding of how to analyze the decisionmaking function of management, what organizational structures and processes can be developed to facilitate effective decisionmaking, and the attendant costs and problems. Other issues which affect the management of health services in corrections will also be discussed during the exercises and group work.

EXTERNAL INFLUENCES
CORRECTIONS
HEALTH CARE MANAGEMENT
RESOURCES
ACTIVITIES
SERVICES
OUTCOMES
HEALTH CARE DELIVERY

HEALTH CARE DECISIONMAKING ASSESSMENT SHEET

Instructions: Identify the important decisions that must be made in managing health care services delivery in an institution(s) or system. Write these across the top of the matrix below. In the left-hand column, list the actors, or the knowledge, or skills that are available or needed to make those decisions. Then identify the roles of each actor in the decisionmaking process by writing the appropriate letter(s) in the boxes of the matrix. Roles include the following:

A - Input: giving and sharing information and advice

B - Review: Critiquing ideas and programs

C - Approval: giving permission and regulating

D - Implementation: carrying out plans and other decisions.

	Decisions				
Actors (knowledge, skills), e.g., correctional officers, health care staff, inmates, outside agencies, etc.	Selecting standards for services	Identifying procedures for delivery of services	Identifying problems with services	Developing solutions to problems	Assigning responsibilities to staff
Health Care Administrator	A, C, D	A, B, C, D	A, C	A, B, C, D	A, B, C, D
Physician	A, C, D	A, B, C, D	A, C	A, C, D	C
Nursing Staff	A, D	A, D	A, D	A	A, D
Medical Society	A	A	B	A	---
Correctional Officers	---	A	A	A	A, D
Corrections Administration	A	B	A, C	A, B	A, B, C
Inmates	A	A	A	A	---

HEALTH CARE DECISIONMAKING ASSESSMENT SHEET

Instructions: Identify the important decisions that must be made in managing health care services delivery in an institution(s) or system. Write these across the top of the matrix below. In the left-hand column, list the actors, or the knowledge, or skills that are available or needed to make those decisions. Then identify the roles of each actor in the decisionmaking process by writing the appropriate letter(s) in the boxes of the matrix. Roles include the following:

A - Input: giving and sharing information and advice

B - Review: critiquing ideas and programs

C - Approval: giving permission and regulating

D - Implementation: carrying out plans and other decisions.

	Decisions						
Actors, (knowledge, skills), e.g., correctional officers, health care staff, inmates, outside agencies, etc.							

Session 7

DAY II

1:15 - 2:30 p.m.

REVIEW OF THE HEALTH CARE DELIVERY SYSTEM: SERVICE DELIVERY AND MANAGEMENT CHANGES BEING MADE, OPTIONS TO CONSIDER

Goals of the Session

At the end of the session, the participants will be able to identify at least one more option that might be applicable to their own health care system.

Rationale

Before correctional health care delivery can be changed or standards implemented, those who will implement those changes need to know what options are available--what has been tried, how problems can be addressed, and so on. Many people expressed interest in learning about alternatives during our planning sessions and needs assessment interviews. Changes are being tried; including changes in recordkeeping, facilities, use of resources, and more. A film highlights some of these alternatives. Following the film, alternatives can be discussed with an expert who has attempted to implement some of these changes.

CONTINUED

1 OF 2

For your information, a list of the names and addresses of people who assisted in making the film, Options in Health Care Delivery, has been provided:

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Correctional Health Assistant
Polk Youth Center
Melvin Lefler
Correctional Health Assistant
Polk Youth Center

Session 8

DAY II

2:45 - 5:15 p.m.

IMPLEMENTING CHANGE IN THE CORRECTIONAL INSTITUTION

Goals of the Session

At the end of the session, participants will be able to:

- Relate needed changes discussed in the previous Workshop session to change strategies and techniques presented in this session;
- Identify at least three of the possible obstacles (or resistances) to change exhibited by correctional staff and management;
- Identify at least three possible techniques for lowering resistance to change;
- Identify at least one approach for getting change accepted by correctional staff and management, and feel comfortable about using it.

Rationale

Respondents to the needs assessment questionnaire and other experts said that, in many cases, they know what the implications of standards are and what has to be changed, but the problem lies in how to implement changes in the correctional setting. Decisionmakers who will be involved in the implementation of changes for correctional health services need to know about theories of change, characteristics of successfully implemented changes, and how theories can be applied. During this session we will present some practical guidelines and provide opportunities to practice applying them. Follow-up discussions will then look at other issues that affect the implementation of change in the correctional setting.

EXTERNAL INFLUENCES
CORRECTIONS
HEALTH CARE MANAGEMENT
RESOURCES
ACTIVITIES
SERVICES
OUTCOMES
HEALTH CARE DELIVERY

POSSIBLE CONDITIONS NEEDING CHANGE

1. Institutional responses to new norms--social, legal, professional
2. Organizational structure or roles
3. Intergroup collaboration
4. Communication
5. Planning
6. Staff motivation
7. Response to a new physical environment
8. Other

CHANGES ARE MOST LIKELY TO BE RESISTED

WHEN THEY AFFECT US PERSONALLY

Communication Patterns

How medical staff and inmates relate

How correctional staff and medical staff relate

The Way Work Is Done

Roles and responsibilities

Procedures

Rules of the game

ORGANIZATIONAL CULTURE

Group norms--changing the way the system operates from closed to open

CHARACTERISTICS OF SUCCESSFUL CHANGE STRATEGIES

1. Comprehensive, planned program (difficult for public agencies)
2. Managers feel the need for change and are committed to the change
3. Relationship to the organization's mission
4. Long-term effort (difficult for public agencies)
5. Focus on changing attitudes, behavior, and performance
6. Stress on groups rather than individuals
7. Proper diagnosis of situation needing change
8. Structural change as required
9. Other

STEPS IN PLANNING CHANGE

Step 1: Identify what the change is and why you want to make it.

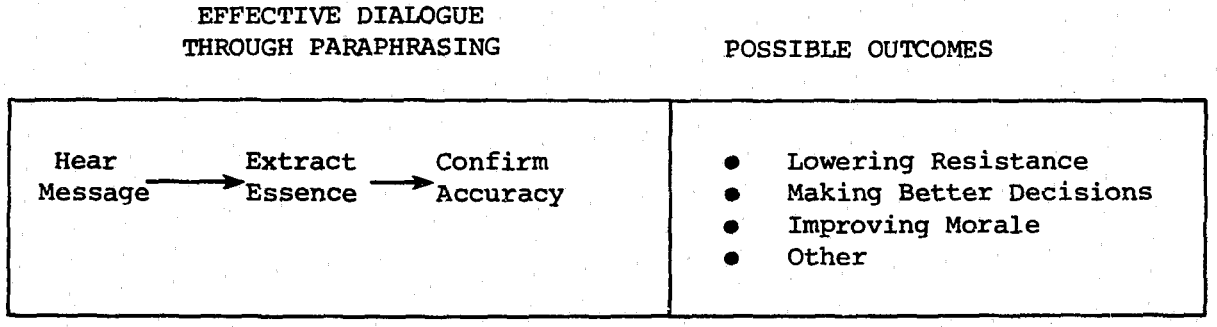
Step 2: Identify resistance to the change, if any. (Don't expect resistance--expectation could be self-fulfilling.)

Step 3: Develop plan to overcome resistances.

TACTICS IN IMPLEMENTING CHANGE

1. Present your case using understandable terms the staff can relate to.
2. Get the top managers committed to the change program.
3. Make everyone aware of the problems and the need for change.
4. Use groups to help make decision about implementation.
5. Make the changes tentative (helps unfreeze attitudes and lets staff test their own reactions).
6. Provide in-service training to staff if necessary.
7. Other.

PARAPHRASING



POSSIBLE TOPICS AND SUGGESTED ARGUMENTS FOR EFFECTIVE LISTENING

1. The use of furloughs in responding to inmate health needs.

Pros:	Cons:
Provide physical and mental change from institutional life.	May contract venereal or other contagious diseases.
Release sexual tensions.	May bring narcotics or other drugs into institution.
Re-establish marital relationships.	Could cause marital problems.
Facilitate community reintegration.	Might fail to return.
Establish employment for release.	Become frustrated from lack of job opportunities.
Complete a successful furlough.	Commit a crime while on furlough.

2. Prison is detrimental to both the physical and mental health of inmates; therefore, they should receive even better health care than the population at large.

Pros:	Cons:
Reduce contagious diseases.	Cost of providing medical treatment.
Reduce staff and inmate exposure to inmates who show psychotic symptoms.	Requires additional segregation unit and more staff.
Lower possibility of infection and contagious diseases spreading to community.	Need sufficient personnel to provide adequate care.
Create a humanitarian environment in the institution.	Coddle inmates when they should be punished; undermine correctional authority.
Make a smoother-running facility.	Inmates become institutionalized.

POSSIBLE TOPICS AND SUGGESTED ARGUMENTS FOR EFFECTIVE LISTENING

3. Inmates assigned to solitary or segregated units need daily medical visits.

Pros:

- Administration apprised daily of physical and mental condition of inmates.
- Comply with laws and court decisions, reducing possibility of litigation.
- Give administrator and supervisors feedback on treatment given inmates by line staff.
- Allow medical staff to make recommendations in reference to inmate's health.

Cons:

- Reduce punishment effect.
- Allow inmates a chance to abuse correctional and medical staff.
- Correctional staff feel that they are not trusted and are constantly monitored.
- Gives inmates opportunity to con their way back to population by feigning mental anguish or physical problems.

4. Inmates should have the right to consult with a private physician in order to monitor those who deliver health in a correctional setting.

Pros:

- Would allow for a second opinion to community people.
- In some situations, would provide an indicator about the adequacy or inadequacy of health care.
- Could improve credibility of medical staff with inmates.
- Provide community interaction with correctional health staff.

Cons:

- Corrections would have to pay additional costs.
- Would provide threatening atmosphere for health care staff.
- Inmate would use private consultation to relieve boredom and for opportunity to escape in some cases.
- Consultations would not be cost-effective.

5. Inmates should have an opportunity to have input into health care procedures.

Pros:	Cons:
Involve inmate population in health care (ownership).	Allow inmates to manipulate procedures.
Improve delivery of services.	Alienate correctional staff.
Insure population needs are being met.	Restrict the quality of health care.

6. Correctional staff should be consulted about health delivery within the correctional system.

Pros:	Cons:
Positive relationship between medical staff and correctional staff.	Reduce inmate's trust in using the system.
Improve accessibility to inmates.	Correctional administration would control medical department.
Provide orientation for correctional staff.	

Case Study I

ACCESS TO MEDICAL CARE

An inmate in the Canterbury Prison told a correctional officer on Friday evening that he had the flu; he asked to see the doctor. With the pressure of other duties, the correctional officer neglected to record the request in the log. The doctor did not come in to the prison until Monday morning, when he was to conduct sick call. At that time the doctor saw the inmate, who had a very high fever, and was delirious. The doctor sent the inmate to the hospital. Following his recovery, the inmate filed a grievance and threatened a law suit for what he felt was the indifference to his physical condition shown by the correctional staff.

Analyze this case following three steps:

Step 1: What needs to be changed and why should a change be made?

Step 2: Identify whether and where resistance to change might exist.

Step 3: What action would you take and what tactics would you employ to overcome resistance?

Case Study II

A STUDY IN CONTINUITY

An inmate sentenced to 18 months in the Spencer County Jail was identified by the jail physician as having hemophilia (an hereditary condition which causes profuse bleeding). Special treatment was required for the inmate and preventive measures were implemented to prevent any possibility of injury. Later, after an investigation, the inmate was found to be a co-conspirator with four other inmates in a contraband ring operating in the institution. He was subsequently transferred to another facility at the other end of the state. Upon admission there, the inmate was medically screened and nothing was said about his condition. Two days later, he got into a fight and, as a result of an injury to his nose, hemorrhaged severely. He was rushed to the hospital and placed in intensive care.

The inmate's family subsequently threatened to sue on the basis of inhuman indifference. The second institution claimed that the inmate did not alert them about his condition. They stated further that the inmate's record file was not received until two days after his transfer from Spencer County Jail. Spencer County Jail authorities stated that when a group of inmates are transferred on short notice to break them up, it usually takes three to four days to compile records and other information on them from the various departments involved and forward the material to the next institution.

Analyze this case following three steps:

Step 1: What needs to be changed and why should a change be made?

Step 2: Identify whether and where resistance to change might exist.

Step 3: What action would you take and what tactics would you employ to overcome resistance?

GROUP DECISIONMAKING OBSERVATION FORM

1. Is there a clear leader? _____

2. How is he or she trying to influence the decision? _____

3. Did the group decide on a process for decisionmaking? _____

4. Who was most influential in keeping the group focused on a task? How?

5. Did the group try to hear everyone's opinions? _____

6. Did they succeed? _____

Session 9

Day III

9:00 - 11:30 a.m.

IMPACTING ON EXTERNAL INFLUENCES

Goals of the Session

At the end of the session, the participants will be able to:

- Identify at least three of the steps in a series of steps that need to be completed (i.e., questions that need to be answered) before presenting a case to a community or political group;
- Develop a strategy for presenting the case for simulated hearing;
- Identify similarities and differences in presenting the case in a simulated situation and in front of other public policy agencies;
- Identify at least three public policy agencies (e.g., legislature, governor's office, federal agency) that may affect correctional health care and that may be persuaded to support improvements for correctional health care.

Rationale

Many of the changes needed to improve correctional health care will require access to additional resources--more money, personnel, better facilities. Some changes will require legal and other actions involving agencies and institutions outside the correctional system. External agencies will have to become involved in enforcement if standards are to have "teeth." Gaining access to these institutions and influencing their decisions so that they are more responsive to the problems of health care delivery in corrections is a need identified by many practitioners and experts in the field. Affecting external institutions involves considerations similar to those applicable to implementing change within the correctional setting. However, all decisionmakers should be aware of some critical differences. These needs are addressed in this session by providing opportunities for practice in and discussion about approaching external institutions.

EXTERNAL INFLUENCES
CORRECTIONS
HEALTH CARE MANAGEMENT
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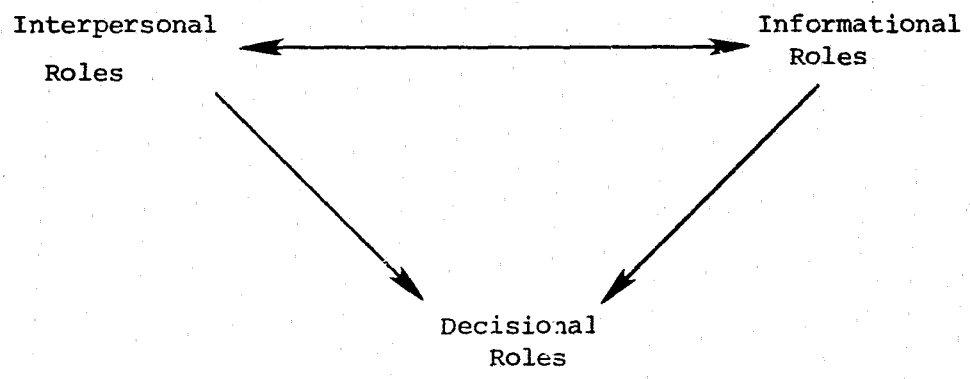
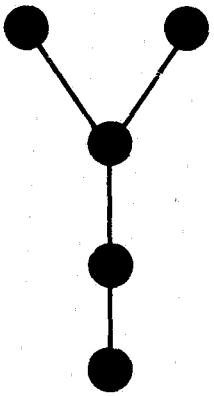
ROLES OF MANAGEMENT

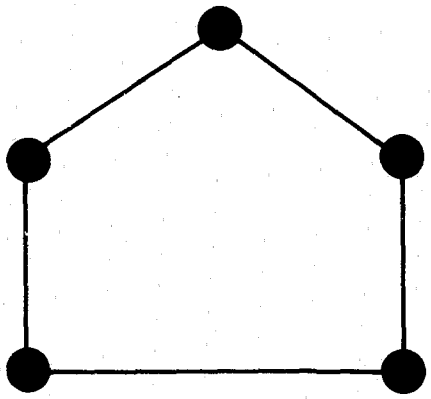


COMMUNICATIONS NETWORK CHART

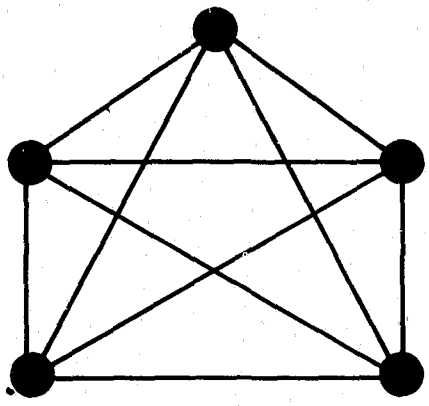
CHAIN



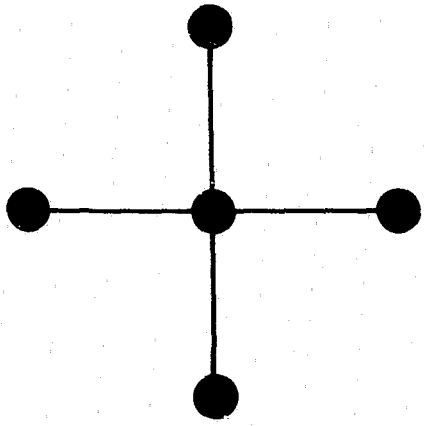
"Y"



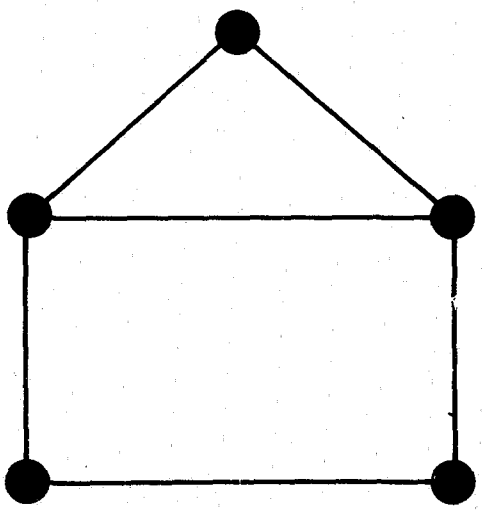
CIRCLE



ALL CHANNEL



WHEEL



SQUARE WITH TRIANGLE

INFLUENCING ATTITUDES AND CHANGING BEHAVIOR

The approach to the process of persuasion outlined here and in the accompanying charts, is following: Decide who is to present the case, how it will be presented, and to what audience it will be presented.[1]

A. To decide who will present the material, consider:

1. The credibility of the communicator (i.e., expertise, trustworthiness, etc.);

2. The ability of the communicator to express some views that are held by the audience in addition to his or her own; and,

3. The charisma of the communicator as the audience perceives it. (The audience's acceptance of the message is frequently influenced by the reaction to the communicator.)

B. How to present the issues is the second factor to address. In addition to the facts and documented needs, the following approaches should be considered:

1. Present one side of the argument if:

   a. The audience is generally friendly,
   b. Yours is the only position that will be presented, or
   c. You want an immediate, but temporary, change in opinion.

2. Present both sides of the argument if:

   a. The audience starts disagreeing with you, or
   b. The audience will hear the other side from someone else. (If both sides are presented, the one presented last will probably be the more effective of the two in swaying opinion.)

3. State your conclusions explicitly, rather than allowing the audience to draw their own. Then the opinion change is most likely to go in the direction you want.

4. Gear the approach to the audience, using varying techniques, such as emotional appeal, factual presentation, and so forth.

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[1] Adapted from Zimbardo, Philip G., and Ebbesen, Ebbe B., Influencing Attitudes and Changing Behavior. Addison-Wesley: Reading, Mass., 1969.

C. Know your audience as individuals, and consider the following:

1. In order to influence attitude change successfully, it is important to understand the underlying reasons for certain attitudes as well as the attitudes themselves.

2. Individuals are influenced by their group membership or affiliation.

3. Individual traits affect susceptibility to persuasion. Individuals whose opinions or attitudes are easily changed will be equally influenced by a counter-communication.

D. Know your audience as a group, and consider the following:

1. The group members are likely to respond in accordance to the nature, purpose, or tenet of the group.

2. A person is rewarded for conforming to the standards of the group and is punished for deviating from them.

3. A person who is most attached to a group is probably most difficult to influence by communication that is in conflict with group norms.

4. Overtness or covertness of certain individuals within a group influences willingness to change opinions held privately.

5. Presence or absence of audience participation influences the outcome. (Group participation helps overcome resistance.)

6. Presence of dissent from even one other person weakens the majority opinion.

7. Intensity and consistency of dissent (even by a minority of two) influence direction.

INFLUENCING ATTITUDES AND CHANGING BEHAVIOR

A. Determine who will present the information based on:

1. Credibility,
2. Ability to articulate audience views as well as personal views,
3. Audience perception of presentor.

B. How to present the issues:

1. Document all facts.

2. If audience is friendly, present your argument.

3. If audience is mixed, discuss both sides of the argument, giving your side last.

4. State conclusions explicitly.

5. Depending on audience, make presentation either emotional or factual.

C. Knowing your audience: <u>individual</u> successful persuasion takes into account:

1. Reasons underlying attitudes as well as the attitudes themselves,
2. Influence of group memberships,
3. Personality traits,
4. Susceptibility to influence.

D. Knowing your audience: group decisions are influenced by:

1. Nature, purpose, or tenets of group,
2. How the group maintains conformity,
3. Strength of group's attachment to norms,
4. Overtness or covertness of individual opinions within group,
5. Presence or absence of group interaction (resistance),
6. Presence of dissent even if only from one person,
7. Intensity and consistence of dissent, even by a minority of two.

M E M O R A N D U M

TO: Warden J. F. McFee

FROM: Chairperson Clay, Budget Committee, State Legislature

SUBJ: Budget Hearing

This is to notify you that on January 7, the committee will be sending to your institution our legislative liaisons to discuss with you and your staff the increased health care budget which we have received from your institution. Although this may seem highly irregular to you, it is necessary because your institution has requested an increase far greater than any other in our system. Consequently, I, and the rest of the committee members, feel that it is necessary to investigate the matter in greater depth before acting on your request.

The liaisons will be responsible for making recommendations to our committee about whether the increase is justifiable and whether it is to be granted in full or in part for this coming fiscal year. The committee will, among other things, look to see if you have explored other means of funding and organized your health care services to minimize costs.

If you have any questions, please contact me before December 20, for I will be out of town after that, until January 3.

Fact Sheet

HEALTH CARE BUDGET REQUEST FOR CORRECTIONAL CENTER

Background

The Correctional Center is a 2,600 man, maximum security correctional institution located in the most rural portion of the state. The population at the Center has increased by 800 over the last nine months. It is also the reception and classification center for the northern half of the state and, as such, processes an average of 3,000 men per year for assignments to other institutions.

Health Care

The medical unit, in the past, has functioned more or less as a dispensary. The institution is now under court order to improve all services for inmates at the institution, including health care services. The court order requires increased amounts of on-site coverage by health care professionals, the distribution of all medication by licensed personnel, and 24-hour nursing services.

In addition to the court order, one of the community hospitals was forced to close this last year as a result of reduced occupancy. There are only eight physicians within a 25-mile radius of the Center. Thus, the institution is attempting to increase its inpatient capability to provide more of the acute care previously provided by the community hospital.

Budget Summary

The proposed budget for FY '78 is outlined below and is compared with that of FY '77:

	(in thousands of dollars)	
	FY '77	FY '78
Personnel	506.6	890.6
Contractual services	132.8	400.0
Commodities	54.0	70.0
Equipment	6.0	114.0
Telecommunications	2.4	3.1
Totals	701.8	1,477.7

Comments on the FY '77 Budget

The budget for last year included funding (under personnel) for the following positions:

2	Physicians
2	Dentists
1	Administrator
1	Pharmacist
1	Lab Technician
1	X-ray Technician
1	Director of Nursing
2	R.N.'s
18	Medical Technical Assistants
2	Secretaries
31	Total

As noted earlier, the health care unit was able to function primarily as a dispensary. Even for these services, there has been heavy dependence on inmates to assist in delivery of them.

Comments on FY '78 Budget Increases

With the requested budget increases, the Correctional Center will add the following positions:

1	Physician
1	Dentist
3	Physician Assistants
3	Dental Aides
1	Dental Hygienist
1	Pharmacist
5	R.N.'s
1	Medical Records Administrator
6	Records and Clerical Staff
1	Physical Therapist
23	Total

The increased equipment allocation will enable the Center to purchase the following:

5 Dental Operatories @ $10,000	$ 50,000
1 Image Intensifier @ $30,000	30,000
1 Set of Physical Therapy Equipment @ $10,000	10,000
1 Set of Medical Records Shelving, etc., @ $5,000	5,000
3 Exam Room Set-ups @ $3,000	9,000
Desks, Typewriters, etc.	10,000
Total	$114,000

These increases will allow the Correctional Center to meet its obligations under the court rulings. Under personnel, there are 23 new positions, including job titles, such as physician assistants and dental aides, not previously used by the agency; the Director, in preliminary hearings, committed the agency to these. The contractual service increase represents expanding use of community resources, particularly for sophisticated diagnostic procedures.

With the increases, the objectives of the medical unit can be met. The unit will be able to provide necessary medical services to 2,650 residents on a 24-hour-a-day, seven-day-a-week basis. It will also have licensed physicians on call 24 hours a day; conduct sick call 40 hours a week; have dental services to treat 240 residents a month; have a new medical records system introduced and maintained by civilian staff; have a first aid room staffed to accommodate 1,800 visits a week; have sick call screening in segregation five days a week; have professional, 24-hour nurse coverage; initiate specialty clinics; have piped oxygen into the wards; have multiphased screening provided to all incoming inmates; and have an expanded physiotherapy department.

CRITERIA	WEIGHT OF CRITERIA AND RATING OF PRESENTATION	COMMENTS
Place an "X" on number representing weight of criteria. Place an "O" (circle) around number rating the presentations.		
Example - How knowledgable were presentors?	10 9 8 7 (6) X 4 3 2 1	Presentor seemed unsure of the data.
1. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
2. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
3. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
4. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
5. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
6. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
7. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
8. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____
9. _____ _____	10 9 8 7 6 5 4 3 2 1	_____ _____

You are representing Representative Day

Rep. Day comes from a blue-collar district saturated with heavy industry. He is known as a "law and order" advocate and is considered a fiscal conservative. There are no prisons in his district. Representative Day is an active member of a local service club.

You are representing Representative Moss

He is from a blue-collar district in the state's largest urban center. He feels the state is already spending too much on prisons and prisoner rehabilitation. He vigorously opposed building new prisons even in the face of reports on overcrowding. He believes that this country is coddling law breakers.

You are representing Representative Jones

He represents a wealthy district in the largest urban area of the state. This district is populated by the so-called kingpins of business and industry. There are no prisons in the district; however, there are a number of group homes for juveniles. Rep. Jones is considered to be a fiscal conservative. While a member of Congress, he sponsored amendments to the act excluding inmates from Medicaid and Medicare. They were defeated.

You are representing Representative Maghan

His district includes the poorest community in the state's largest urban area. There are no prisons in the district. Unemployment is twice the state average. He is considered a social reformer and is responsible for legislation to provide commercial insurance to prisoners.

You are representing Representative Clay

Rep. Clay has two prisons in his district including the one currently under review. He advocates increasing the prison's ability to provide all services within the institution to minimize the community contact with prisoners. Essentially, his is a rural district with very little industry and very high unemployment. Rep. Clay opposed a bill to provide commercial insurance to prisoners during the last term of the legislature because his constituents are unable to afford such coverage.

You are representing Representative Flagg

Rep. Flagg's constituents are mostly farmers who have among the most productive farms in the state. He is basically a liberal. There are two prisons in the district, but the prison revenue is not the basis for survival of the community. Due to location, it has been difficult to attract health care professionals into the district; consequently, there is a shortage.

Session 10

DAY III

11:30 a.m. - 12:30 p.m.

DEVELOPING ACTION PLANS

Goals of the Session

At the end of the session the participants will have identified at least one of the following action plans:

- One change that they believe they can make in correctional health related practices at home;
- One new option or activity that they believe they can introduce in the existing correctional health related practices at home;
- An assessment of their existing health care systems to determine how effective the health care system is and to determine where new alternatives or improved practices could be introduced.

In addition, participants will identify potential resistances to the change and steps to soften these resistances.

Rationale

One goal of the Health Care in Correctional Institutions Executive Training Program is to encourage participants to commence planning for implementation of new ideas for improving existing health care systems. In order to facilitate this goal, we have built into the Workshop an opportunity for you to think about some action you might wish to take when you leave as well as to analyze such actions in terms of the potential resistances you may encounter.

ACTION PLAN

Step I

a. Clearly identify and describe the change you want.

b. Clearly define the reason why you want to make the change.

Step II

a. Identify whether there will be resistance to the change(s) (don't expect resistance by creating it).

b. Identify where the resistance will come from and the reason for the resistance.

Step III

Identify strategies you might take to overcome resistance. (Refer to Sessions 7 and 8 when necessary.)

Step IV

Identify the degree of success you expect to have in accomplishing the desired change. (Circle one)

Very Probable 1 2 3 4 5 Improbable

Session 11

DAY III

12:30 - 1:00 p.m.

WRAP-UP

Goals of the Session

To wrap up loose ends, answer final questions, and thank participants for their interest and attention.

Rationale

The purpose of this session is to bring a closure to the Workshop as well as to clear up administrative details.

APPENDIX

GLOSSARY OF CORRECTIONAL HEALTH CARE TERMS

This Glossary defines certain of the terms used in this Handbook and training program. Where pertinent definitions were readily available in the literature, they have been used directly or adapted. In all instances, however, the definition reflects the meaning of the term as used in this document.

ACCREDITATION

Accreditation means that a program or facility meets a set of defined standards and has been certified by an accrediting body to that effect. It is used most frequently in relation to facilities such as hospitals, nursing homes, etc. The standards are usually defined in terms of: the physical plant, governing body, administration, medical, nursing, and other staff, and scope, type and organization of services. These standards are usually defined by a non-governmental organization, either national, state, or regional in scope, which represents both the facilities concerned and appropriate professional organizations. Examples include: the Joint Commission on Accreditation of Hospitals; the National Council for Accreditation of Nursing Homes; and state or regional organizations for accreditation of laboratories, blood banks, or other facilities. Accreditation is also used in relation to training programs such as those for internship, residency, nursing, and medical and dental specialty training.

ACUTE DISEASE

A disease of short and relatively severe duration.

AMBULATORY CARE

Ambulatory care usually refers to all types of services which may be provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be "ambulatory," the term "ambulatory care" usually implies that the patient has come to a location to receive services and has departed the same day after receiving those services.

AMERICAN SPECIALTY BOARDS

American Specialty Boards certify physicians and dentists as specialists or subspecialists in various fields of medical and dental practice. The standards for certification relate to length and type of training and experience and include written and oral examination of applicants for specialty certification. Boards exist in 19 medical and 8 dental specialties, with certification of subspecialties being carried out by some existing Boards.

CHRONIC DISEASE

Chronic diseases are all impairments or deviations from normal which have one or more of the following characteristics: are permanent; leave residual disability; are caused by nonreversible pathological alteration; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation, or care.

COMMUNICABLE DISEASE

One resulting from spread or transmission of an infectious agent, e.g., bacterium or virus.

CONSULTATION

In medical or dental practice, consultation refers to the custom of requesting advice from a qualified consultant, usually a specialist, regarding the diagnosis and/or treatment of a patient. The consultant reviews the history, examines the patient, and then provides his written or oral opinion to the requesting practitioner. Referral for consultation should be distinguished from referral for services, in that responsibility for patient care is not always delegated to the consultant. (See: Referral)

DISABILITY

Disability refers to any limitation of physical, mental, or social activity of the impaired individual as compared with the activities of unimpaired individuals of similar age, sex, and occupation. It is frequently used to refer to limitation of the usual or major activities, most commonly vocational.

FEE FOR SERVICE

Fee for service is the term usually applied to the practice of providing reimbursement to the provider of services on the basis of a designated fee for each item of service performed.

FEE SCHEDULE

A fee schedule is a listing of accepted fees or established allowances for specified medical or dental procedures. As used in medical care programs, it usually represents the maximum amounts the program will pay for services provided.

FOLLOW-UP

Follow-up implies some continued contact with the patient by the physician, by other health personnel, or by health or social agencies in order to insure that the patient understands and pursues the appropriate steps to secure diagnosis, treatment, or rehabilitation necessary to achieve maximum benefit from medical care.

FORMULARY (DRUG FORMULARY)

A formulary is a listing of drugs, usually by their generic names. The listing is intended to include a sufficient range of medicines to enable the physician or dentist to prescribe medically appropriate treatment of all illnesses. Formularies are used by hospitals and

other medical care programs and are the most widely used mechanism for expenditure control related to drugs.

GROUP PRACTICE

Group practice is a systematic relationship between physicians and/or dentists organized for the conduct of practice. A range of kinds of group practices exists depending upon the scope and content of relationships. The Public Health Service has defined group practice as: Any group of three or more physicians (full-time or part-time) formally organized to provide medical services, with income from medical practice distributed according to some prearranged plan. Comprehensive group practice may include the provision of preventive, diagnostic, and curative services by family or personal practitioners, specialists, and other professional and subprofessional technical staff working as a team in a center, pooling their knowledge, experience, and equipment as well as their income.

HEALTH INSURANCE

Health insurance is a method of pooling the risks of medical expenses based on the fact that total risk for a large group, and therefore the extent of financial resources necessary to meet that risk, is predictable. It is the pooling of funds by a large group from which amounts are withdrawn to pay, or assist to pay, unpredictable health and medical care expenses of the individuals in the group. It is a method of budgeting in advance for medical care of an individual by sharing the risk and cost in a group. (See also: Prepayment Plans)

HOSPITAL

A hospital is a facility which has an organized medical staff providing services primarily for inpatient care of individuals who require definitive diagnosis and treatment of illness, injury, or other disability, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services, and other equipment and services for definitive clinical treatment.

INCIDENCE

Incidence is a number of cases of disease, of infection, or of some other event occurring during a prescribed period of time in relation to the unit of population in which they occur. It measures morbidity or other events as they happen over a period of time, for example, the number of accidents occurring in a manufacturing plant during a year in relation to the number of employees in the plant; or the number of cases of mumps occurring in a school during a month in relation to the pupils enrolled in the school. (See also: Morbidity; Prevalence)

INDEMNITY

Under health insurance policies, indemnity refers to benefits in the form of cash payments rather than services. The indemnity insurance contract usually defines specifically which services are and are not covered and the maximum amounts which will be paid for the various covered services. In most cases, after the provider of service has billed the patient in his usual way, the insured person submits to the insurance company proof that he has paid the bills and is then

reimbursed by the company in the amount of his covered costs. In some instances, the provider of service may complete the necessary forms and submit them to the insurance company directly for reimbursement, billing the patient for costs which are not covered. Indemnity benefits are contrasted with service benefits.

JAIL

A correctional institution operated at the county or municipal level of government; usually for holding persons awaiting trial and persons serving short sentences.

JOINT, THE

The term for a state prison.

LENGTH OF STAY

Length of stay is a measure or utilization usually reported as an average of the number of days spent in a hospital or other facility per admission or discharge. It is calculated as follows: Total number of days in the hospital for all discharges and deaths occurring during a given period divided by the number of discharges and deaths during the same period of time.

MAXIMUM SECURITY INSTITUTION

A correctional institution to which inmates who are high escape risks are sent; comprehensive security and surveillance techniques are utilized to ensure that inmates will not escape.

MEDICAID

A program of Federal grants to states to operate a medical assistance program for all Federally aided public assistance recipients (the aged, blind, disabled, and families with dependent children); for comparable groups of medically needy people who have enough income or resources for daily living but not for medical expenses, and who, except for income, would meet their state's eligibility requirements for public assistance; and for all children under 21 whose parents cannot afford to pay their medical bills. The program provides payment to providers of health services, including inpatient hospital care, outpatient hospital care, doctors' services, skilled nursing home care for people over 21, and other laboratory services.

MEDICAL AUDIT

A medical audit is the detailed review and evaluation of selected clinical records by qualified professional staff. Medical audits are used in some hospitals, group practices, and in some cases in private, independent practice as a means for evaluating professional performance by comparing it with accepted standards and current professional judgment.

MEDICAL CARE

Medical care refers to all types of personal health services, including the range of services from prevention, diagnosis and treatment, to rehabilitations, provided by physicians, dentists, nurses, and other

health personnel. Medical care includes the complex of personal relationships and organized arrangements through which health services of a personal nature are made available to the population.

MEDICAL CARE ADMINISTRATION

Medical care administration is the process fundamental to all medical care programs by which program goals are defined, program structure organized, and program functions performed in relation to people needing health services, people providing services, and other organized medical care arrangements. Medical care administration utilized the procedures of planning, management, and evaluation.

MEDICAL CARE PROGRAM

A medical care program is an organized arrangement whose principal function is to organize the delivery of personal health services and/or to finance the purchase of these services.

MEDICARE

A program of health insurance for persons 65 or older. The program provides two types of health insurance: hospital insurance financed through the social security mechanism by compulsory contributions from workers and their employers; and voluntary medical insurance paid for by enrollees through monthly premiums which are matched by Federal funds. The hospital insurance helps to pay the cost of hospital care, extended care facilities, home health care, and outpatient diagnostic services. The medical insurance helps pay bills for doctors' services and other services not included in the hospital insurance.

MINIMUM SECURITY INSTITUTION

A correctional institution to which inmates are sent who present low risk of escape; security and surveillance procedures permit considerable movement in and out of the institution.

MORBIDITY

Morbidity relates to the extent of illness, injury, impairment, or disability in a population. It is usually expressed in general or specific rates of incidence or prevalence. (See also: Incidence, Prevalence)

MORTALITY

Mortality is used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as rates specific for disease and sometimes or additionally for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a year).

OVER-THE-COUNTER MEDICATION

Medication which can be purchased without a prescription.

PREPAYMENT PLAN

Prepayment plans are those in which payments (premiums, dues) are made in advance into a fund used to pay for health services when the need arises. The term applies to insurance contracts, non-profit plans, self-insured plans, health and welfare funds. It includes industrial plans, union plans and health centers, medical society sponsored plans, private group clinic plans, etc. (See also: Health Insurance)

PREVALENCE

Prevalence is the number of cases of disease, of infected persons, or of persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It is a measurement of morbidity at a moment in time. (See also: Morbidity; Incidence)

PRISON

A correctional institution operated at the state level, usually for offenders sentenced for longer than one year.

REFERRAL

Referral is the practice of sending a patient to another practitioner or to another program for services or consultation the referring source is not prepared or not qualified to provide. In contrast to referral for consultation, referral for services always involves a delegation of responsibility for patient care to another practitioner or program, and the referring source may or may not follow-up to ensure that services are received. (See: Consultation)

REHABILITATION

Rehabilitation is the restoration of a disabled or handicapped individual to the fullest physical, mental, social, vocational, or economic usefulness of which he is reasonably capable.

SCREENING

Screening is the use of quick, simple procedures to sort out apparently well persons who have a risk of having a disease from those who probably do not have the disease. It is used to identify suspects for more definitive or diagnostic studies. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests performed by technicians under medical direction and applied to large groups of apparently well persons.

SHERIFF

Elected law enforcement official at the county level of government.

SICK CALL

A period of time during which inmates can receive ambulatory services; analagous to the clinic hours of a private physician or group practice.

SPECIALIST

A specialist is a physician or dentist who limits his practice to a certain branch of medicine or dentistry related to: (1) specific services or procedures, e.g., surgery radiology, pathology;

(2) certain age categories of patients, e.g., pediatrics, geriatrics; (3) certain body systems, e.g., dermatology, orthopedics, cardiology; or (4) certain types of diseases, e.g., allergy, psychiatry, periodontics. Specialists usually have special education and training related to their practice, and they may or may not be certified as specialists by the related American Specialty Board.

STANDARDS

Standards define the level of quality of medical care acceptable to a program, or the the organization defining the standard. Standards may be defined in relation to: (1) the actual or predicted effects of care; (2) the performance of individual professional personnel; and/or (3) the capacity for quality represented in the environment in which care is provided. Standards are principles with teeth. Standards may represent minimal or maximal levels of acceptable medical care and are a basis for evaluating and controlling quality.

UTILIZATION

Utilization refers to the actual use of personal health services, and is usually expressed in rates per unit of population at risk for a given period, e.g., number of admissions to hospitals per 1,000 persons in a given population per year; number of visits to physicians or dentists per person per year; number of clinic visits per 1,000 persons per year.

WARDEN

Chief administrator of a prison.

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