

# **Health Services in County Correctional Settings**

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## **The Public Health Role**



**A report from the  
State Community Health Services Advisory Committee  
Correctional Health and Local Public Health Work Group**

**Updated Report  
November 2007**



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Revised Report  
April 2006

This report was partially supported by the Preventive Health and Health Services (PHHS) Block Grant from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.



# Table of Contents

Executive Summary .....	1
Work Group Charge and Membership.....	5
Background Information.....	7
Minnesota’s County Correctional System .....	9
Local Public Health Department Roles in Correctional Health.....	11
Stakeholders in the County Correctional Health System.....	13
Roles, Responsibilities, and Authorities Related to County Correctional Health .....	17
Issues for County Correctional Health.....	20
Recommendations .....	29

## Appendices

A. MN Rules Chapter 2911 .....	33
B. Definitions of Local Adult Correctional Facilities by Class .....	35
C. Essential Local Public Health Activities.....	36
D. Summary of Issues Reported by Correctional Health Nurses.....	40
E. Eligibility for Minnesota Health Care Programs.....	44
F. Discharge Planning for Serious and Persistent Mental Illness (SPMI) .....	45
G. Mental Health Release Plan Template .....	46
H. Minnesota Innovations in Service Delivery .....	49
I. Correctional Health Resources .....	51



## Executive Summary

The health of all Minnesotans is important. There is interconnectedness between the health of special populations and the health of the entire community. The health status of the correctional population in county facilities, which includes inmates, detainees, juveniles, night residents, etc., cannot be viewed in isolation and must be considered in light of how it affects the health of the general population. Inmates return to their families and their communities.

The adult correctional bed capacity in county facilities has increased by 62% in the past eight years, from 5,341 to 8,626. This volume increase coupled with the serious health issues of many inmates (e.g., use of methamphetamines and other drugs, mental illness, infectious diseases, and complex medical needs) is straining the system's capacity. Correctional health is a public health issue and all local health departments have a defined public health role with the correctional population. Addressing correctional health issues is often more difficult due to the complexity of the correctional system.

The correctional system in Minnesota is comprised of multiple local and state stakeholders with varying degrees of involvement in correctional health. Stakeholders include county entities and their corresponding associations: county commissioners (Association of Minnesota Counties), county attorneys (Minnesota County Attorneys Association), sheriffs and jail administrators (Sheriffs Association/Division of Jail Administrators), local health departments (Local Public Health Association of Minnesota), local social services (Minnesota Social Service Association), correctional health nurses (American Correctional Health Services Association) as well as several state agencies: the Department of Corrections, the Minnesota Department of Health, the Department of Human Services, and the Department of Public Safety.

Health care in county correctional facilities for adults is governed by Minnesota Rules Chapter 2911. The Department of Corrections is responsible for inspecting jail facilities and enforcing the rules. Each county decides how it will fulfill the health care responsibilities defined in the rules, which includes the delivery of direct health care services. Options include contracting for health care services with a private organization or agency, such as a hospital or clinic, hiring staff as a direct employee of the correctional office, or through an agreement with the local health department.

Sixty-one percent of Minnesota's local health departments provide some type of direct health care services in county correctional facilities. Issues that have been identified related to the provision of direct health care services in those facilities include the following:

**Health issues in correctional populations** including but not limited to inmates with methamphetamine (meth) use; medical conditions or diseases such as diabetes, cancer; mental health issues and psychiatric conditions; longstanding dental needs; and infectious diseases.

**Nurse practice issues** such as lack of a structure to support nursing practice in local correctional health settings; lack of clear roles, responsibilities and lines of authority; lack of consistent policy interpretation and standards for practice; lack of nurse staffing level guidelines for safe practice; medication administration issues; and confidentiality issues.

**Policy issues** including the need for cost containment in the face of increasing health issues; limited coordination or collaboration between correctional health stakeholders; increasing demand for nursing hours; lack of discharge planning; and difficulty fulfilling the broader public health role given the demands on public health staff to meet immediate acute care needs.

In light of the seriousness and the costs of these issues, many stakeholders came together to participate in the development of this report. Correctional Work Group participants included county commissioners, a representative from the Association of Minnesota Counties (AMC), a jail administrator, local health department directors and staff, a representative from Local Public Health Association of Minnesota (LPHA), correctional health nurses, as well as representatives from the Department of Corrections, the Minnesota Department of Health (MDH), and the Department of Human Services (DHS). Additionally, the work group met with the Commissioners of Health, Corrections, Human Services and Public Safety to discuss the findings in this report as well as potential steps that might be taken to address the issues identified. The ideas generated at that meeting have been incorporated into this report.

## **Recommendations**

This report is intended to bring awareness of issues and gaps in correctional health to all stakeholders and policymakers. The issues cut across many levels and organizations and will take multi-agency collaboration to resolve. Listed below are 18 recommendations identified by the State Community Health Services Advisory Committee (SCHSAC) Work Group to begin the work of addressing the concerns highlighted in this report. While these recommendations are not sufficient to address the myriad of issues identified, they can maintain and perhaps accelerate the momentum of the multi-agency discussions that have begun and ultimately, lead to improvements in this increasingly problematic situation.

As lead public health agency for the state, the MDH plays a key communications role regarding a range of issues that affect the health of Minnesotans. **It is recommended that the Commissioner of Health and MDH take the following actions:**

1. Present the Correctional Health Work Group report to the SCHSAC and obtain feedback and suggestions for use of report.
2. Convene a meeting of state agency representatives with the Correctional Health Work Group to discuss the findings in the report. (Held on February 10, 2006.)
3. Arrange for a correctional health presentation or presentations at the annual Community Health Conference in the fall of 2006.
4. Develop and disseminate a PowerPoint presentation and talking points highlighting the findings of the Correctional Health Work Group, to be used by interested stakeholders.
5. Offer a presentation on correctional health for county commissioners via videoconference during one of the scheduled twice-yearly videoconference sessions.
6. Publish resources for correctional health, as they are shared by partners, in the Community Health Services Mailbag.

The Association of Minnesota Counties (AMC) is a leader in stimulating action on issues that affect counties. As an organization, it is well situated to serve as a convener and to work to address policy issues. Since the membership of AMC consists of counties and includes many SCHSAC representatives, these members are encouraged to approach AMC about taking action

on correctional health issues. **Actions that AMC is uniquely situated to take include the following:**

7. Sponsor a Correctional Health Summit to bring greater awareness and attention to the various issues related to correctional health.
8. Provide a focal point for county discussions of correctional health policy issues (e.g., group purchasing options, statewide formulary).
9. Conduct a session on correctional health at the AMC Legislative Conference or Annual Conference to increase awareness of the issues surrounding correctional health and need for collaboration of efforts to resolve the issues. (Held on March 29, 2006.)
10. Work through the National Association of Counties on issues requiring federal action, such as financial coverage of health services provided to county correctional populations.

The Department of Human Services (DHS) administers the Medical Assistance program and provides instructions and support to county administered social service program staff. The complexities of discharge planning and medical coverage when transitioning to and from county correctional facilities may not be well understood by public health staff that work with inmates in the correctional facility. Additionally, it may be possible for state and local governments, in collaboration, to improve efficiency and coverage for the local correctional population.

**Provision of care and discharge planning for county correctional populations could be enhanced if DHS takes the following actions:**

11. Provide information on rules governing medical coverage to interested partners.
12. Support the utilization of the newly created release planning template developed by the Department of Corrections for the severely and persistently mentally impaired (SPMI).
13. Work with counties to explore systems changes in the financing and delivery of health care to local correctional populations that will increase efficiency and/or reduce costs.

As noted throughout this report, local health departments have a significant role to play in correctional health, through both the broader population health responsibilities held by governmental public health jurisdictions; and through the provision of health services to inmates in many county correctional facilities. **Local health departments are encouraged to take the following actions:**

14. Distribute information on the options of medical care coverage before release in order to inform and assist those in need of continuity of medical services in the community, as well as to promote adjustment and reduce the likelihood of recidivism in the correctional system.
15. Implement the Essential Local Public Health Activities as they apply to correctional populations.
16. Use the Essential Local Public Health Activities framework outlined in this report as a resource when working with governing boards and local partners on the issue of local public health roles in correctional health.
17. Explore ways for public health departments to work collaboratively to address issues of common concern, such as the rising costs of medications and difficulties in recruiting and retaining correctional health nursing staff. The Local Public Health Association may be an appropriate venue to coordinate such discussions.

During the course of the SCHSAC Work Group process, the complexity of correctional health roles and responsibilities became apparent. The work group realized that it will take collaboration by a wide variety of stakeholders to address the issues that were identified, since there is no one organization that has overall responsibility. Therefore the following recommendation is made to all stakeholders in the hope that continued collaboration will occur—even though the details of “who” and “how” have not yet been addressed.

**18. All correctional health stakeholders are encouraged to:**

- Continue to share resources and include other stakeholders in discussions of issues of concern;
- Support efforts to study staffing levels in jails to assure safe and adequate staffing ratio of RNs to inmates;
- Explore options for making technical assistance and support available to nurses providing health care services in county correctional facilities; and
- Participate in developing longer term solutions and systems changes to address the important issues identified in this report.

# Work Group Charge and Membership

## Work Group Charge

Review and update the report of the SCHSAC Correctional Health Work Group (completed in 1997) that identified the range of existing and potential activities of local health departments in correctional health services and recommended ways that MDH and the Minnesota Department of Corrections could support correctional health activities provided by local health departments.

## Work Group Membership

### County Commissioners

Katy Wortel, Work Group Chair  
John Baerg  
David Benson  
Ben Brunsvold

### Representing

Blue Earth County  
Watonwan County  
Nobles-Rock County  
Clay-Wilkin County

### Other Work Group Members

Lois Ahern  
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Terri Allen  
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Bonnie Brueshoff  
Anita Cardinal  
Renee Frauendienst  
Althea Freidrichs  
Linda Grupa  
Marina McManus  
Jeanne Schumacher

### Representing

Freeborn County Public Health Nursing Service  
Ramsey County Community Corrections  
Carlton County Public Health  
Carver County Sheriffs Office  
Dakota County Public Health  
Inter-County Nursing Service  
Stearns County Human Services  
Sibley County Public Health Nursing  
Houston County Public Health  
Anoka County Community Health  
Washington County Public Health

## Other Participants

Diane Grinde, Inspection and Enforcement, Minnesota Department of Corrections  
Nanette (Schroeder) Larson, Director, Health Services, Minnesota Department of Corrections  
Kim Carolan, Health Care Eligibility and Access, Minnesota Department of Human Services  
Pat Coldwell, Policy Analyst, Association of Minnesota Counties  
Julie Ring, Director, Local Public Health Association  
Debra Burns, Director, Office of Public Health Practice, Minnesota Department of Health  
Mary Sheehan, Director, Community and Family Health, Minnesota Department of Health  
Carol Woolverton, Assistant Commissioner, Minnesota Department of Health

## Staff to the Work Group

Wendy Kvale, Public Health Nurse Consultant, Minnesota Department of Health  
Linda Olson Keller, Public Health Nurse Consultant, Minnesota Department of Health

(Special thanks to Linda Grupa for assisting with the analysis of the Correctional Health and Local Public Health Survey data.)



## Background Information

### Why Address Correctional Health?

Reviewing the case of *Estelle v. Gabel* in 1976, the Supreme Court of the United States found in the Eighth Amendment to the Constitution<sup>1</sup> that inmates had a constitutional right to medical care. The Court noted that an individual in custody is unable to seek medical care and is totally dependent on the employees of the institution for their health care. Therefore, failure to provide that care would be considered “cruel and unusual punishment.”<sup>2</sup>

Minnesota’s county correctional system is responsible to provide health care to those being held within the county facilities. MN Rules Chapter 2911 (see Appendix A) specifies the requirements for a safe and secure correctional environment for the adult population; health is one component of the statute. The rules define limited standards for medical, mental and dental health. Each correctional facility creates policies and protocols to implement the standards and fulfill the health care responsibilities. Methods of implementation vary across the state.

The Department of Corrections is responsible for inspecting the jails and enforcing the rules. These health services must be provided for the facility to be licensed:

- § Medical, mental and dental care;
- § Posting of available resources;
- § Hospitalization of prisoners;
- § First aid;
- § Preventive health services (personal hygiene);
- § Delivery, supervision, and control of medications;
- § Reporting suspected communicable disease;
- § Separation of prisoner suspected of having a communicable disease;
- § Management of mentally ill prisoners.

Options for the delivery of direct health care services to individuals include contracting for health care services with a private organization or agency, such as a hospital or clinic, hiring staff as direct employee of the correctional office, through an agreement with the local health department, or by sharing resources with nearby counties. (Not all counties have jails.) Health departments in 55 counties reported that they provide some type of direct health care services in their county correctional facilities.

Many local health departments initially became involved in correctional health when legislation was passed regarding tuberculosis testing in the mid 1990’s. This involvement rapidly led to a variety of correctional health roles, activities, and protocols for local health departments. Correctional health services ranged from the sheriff’s department contracting with the public health department for tuberculosis testing to having public health nurses on call for health issues in the jail 24 hours a day.

In order to address the many issues of providing health care to persons incarcerated in county correctional facilities, a SCHSAC Work Group was convened in 1997 to clarify roles and responsibilities of local health departments for correctional populations.

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<sup>1</sup>*Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.* Eighth Amendment, Constitution of the United States.

<sup>2</sup>*Standards for Health Services in Correctional Institutions, Second Edition.* 1986. American Public Health Association, Washington, DC.

## 1997 Recommendations

The 1997 Work Group recommended that the Commissioner of Health:

- § Publish the report and recommend that county boards, community health boards, local public health departments, and local corrections staff use the report as a resource in determining how to most appropriately provide correctional health services in county correctional facilities.
- § Recommend that local public health departments use this report as a resource for determining whether to provide health services, based on the core public health functions, to the population incarcerated in local correctional facilities.
- § Provide technical assistance to counties regarding correctional health services and public health interventions in county correctional facilities.
- § Support community initiatives that develop or explore innovative models for efficient, cost-effective health care and public health services to an incarcerated population.
- § Explore options to assure and/or maintain the health coverage of incarcerated individuals.
- § Work with the Minnesota Department of Corrections and the Minnesota Department of Human Services to examine the serious public health problem of mental illness among incarcerated individuals and its significant impact on county correctional facilities.

Seven years later, in 2004, local health departments expressed deepening concerns related to the escalating costs of correctional health services associated with a rapid increase in the incarcerated jail population, the impact and management of major issues such as a history of methamphetamine use and mental illness in the correctional population, and the numerous requests for additional correctional health services. In response to these concerns, a SCHSAC Correctional Health Work Group was convened in 2005 to review and update the report from the 1997 SCHSAC Correctional Health Work Group.

The 2005 Correctional Health Work Group determined that the 1997 recommendations had only been minimally achieved. The work group identified that the primary reason that these recommendations had not been fully achieved was that the correctional system is very complex with multiple stakeholders. The work group recognized that collaboration would be required to seriously address identified correctional health issues and concerns. As a result of this analysis, the work group invited other stakeholders to participate in the work group, including representatives from the Association of Minnesota Counties, the Local Public Health Association, the Department of Corrections and the Department of Human Services.

## The Work Group Report

This report addresses two distinct components of correctional health. *Direct health care services* are provided individually to inmates and governed by Minnesota Department of Corrections rules. The second component is *public health's role with the correctional population*. Regardless of how a county board decides to provide correctional health direct care services, local public health departments have a role to play in promoting the health of the correctional population. Only government is required to assure that the health of the entire population is protected, promoted, and maintained. The correctional population is a special population within the overall population. This report applies the Essential Local Public Health Activities framework to the correctional population and identifies potential public health roles.

**NOTE:** *The population addressed by this report includes only those adult individuals incarcerated in county correctional facilities and under the jurisdiction of the county correctional system. Also, not all local public health departments provide individual correctional health services and not all counties have jails.*

## Minnesota's County Correctional System

It is necessary to understand the county correctional system and the dramatic changes that have taken place over the past few years to appreciate the present concerns regarding the responsibilities for providing health care in the county facilities. This report primarily addresses the adult population and does not include issues related to the juvenile system.

Local detention facilities are an integral part of the Minnesota criminal justice system. There are 91 local adult detention facilities currently in operation in Minnesota distributed across 79 counties. Eight counties – Big Stone, Dodge, Grant, Pope, Red Lake, Rock, Stevens, and Wilkin – do not have a facility and contract with other counties for correctional services. These local facilities are generally run by the county sheriff and house adult offenders who are at various stages of court proceedings. Local correctional services are generally funded through county resources. The breakdown of types and number of facilities in 1997 in comparison to 2005 are listed in Table 1 below. (See Appendix B for definitions of Class facilities.)

**Table 1. Number and capacity of Minnesota county adult correctional facilities comparison of 1997 and 2005 data**

Type	1997 Number of Facilities	2005 Number of Facilities	1997 Capacity	2005 Capacity	Percent Change
Jail (Class III Facility)	59	68	2,892	5,583	+ 93%
Jail Annex (Class IV Facility)	7	4	509	430	-15.5%
Adult Detention Facility (Class V Facility)	2	2	746	1,310	+ 75.6%
Adult Correctional Facility (Class VI Facility)	5	4	1,029	1,191	+ 15.7%
90 day lockup (Class II Facility)	6	5	69	52	-24.6%
72 hr hold (Class I Facility)	8	6	40	40	0
72 hr hold/no work release	2	2	54	20	-62.9%
24 hr hold/no work release	1	0	2	0	-200%
<b>Totals</b>	<b>90</b>	<b>91</b>	<b>5,341</b>	<b>8,626</b>	<b>+61.9%</b>

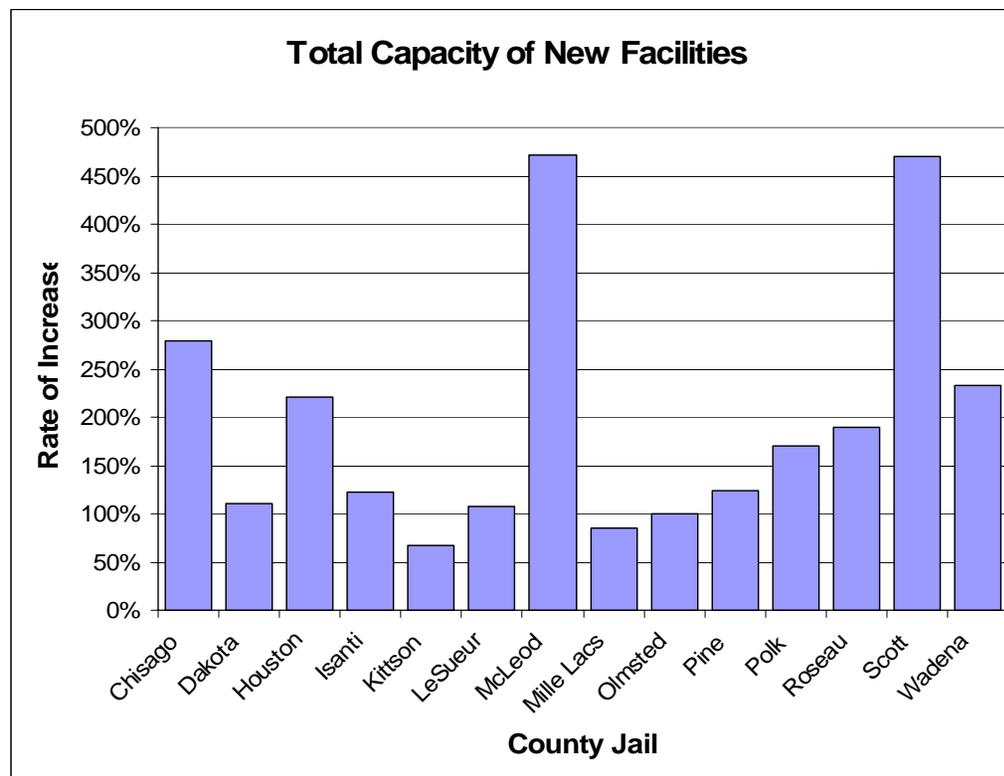
Source: "General Facility Information" is from the Statewide Inmate Per Diem Report. Minnesota Department of Corrections, August 2005

The largest facility in the state has 839 beds (Hennepin ADC) and the smallest only three beds (Norman and Traverse). The average daily population range is 651 maximum to 0 minimum. Jails account for two-thirds of all correctional facilities in the state. Only 16 percent of the facilities are located in the metro counties. However, the fourteen metro facilities account for over a third of the states total capacity.<sup>3</sup>

This information highlights the considerable differences across facilities throughout the state. These differences impact the operation of the facilities and are also indicative of the wide range of services (including correctional health services) provided in county and municipal facilities.

**Forty-four counties in Minnesota are in some phase of building a new jail facility** which will either double or even triple the current bed capacity of the current facilities (see Figure 1). This increase in capacity poses significant implications for the maintenance of the facilities, including the provision of health care services.

**Figure 1. Rate of increase of new county correctional facilities**



Source: 2005 Correctional Health and Local Public Health Survey

<sup>3</sup> Information contained in "General Facility Information" is from the Statewide Inmate Per diem Report. Minnesota Department of Corrections. August 2005.

# **Local Public Health Department Roles in Correctional Health**

## **Why is Correctional Health a Public Health Issue?**

Government has a fundamental responsibility to protect and promote the public's health. The health of people in county correctional facilities can not be viewed in isolation. Their health must be evaluated in light of how it affects and reflects the health of the general population. Persons incarcerated in county facilities return to their families and communities, thereby impacting the health status of the community. In addition, incarcerated inmates reside in close proximity in confined housing that favors the spread of infectious diseases. This is of particular concern as instances of overcrowding occur and as larger portions of the community population are housed in correctional facilities. Lastly, interventions in correctional settings provide an opportunity to address a high risk population that is difficult to reach when that population is out in the community setting. This population may also have difficulty accessing the health care system for prevention and case management services. As local health departments assess the health needs of their communities, incarcerated individuals may be identified as a target population in need of public health services.

Public health responsibilities are shared among local, state and federal governments. In 2004, a SCHSAC Work Group identified essential local public health activities for six areas of public health responsibility that should be available in all parts of the state. The Essential Local Activities Work Group defined the essential local activities as the basic, indispensable and necessary activities that all local health departments in Minnesota do to protect and promote the health of Minnesotans. The Correctional Health Work Group applied the Essential Local Activities framework to correctional health (see Appendix C for complete framework). The following activities were identified as potential public health roles with the correctional population.

## **Assure an Adequate Local Public Health Infrastructure**

1. Include the correctional population in the community assessment and action planning process.
  - a. What information is available regarding the health problems of incarcerated individuals?
  - b. What are the health problems of the correctional population?
  - c. Are there health needs that are not being met? Who could best provide these services?
  - d. What is the appropriate allocation of resources to address those needs?
  - e. Would allocation of county resources for prevention education services to the correctional population be advisable?
2. Work with community partners and stakeholders to develop strategies for programs to meet the multiple health needs of the correctional population, including appropriate placement at release.
3. Provide nursing students an overview of Correctional Health during public health nursing clinical experiences.

## **Promote Healthy Communities and Healthy Behaviors**

1. Based on community assessment, resources, and capacity, work with community partners and stakeholders to develop action plans to promote healthy behaviors such as physical activity, nutrition, mental health, unintentional pregnancy, maternal and child health, and the prevention of tobacco, alcohol and other drug use, HIV/AIDS, sexually transmitted infections, injury and violence in the correctional population.

2. Inform and educate county boards, community health boards, sheriffs, and other community partners about the health status and health risks of the correctional population.

### **Prevent the Spread of Infectious Diseases**

1. Conduct ongoing surveillance for infectious diseases, including tuberculosis, hepatitis, AIDS/HIV, sexually transmitted infections.
2. Conduct Mantoux testing on all inmates incarcerated more than 14 days.
3. Work with local physicians on the treatment and follow-up of positive TB testing.
4. Assure follow-up continues upon release.
5. Detect and respond to infectious disease problems and outbreaks in the inmate population, including hepatitis, AIDS/HIV, sexually transmitted infections, pediculosis, scabies, Methicillin-resistant *Staphylococcus Aureus* (MRSA).
6. Assure isolation and separation policies and procedures are in place.
7. Assure that reportable infectious diseases occurring in correctional setting are reported in a timely and accurate manner.
8. Conduct testing and follow-up for sexually transmitted infections.
9. Immunize correctional population as appropriate.

### **Protect Against Environmental Health Hazards**

1. Provide consultation regarding environmental health hazards in the correctional setting for issues such as methamphetamine contamination, sharps disposal, storage and use of chemicals, blood and body fluid exposures.
2. Provide follow up/enforcement for OSHA regulations.

### **Prepare for and Respond to Disasters, and Assist Communities in Recovery**

1. Assist with the development of all hazard emergency policies, procedures, and plans.
2. In collaboration with correctional staff, develop and participate in preparedness tabletops, drills and exercises.
3. Assure that public health staff who work in correctional settings are trained in emergency policies and procedures.
4. Include the consideration of the correctional population in county health emergency preparedness response plans.

### **Assure the Quality and Accessibility of Health Services**

1. Advocate to policy makers regarding the need for and benefit of providing preventive services in correctional settings.
2. Work with federal and state health and correction agencies on the development of legislation and rules that affect the health of the correctional population (Medical Assistance reimbursement, medication purchasing).
3. Facilitate coordination between the correctional, public health, human services, and medical care systems to assure continuity of medical, dental and mental health services (including medications) upon release.

## **Stakeholders in the County Correctional Health System**

The correctional system in Minnesota is comprised of multiple local and state stakeholders with varying degrees of involvement in correctional health. Figure 2 (page 15) graphically illustrates the complexity of this system. Correctional health is primarily administered and funded at the local level. County commissioners have the authority to set the county levy and allocate local tax dollars to the county departments. County sheriffs and county attorneys are also key decision-makers in how correctional health services are delivered within the county correctional facilities. All three entities - county commissioners, county sheriff, and county attorney- are elected officials, and cannot direct or be directed by other elected officials.

County commissioners have direct authority over county departments, such as local health departments and local social services. Sheriffs have authority over the jail, who may or may not decide to contract with local health departments for correctional health services. Local social services involvement with correctional health includes determining eligibility for health care services upon release.

Each local stakeholder also has a corresponding professional association/organization that provides advocacy and policy development in areas of interest to their membership. Many of these professional association/organizations are also actively involved in correctional health issues.

Several state agencies are important stakeholders to correctional health. The Department of Corrections enforces the rules that govern the mandatory requirements of health services and resources to inmates. The Minnesota Department of Health is responsible for controlling communicable diseases, as well as assuring that the Local Public Health Act is implemented through it's partnership with local health departments. The Minnesota Department of Human Services supervises Minnesota health care programs, including the Medical Assistance Program, and is the designated mental health authority for the state.

### **Stakeholders**

County entities and their corresponding associations:

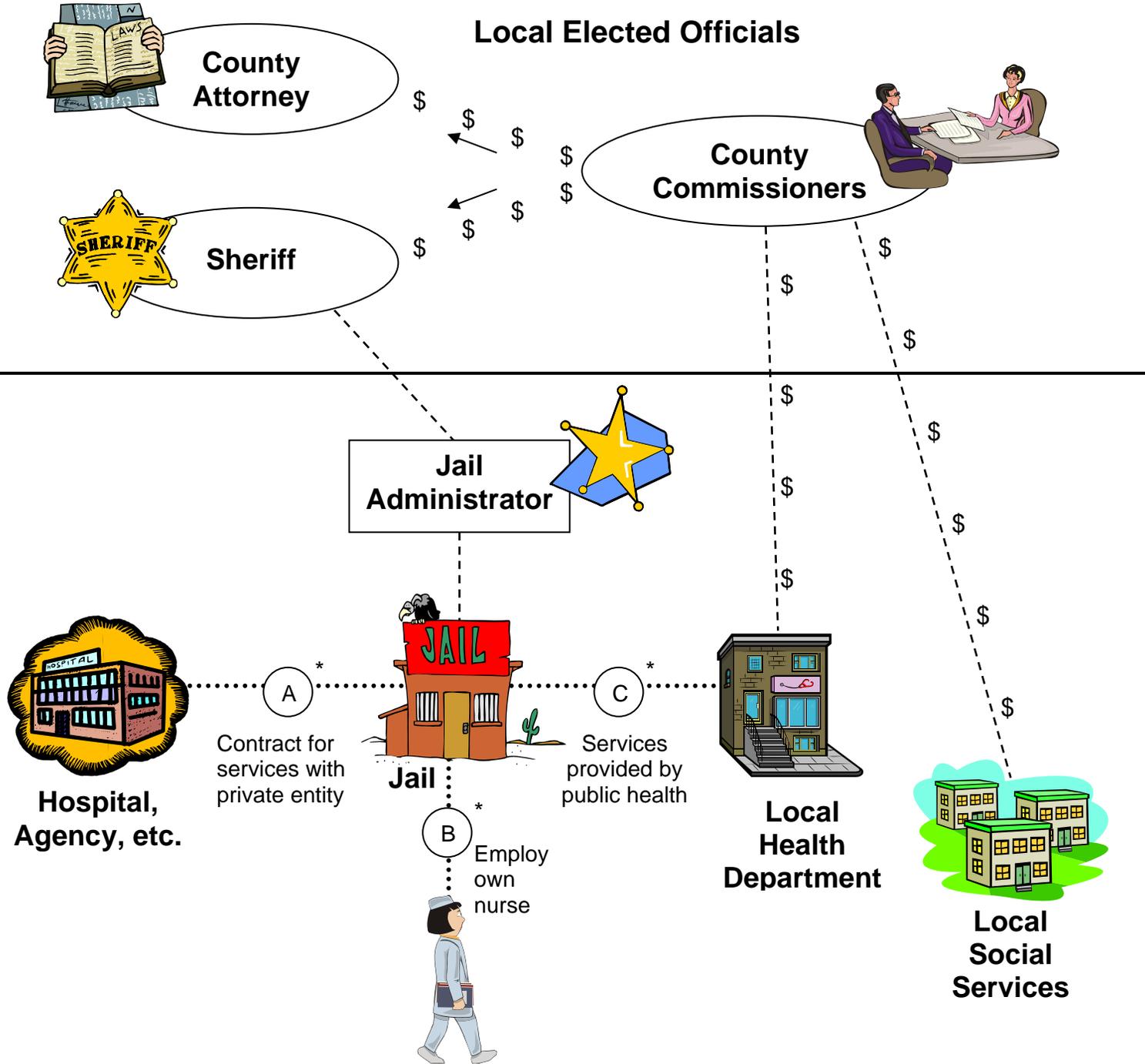
- County commissioners (Association of Minnesota Counties)
- County attorneys (Minnesota County Attorney Association)
- Sheriffs and jail administrators (Sheriffs Association/Division of Jail Administrators)
- Local health departments (Local Public Health Association of Minnesota)
- Local social services (MN Association of County Social Service Administrators)
- Correctional health nurses (American Correctional Health Services Association)

State agencies:

- The Department of Corrections
- The Minnesota Department of Health
- The Department of Human Services
- The Department of Public Safety



# Local Correctional Health System



## State Agency Roles in Correctional Health



### Minnesota Department of Corrections

- Inspection and Enforcement of Rule 2911 & Rule 2960



### Minnesota Department of Health

- Communicable Disease Control
- 145A Local Public Health Act



### Minnesota Department of Human Services

- Supervision of MN Health Care Programs
- Mental Health Authority



# Roles, Responsibilities, and Authorities Related to County Correctional Health

To assist in understanding correctional health, it is important to clarify the roles and responsibilities of each of the stakeholders, as well as the source of authority for these responsibilities. The work group members created a brief list of examples of correctional health activities for each of the stakeholders mentioned.

## Roles and Responsibilities Related to Correctional Health: County Level

### County Commissioners (elected\*):

- Sets county levy, budgets and staffing for all county departments, including the jail
  - Responsible for structure and function of all county departments
  - Balances the work between county departments
  - Sets policy and direction for county government
  - Promotes state policy that supports counties
- Authority:* Statutory (Cannot direct other elected officials, i.e., sheriff, county attorney)

### County Attorney (elected\*):

- Influences court decisions and processing of inmates thru the system
  - Influences release, furlough, sentencing
  - Advises on litigation matters that involves county government
- Authority:* Statutory

### Sheriff (elected\*):

- Public safety authority; enforces laws
  - Assures compliance with Department of Corrections requirements at local level
  - Runs the jail and law enforcement, including policy decisions
  - Ultimate authority for health services in jail facility
- Authority:* Statutory

### Jail Administrator:

- Responsible for daily operations of jail
  - Oversees provision of cost effective medical care for inmates as required by state/federal law
  - Budgetary authority over operations of jail
  - Interacts with public health departments
- Authority:* Functions under the authority of sheriff

### Local Health Department:

- Implements MN Statute 145A through Community Health Board
- Infectious disease reporting which includes reporting, protection, and control
- If designated by county, provides statutory required services for health care in the jail e.g., 14 day assessments, Mantoux tests, sick call
- Prevention and health promotion focus
- Collaborates with partners and has knowledge of state, regional and community systems
- Discharge planning/community referrals
- Risk management, if requested--environmental health inspects kitchens of correctional facilities

*Authority:* Statute 145A

\* *Elected officials accountable to the electorate*

## **Roles and Responsibilities related to Correctional Health: Minnesota State Agencies**

### **Department of Corrections**

- Enforces implementation of Rule 2911
- Inspection and licensing of jail facilities
- Community Corrections (for those counties who opted for community corrections)
  - Probation, community services/supervision
- Provides guidance for standards of health care services

### **Department of Health**

- Application of MDH's mission to protect, promote and maintain the health of all Minnesotans, including the correctional population
- Provides technical assistance to local health departments and Community Health Boards in carrying out required duties\*
- Disease surveillance
- Develops guidelines on infectious disease management
- Convenes and collaborates with partners at all levels
- Provides assistance for designation of Health Professional Shortage Areas (HPSA)
- Environmental health – inspection of kitchen facilities upon request  
(\*local health departments looks to MDH as partner for technical assistance under 145a)

### **Department of Human Services**

- Provides instructions and support to county administered social service program staff
- Administers Medical Assistance program\*  
(\*Role is after release of inmate from jail, as the incarcerated are not eligible for social service programs, except for a small group that maintains eligibility for GAMC)

## **Roles and Responsibilities related to Correctional Health: Professional Organizations**

### **Association of Minnesota Counties (AMC)**

- Builds partnerships between counties
- Provides services to counties so they can provide services to constituents
- Educates commissioners on state mandated services and gives recommendations on how best to provide these services
- Advocates for county services with the state legislature  
*Authority:* Association Bylaws

### **Local Public Health Association of Minnesota (LPHA)**

- Advocacy organization for local health departments
- Meets monthly with local public health management
- Works closely with AMC and local boards to help them understand legislation and services  
*Authority:* Association Bylaws (voluntary participation; membership limited to local health departments)

**Sheriff Association/Division of Jail Administrators**

- Education and training for membership
- Network between membership
- Provide and share related resources

*Authority:* Association Bylaws

**American Correctional Health Service Association, Minnesota Chapter**

- Provides education
- Provides coordination between counties through regional meetings
- Provides resources
- Networking and support between members
- Presents on medical issues at numerous conferences

*Authority:* Association Bylaws

## Issues for County Correctional Health

Issues being addressed by local public health in the correctional system rose to the level of attention to initiate the SCHSAC 2005 Correctional Health Work Group. A primary issue of concern is the increase in the number of inmates (incarcerated, detainees, night residents) and the associated health conditions since the SCHSAC 1997 Correctional Health report. The 2005 work group findings confirm that Minnesota's correctional health system faces many serious issues. The issues identified in this report are beyond the scope of any one organization's ability or authority to address. It is the intent of the work group that this report serve as a resource to further engage stakeholders at all levels to address the correctional issues described herein.

### Local Health Departments and Correctional Health

In 1991, the Minnesota legislature granted statutory authority to the Minnesota Department of Corrections to develop rules for tuberculosis screening of correctional facility employees, including jails. These rules were developed in consultation with the Minnesota Department of Health. Beginning January of 1994, additional legislation was passed to allow for the tuberculosis screening of inmates in county jails. Because control of infectious diseases (including tuberculosis) is a public health function, many local correctional facilities began to rely on the expertise of local health departments to provide this screening. As local public health staff became a more constant fixture in county jails, they began to see additional health needs and the need for prevention education and follow-up. In addition, because they were already part of the county system, county corrections staff began to request and rely on public health nurses to provide sick call services for prisoners.

The 2005 Correctional Health Work Group initiated a written survey of local health departments on their role and issues of concern in correctional health. Seventy-three of 87 counties (83%) responded to the survey. For those health departments that did not return the survey, a phone call inquiry was made to collect basic information on the provision of correctional health services. In addition, staff attended regional correctional health nurse meetings in the spring of 2005. Information gathered from the regional meetings is included in the issues identified in this report (see Appendix D for summary).

Local health departments reported on the provision of direct correctional health services to 47 adult detention facilities and nine juvenile centers in Minnesota. Correctional health services provided by local health departments range from a minimal service of TB testing (Mantoux tests) on request of the correctional officer, to regularly scheduled sick call coverage, and for some departments, the provision of full clinic services in the correctional facility (see map on page 21).

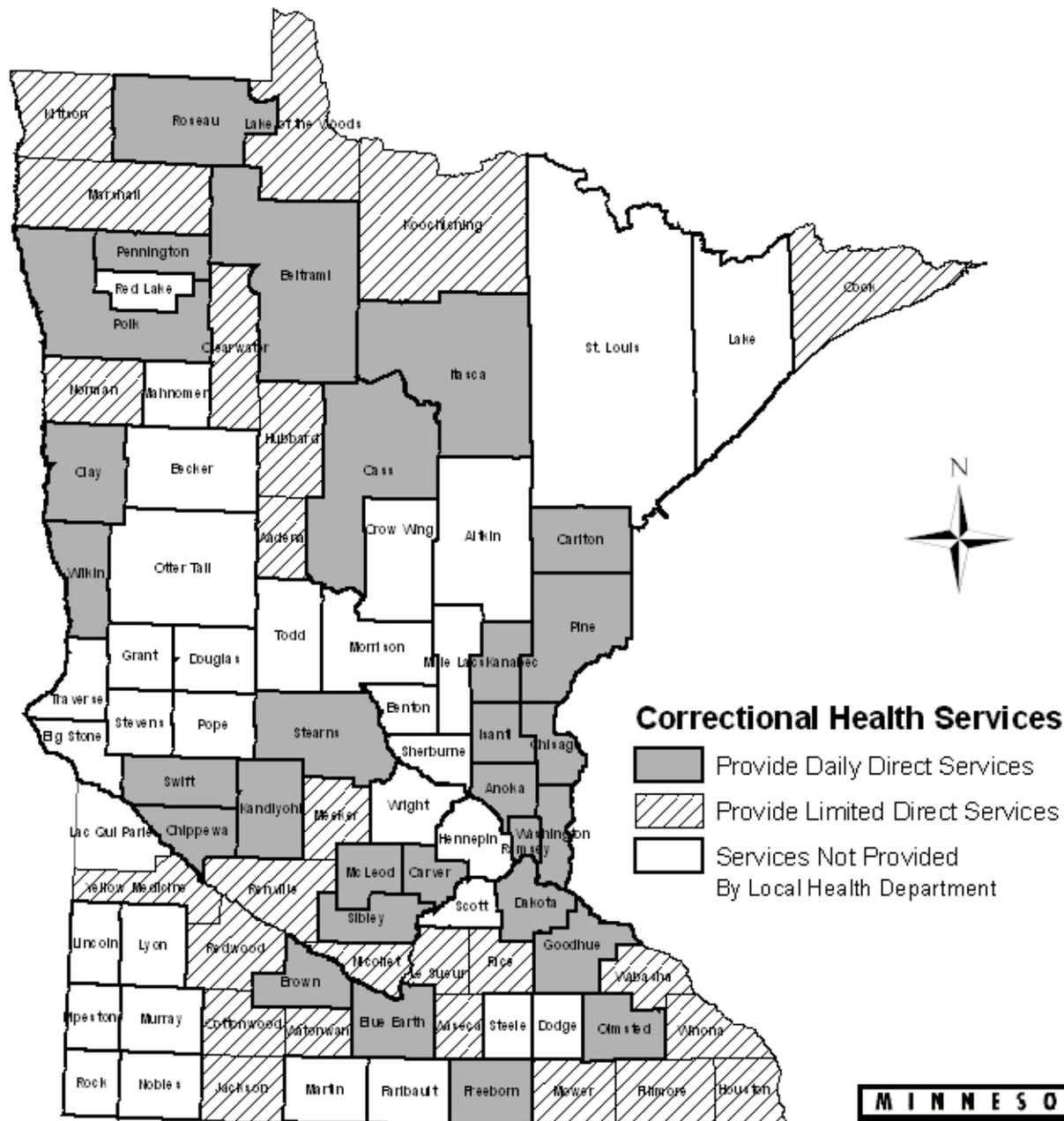
Forty-five local health departments provided data (see Table 2) on number of beds in the correctional facilities for which they provide direct health care services. Local health departments were responsible for the direct health care services of 4,585 incarcerated adults and 365 juveniles in 2005.

**Table 2. Number of incarcerated individuals provided direct care by local health departments**

<b>Adult Males</b>	<b>Adult Females</b>	<b>Adult Total</b>	<b>Juvenile Males</b>	<b>Juvenile Females</b>	<b>Juvenile Total</b>	<b>Total</b>
4,021 (87.7%)	564 (12.3%)	4,585	338 (92.6%)	22 (7.4%)	365	4,950

Source: 2005 Correctional Health and Local Public Health Survey (n = 45 Local Health Departments [LHD] reporting, September 2005)

# Correctional Health Services Provided by Local Health Departments



Minnesota Department of Health  
October 2007



Counties with no correctional facilities: Big Stone, Dodge, Grant, Pope, Red Lake, Rock, Stevens

## Issues Related to Changes in the Health of the Correctional Population

The increase in the number of people who are incarcerated in correctional facilities has resulted in the need for more correctional health services. In addition, there are changes in the demographics of the population. Correctional health staff reports that they are seeing many more women in the jails, as well as more elderly men aged 70–90 years. These sub-populations have greater and unique health needs, as compared to the rest of the jail population.

Survey respondents and correctional health nurses report that the health status of the correctional population has changed in the past decade. Health status issues identified include increasing numbers of inmates with needs associated with chemical abuse, methamphetamine (meth) use, dental health, mental illness, chronic medical conditions, infectious diseases and other medical issues. These, and other correctional health issues, were rated by level of importance to the local health department in the survey. The cumulative results are displayed in Figure 4.

**Figure 4. Correctional health issues ranking of importance by local health departments**

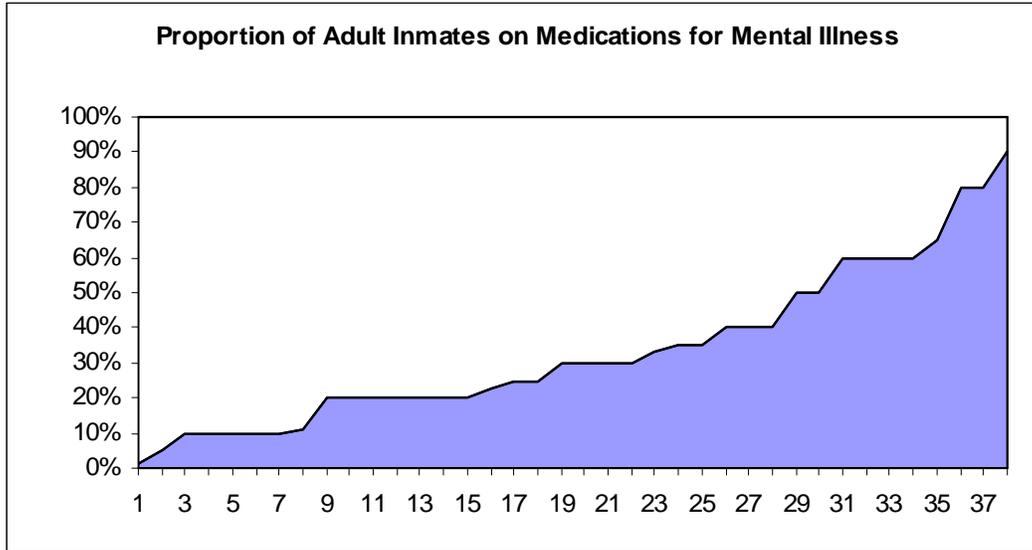


Source: 2005 Correctional Health and Local Public Health Survey (n = 43 LHD survey responses)

- Managing an increasing number of inmates with mental health issues and psychiatric conditions, particularly inmates who are severely mentally ill, is a challenge for correctional staff. There is a lack of mental health providers and services, with little or no psychological counseling services available. There are very few county correctional facilities that have resources for seriously mentally ill inmates.
- The number of inmates on medications, particularly psychotropic medications for mental illness, is increasing. (see Figure 3 on page 23).

“Half of our inmates are on psychotropic meds for psychiatric conditions. Many of our inmates have 6-12 medications.” - quote from a correctional health nurse

**Figure 3. Estimated percentage of inmate population on medications for mental illness as reported by local health departments providing direct services in 38 county jail settings**



Source: 2005 Correctional Health and Local Public Health Survey (n = 38 LHD survey responses)

- The numbers of methamphetamine (meth) users coming into the correctional system has been a big change from ten years ago. Inmates often come in violent and are difficult to detoxify. The withdrawal period for meth is 60 days compared to 5-7 days for alcohol. Detox centers are often a long distance away or will not take the offender.

“70 - 80% of our population is there because of meth” - quote from a correctional health nurse

- Chemical abuse, including inmates with a chronic alcohol usage history, as well as other multiple chemical usage, including heroin, and/or cocaine, alcohol, meth, and ecstasy are a concern. Correctional facilities are often forced to monitor inmates experiencing detox because crisis units will not take them. Their health status is vulnerable during this time.

“We had an inmate with AIDS whose medications cost \$3500 per month. We spent over \$100,000 on one inmate.” - quote from a correctional health nurse

- Disease management and services for an increasing number of inmates with medical conditions and diseases, such as diabetes, hypertension, kidney failure and cancer, result in costly medical expenses being charged to the county.

- Dental needs in the correctional population are increasing. One contributing factor is dental deterioration due to meth. Meth users often come in with teeth broken off at the gum line. Dental services are provided for severe pain and abscesses by extraction only, no restorative services. There is very limited access to dental services, due to a lack of dental providers who will see inmates, particularly oral surgeons.

- Infectious diseases are a concern within the correctional population, particularly hepatitis and the number of inmates with positive Mantoux tests. The close quarters and overcrowding conditions in many jail settings are particularly suited for transmission of disease organisms. While incarcerated, it is an opportune time to provide treatment before they are returned to the community.

## Nursing Practice Issues Related to Correctional Health

Survey respondents and correctional nurses have reported that as the health issues of the correctional population have changed, many nurse practice issues have emerged. Nurse practice issues are important because most correctional health services are provided through nurses who are either employees of health departments or contract employees. Professional nurses practice under the auspices of the Nurse Practice Act, which clearly outlines roles, responsibilities, and lines of authority. These roles, responsibilities, and lines of authority are not always clearly defined in the correctional health setting, particularly with regard to medication administration.

- Confidentiality was ranked the number one practice issue in the survey (see Figure 5). Privacy of personal medical information is a concern of many these days. Questions such as: Who has access to the record? Is it on a need to know basis? Who has control of the jail health record? Often times the facility does not have the space to allow for medical services and/or interviewing that allows for confidential interactions that protect individual privacy.

**Figure 5. Importance ranking of correctional health practice issues**



Source: 2005 Correctional Health and Local Public Health Survey (n = 43 LHD survey responses)

- Staff safety and adequate staffing were identified as concerns in the survey results. Training in security measures and protocols in correctional settings has been reported as a need for correctional health staff. Guidelines for nursing staffing levels in county jails are currently being developed by a committee convened by DOC.
- As a nursing specialty, correctional health nurses need a structure that supports their practice in an independent setting. Correctional health consultation is difficult to access for practice issues. The lack of consistent statewide policy interpretation and standards for practice, greatly contribute to concerns about nursing practice in the correctional setting. One area of practice that is a concern to correctional nurses is the delegated function of medication administration. It is a nursing function delegated as defined in the Nurse Practice Act. When medications are administered to inmates by correctional officers, under whose license is that

function being performed? Who is responsible for assuring that the right medication is administered in the right dose at the right time to the right inmate? Does the individual license holder hold the liability?

- Not all roles are clearly defined within the correctional health system. Some questions are unanswered, such as who is ultimately responsible for what? Who has medical authority over an inmate? What is the public health authority in the jail? Who determines the level of treatment? Correctional health staff report on an increasing awareness and “culture of entitlement” about the inmate’s right to health care under the law, i.e.,” You have to take care of me.”

Several inmates complained to the Board of Nursing about a nurse and the level of care they received. While the issue was resolved, it was very difficult for everyone involved. There is currently a lawsuit in process over an inmate’s “constitutional right to narcotics”.

- Nurses have been threatened with litigation. The potential loss of a nursing licensure is a source of much concern. This contributes to the difficulty of recruiting nurses to work in a correctional setting.
- Nurses must balance the ongoing tension between wanting to provide good medical care and the knowledge that at times, inmates may be trying to manipulate the system. This can also be particularly difficult when working with other health providers in the community who are not accustomed to working with the correctional population.

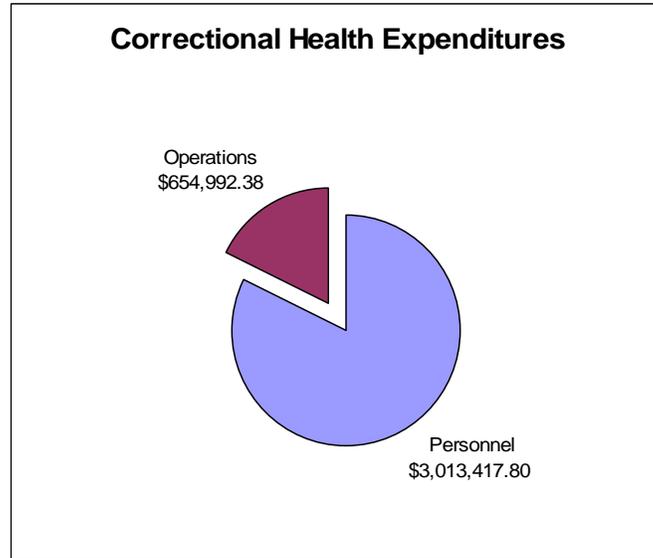
Correctional health nursing is very different from other areas of nursing practice. It requires clear boundaries, the ability to say no, someone firm, the ability to discern lying and manipulation behavior.”

## Policy Issues Related to Correctional Health Infrastructure

As the correctional health system responds to the changing health issues in the correctional population, many policy issues emerge. The work group identified the **escalating costs of correctional health programs, staffing issues and lack of policy coordination between correctional health stakeholders** as the highest priorities today. Other policy issues include increasing requests for health services, lack of release planning which leads to recidivism and the tension between the public health prevention role and treatment services.

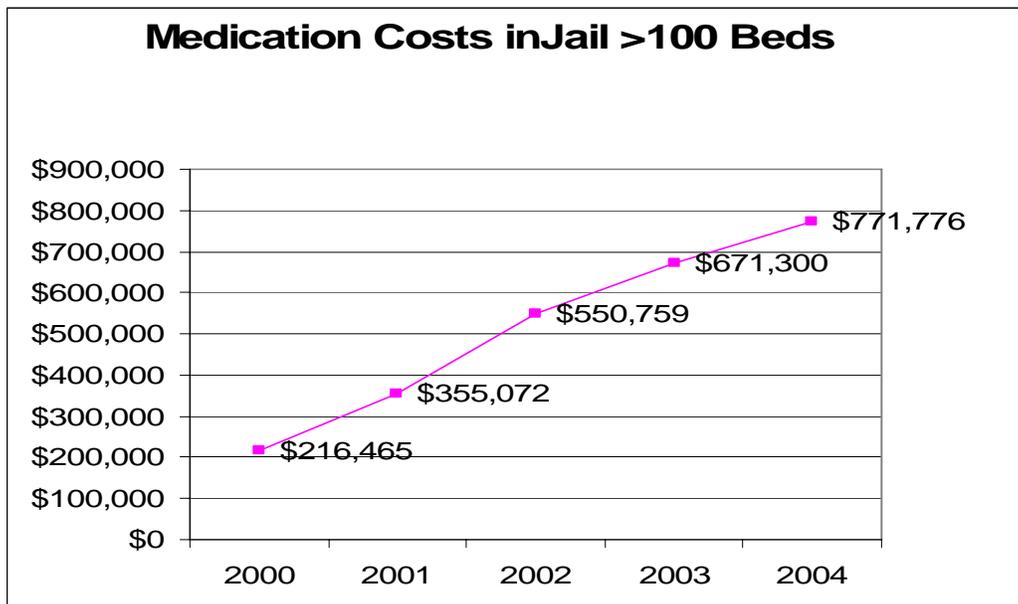
**The work group members emphasized the need for cost containment in the face of increasing health issues.** Un-reimbursed health care expenses (including the cost of medications and medical, dental, mental health services) are a burden to local governments and health departments. Inmates who have medical assistance (MA) coverage immediately lose MA when they are incarcerated, which shifts their costs to counties (see Appendix E for further explanation of MN health care program eligibility). In addition, work group members reported that a recent decrease in funding for regional mental health treatment centers, has resulted in an additional cost shift to counties. Figure 6 on page 26 identifies the dollars that 22 local health departments expended on county correctional health services in 2005, a total of \$3,668,410.18. (This figure does not include medications or provider health care services.) Figure 7 on page 26 displays the increasing cost to county budgets for medications in six large jail facilities.

**Figure 6. Proportion of correctional expenditures**



Source: 2005 Correctional Health and Local Public Health Survey

**Figure 7. Increase in annual medication costs in county jails**



Source: 2005 Correctional Health and Local Public Health Survey (N=6 Jails range in size from 155 to 385)

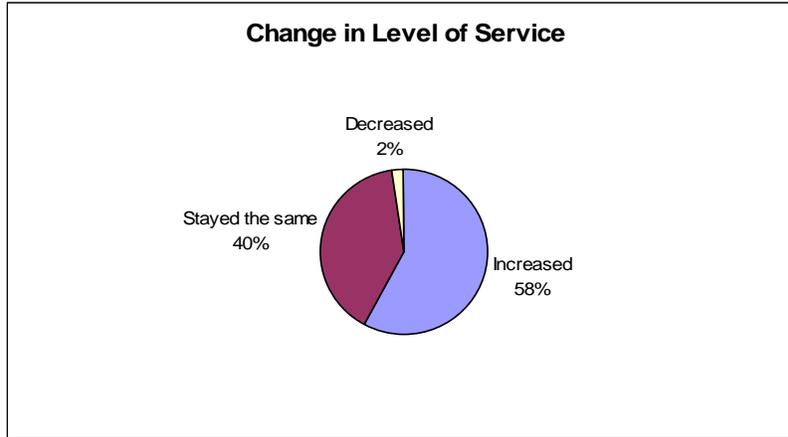
As the correctional population increases, so do the costs associated with managing the supervision and care.

**Staffing at an appropriate level is a challenge.** While the jail population has increased, the number of nursing hours provided has not kept pace with the increase in population. Besides the limits of budgets, recruiting and retaining staff are also an issue for staffing levels.

More local public health departments are providing nursing services on a regular basis in 2005 than in 1997. As Figure 8 on page 27 illustrates, 58% of local health departments reporting in the 2005 survey, reported an increase in levels of correctional health services.

At any one moment on a weekday, there are approximately 60 nurses from local health departments working in correctional facilities. The average correctional health nurse is responsible for 64 inmates.

**Figure 8. Public health services in county correctional facilities during past five years**



Source: 2005 Correctional Health and Local Public Health Survey

As previously described in this report, **local health departments have a broader public health population-based role that focuses on health promotion and disease prevention and control.** For example, the public health role looks at systems level issues and seeks ways to promote healthy and safe communities and decrease criminal activity that leads to incarceration. Public health supports activities that contribute to breaking the cycle of recidivism. Unfortunately, it is often difficult to fulfill that role when much of the public health staff's time is spent on immediate acute care needs. Many correctional health nurses are required to spend their time providing individual medical services, not public health services. "It is like running an emergency room, not providing public health," as illustrated by the following actual report from a local health department:

Tuesday July 19<sup>th</sup> evening shift. One nurse on duty. Regular hours are 2:30 – 11pm. Nurse worked from 2:30pm to 1am. In addition to her regular duties of reviewing bookings, verifying medications, passing medications, etc., complicated inmates required extra time and attention.

- Two inmates in alcohol withdrawal requiring monitoring and medication administration. (Alcohol withdrawal requires extra 1:1 time from the nurse.) New inmate, diabetic with a tracheotomy.
- 88 year old with incontinence requiring assistance and development of a bladder program, came in with 2 shoe boxes full of medications.
- HIV positive inmate on complicated medication regime, also has glaucoma.
- Inmate with possible broken jaw needing assessment and x-ray.
- Female inmate needing supervision when on the medical unit pumping her breasts (needs privacy and an outlet and the medical unit is the only option). Corrections officers not available to supervise due to staffing.

There is a general **lack of release/discharge planning**. Many released inmates need help with their medications; they cannot (and often do not) follow-up with their medication regimes or health care management. Many released inmates need supervised living situations because they cannot manage by themselves.

“Inmates have no housing when they get out – we just get them back. We need to stop the revolving door.”

A new state law passed in 2005 that requires jail staff to do discharge planning for inmates who are diagnosed severely and persistently mentally ill (SPMI) and in jail for more than 90 days (see Appendix F). A template for a mental health release plan was created in December 2005 by the Department of Corrections for use in correctional facilities (see Appendix G).

There has been very **limited coordination or collaboration between correctional health stakeholders**, which has resulted in lost efficiency and support. The stakeholders include the Minnesota Department of Health (MDH), Department of Human Services (DHS), Department of Corrections (DOC), and the Department of Public Safety, county commissioners, county attorneys, county sheriffs, jail administrators, local social services, local health departments, and correctional health nurses. Each county entity also has a corresponding professional association: the Association of Minnesota Counties (AMC), the Minnesota Association of County Attorneys, the Sheriff Association and Division of Jail Administrators, the Minnesota Association of County Social Service Administrators (MACSSA), the Local Public Health Association (LPHA), and the American Correctional Health Services Association (ACHSA).

Innovative approaches to correctional health issues are being tried and found to be successful by public health departments. Some of these innovations were captured through the Correctional Health and Local Public Health Survey and are listed in Appendix H. A few approaches were discussed during the work group sessions as promising for the future. One of these was the use of a computerized documentation system for record keeping and tracking that would be consistent across the state. This would facilitate information sharing and continuity of services when inmates are transferred between facilities. Team discharge planning for individuals with mental illness has been very successful in Stearns and Olmsted Counties. Mid-level practitioners are being utilized and have greatly decreased trip expenses and personnel time for visits outside of the correctional facilities. Telemedicine is being pursued in a rural area with limited access to medical services. Public health departments have found the National Commission on Correctional Health Care's, “Standards for Health Services,” publication useful for establishing benchmarks for quality improvement and quality assurance purposes. Other correctional health resources available, both state and national, can be found in Appendix I.

## Recommendations

This report is intended to bring awareness of issues and gaps in correctional health to all stakeholders and policymakers. The issues cut across many levels and organizations and will take multi-agency collaboration to resolve. Listed below are 18 recommendations identified by the State Community Health Services Advisory Committee (SCHSAC) Work Group to begin the work of addressing the concerns highlighted in this report. While these recommendations are not sufficient to address the myriad of issues identified, they can maintain and perhaps accelerate the momentum of the multi-agency discussions that have begun and ultimately, lead to improvements in this increasingly problematic situation.

As lead public health agency for the state, the MDH plays a key communications role regarding a range of issues that affect the health of Minnesotans. **It is recommended that the Commissioner of Health and MDH take the following actions:**

1. Present the Correctional Health Work Group report to the SCHSAC and obtain feedback and suggestions for use of report.
2. Convene a meeting of state agency representatives with the Correctional Health Work Group to discuss the findings in the report. (Held on February 10, 2006.)
3. Arrange for a correctional health presentation or presentations at the annual Community Health Conference in the fall of 2006.
4. Develop and disseminate a PowerPoint presentation and talking points highlighting the findings of the Correctional Health Work Group, to be used by interested stakeholders.
5. Offer a presentation on correctional health for county commissioners via videoconference during one of the scheduled twice-yearly videoconference sessions.
6. Publish resources for correctional health, as they are shared by partners, in the Community Health Services Mailbag.

The Association of Minnesota Counties (AMC) is a leader in stimulating action on issues that affect counties. As an organization, it is well situated to serve as a convener and to work to address policy issues. Since the membership of AMC consists of counties and includes many SCHSAC representatives, these members are encouraged to approach AMC about taking action on correctional health issues. **Actions that AMC is uniquely situated to take include the following:**

7. Sponsor a Correctional Health Summit to bring greater awareness and attention to the various issues related to correctional health.
8. Provide a focal point for county discussions of correctional health policy issues (e.g. group purchasing options, statewide formulary).
9. Conduct a session on correctional health at the AMC Legislative Conference or Annual Conference to increase awareness of the issues surrounding correctional health and need for collaboration of efforts to resolve the issues. (Held on March 29, 2006.)
10. Work through the National Association of Counties on issues requiring federal action, such as financial coverage of health services provided to county correctional populations.

The Department of Human Services (DHS) administers the Medical Assistance program and provides instructions and support to county administered social service program staff. The complexities of discharge planning and medical coverage when transitioning to and from county correctional facilities may not be well understood by public health staff that work with inmates in the correctional facility. Additionally, it may be possible for state and local governments, in

collaboration, to improve efficiency and coverage for the local correctional population.

**Provision of care and discharge planning for county correctional populations could be enhanced if DHS takes the following actions:**

11. Provide information on rules governing medical coverage to interested partners.
12. Support the utilization of the newly created release planning template developed by the Department of Corrections for the severely and persistently mentally impaired (SPMI).
13. Work with counties to explore systems changes in the financing and delivery of health care to local correctional populations that will increase efficiency and/or reduce costs.

As noted throughout this report, local health departments have a significant role to play in correctional health, through both the broader population health responsibilities held by governmental public health jurisdictions; and through the provision of health services to inmates in many county correctional facilities. **Local health departments are encouraged to take the following actions:**

14. Distribute information on the options of medical care coverage before release in order to inform and assist those in need of continuity of medical services in the community, as well as to promote adjustment and reduce the likelihood of recidivism in the correctional system.
15. Implement the Essential Local Public Health Activities as they apply to correctional populations.
16. Use the Essential Local Public Health Activities framework outlined in this report as a resource when working with governing boards and local partners on the issue of local public health roles in correctional health.
17. Explore ways for public health departments to work collaboratively to address issues of common concern, such as the rising costs of medications and difficulties in recruiting and retaining correctional health nursing staff. The Local Public Health Association may be an appropriate venue to coordinate such discussions.

During the course of the SCHSAC Work Group process, the complexity of correctional health roles and responsibilities became apparent. The work group realized that it will take collaboration by a wide variety of stakeholders to address the issues that were identified, since there is no one organization that has overall responsibility. Therefore the following recommendation is made to all stakeholders in the hope that continued collaboration will occur—even though the details of “who” and “how” have not yet been addressed.

**18. All correctional health stakeholders are encouraged to:**

- Continue to share resources and include other stakeholders in discussions of issues of concern;
- Support efforts to study staffing levels in jails to assure safe and adequate staffing ratio of RNs to inmates;
- Explore options for making technical assistance and support available to nurses providing health care services in county correctional facilities; and
- Participate in developing longer term solutions and systems changes to address the important issues identified in this report.

# Appendices



## Appendix A

### MN Rules Chapter 2911 Availability of Medical and Dental Resources

#### ENVIRONMENTAL-PERSONAL HEALTH AND SANITATION

#### 2911.5800 AVAILABILITY OF MEDICAL AND DENTAL RESOURCES.

Subpart 1. **Availability of resources, general.** Under the direction of a health authority, a facility shall develop a written policy and procedure which provides for the delivery of health care services, including medical, dental, and mental health services.

Subp. 2. **Health care.** Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or qualified psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel. (Mandatory)

Subp. 3. **Health care policy review.** Facility policy shall ensure that each policy, procedure, and program in the health care delivery program is reviewed at least annually under the direction of the health authority and revised as necessary.

Review and revision of each policy, procedure, and program shall be documented.

Subp. 4. **Emergency health care.** A facility shall develop a written policy and procedure which requires that the facility provide 24-hour emergency care availability as outlined in a written plan, which includes provisions for the following arrangements: (Mandatory)

A. emergency evacuation of the inmate from within the facility;

B. use of an emergency medical vehicle;

C. use of one or more designated hospital emergency rooms or other appropriate health facilities;

D. emergency on-call physician and dental services when the emergency health facility is not located in a nearby community; and

E. security procedures that provide for the immediate transfer of inmates when appropriate.

Subp. 5. **Health care liaison.** In a facility without full-time qualified health care personnel, a designated staff member may act as liaison to coordinate the health care delivery in the facility under the direction of the health authority.

Subp. 6. **Medical screening.** A facility shall develop a written policy and procedure which requires that medical screening is performed by trained staff on all inmates on admission to the facility. The findings are to be recorded in a manner approved by the responsible physician. The screening process shall include procedures relating to: (Mandatory)

A. Inquiry into:

(1) current illness and health problems, including dental problems, sexually transmitted diseases, and other infectious diseases;

(2) medication taken and special health requirements;

(3) use of alcohol and other drugs which include types of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of problems that may have occurred after ceasing use, for example, convulsions;

(4) past and present treatment or hospitalization for mental illness or attempted suicide; and

(5) other health problems designated by the responsible physician.

B. Observations of:

(1) behavior which includes state of consciousness, mental status, appearance, conduct, tremor, and sweating; and

(2) body deformities, trauma markings, bruises, lesions, and jaundice.

C. Disposition to:

(1) general population;

- (2) general population and referral to appropriate health care service;
- (3) referral to appropriate health care service on an emergency basis; and
- (4) other.

Subp. 7. **Health appraisal.** A facility shall develop written policy and procedures which require that an inmate who presents with a chronic or persistent medical condition be provided with a health appraisal within 14 days of admission.

The health appraisal includes the following:

- A. review of the receiving screening in subpart 6;
- B. collection of additional data to complete the medical, dental, psychiatric, and immunization histories;
- C. recording of height, weight, pulse, blood pressure, and temperature;
- D. administration of other tests and examinations as appropriate; and
- E. initiation of treatment when appropriate.

Subp. 8. **Health complaints.** A facility shall develop a written policy and procedure which requires that inmates' health complaints are acted upon daily by health-trained staff, followed by triage and treatment by health care personnel if indicated. (Mandatory)

Subp. 9. **Sick call.** A facility shall develop a written policy and procedure which requires that there is a continuous response to health care requests and that sick call, conducted by a physician or other health care personnel is available to each inmate as follows:

- A. in small facilities of less than 50 inmates, sick call is held once per week at a minimum;
- B. in medium sized facilities of 50 to 200 inmates, sick call is held at least three days per week;
- C. in facilities of over 200 inmates, sick call is held a minimum of five days per week; and
- D. if an inmate's custody status precludes attendance at sick call, arrangements are made to provide sick call services in the place of the inmate's detention.

Subp. 10. **Infirmary.** Operation of an infirmary within a facility: male and female inmates may be housed in separate rooms in a common infirmary area. Direct staff supervision of the infirmary must be provided at all times when male and female inmates reside in the infirmary.

Subp. 11. **Examinations.** Examinations, treatments, and procedures affected by informed consent standards governed by state or federal law shall be observed for inmate care.

(Mandatory)

The informed consent of the parent, guardian, or legal custodian must be obtained when required by law.

Where health care treatment must be provided against an inmate's will, it must be provided according to law.

Subp. 12. **Ambulance services.** Ambulance services shall be available on a 24-hour-a-day basis.

(Mandatory)

STAT AUTH: MS s 241.021

HIST: 23 SR 1834

### **Infectious Disease Section**

#### **2911.7000 TUBERCULOSIS SCREENING; SEPARATION OF INMATES WITH INFECTIOUS DISEASE.**

Subpart 1. **Separation.** A facility shall develop a written policy and procedure which will address the management of serious and infectious diseases. This policy and procedure shall be updated as new information becomes available. (Mandatory)

Subp. 2. **Screening.** Employees and inmates shall be screened for tuberculosis according to Minnesota Statutes, section 144.445. The Department of Corrections adopts by reference Minnesota Department of Health requirements for tuberculosis screening of employees and inmates in facilities governed by this chapter. (Mandatory)

STAT AUTH: MS s 241.021 HIST: 23 SR 1834

(For the complete document visit: <http://www.revisor.leg.state.mn.us/arule/2911/>)

## Appendix B

### Definitions of Local Adult Correctional Facilities by Class

Rule 2911 address multiple classes of facilities for adults, which include:

Class I Facility	Holding Facility (72 hour hold) – means a secure adult detention facility used to confine prisoners, prior to their appearance in court, for a time not to exceed 72 hours excluding holidays or weekends.
Class II Facility	Lockup Facility (90 day lockup) – means a secure adult detention facility used to confine prisoners for a time not to exceed 90 days.
Class III Facility	Jail Facility (Jail) – means a secure adult detention facility used to confine sentenced prisoners for a time not to exceed one full year per conviction, adult pretrial and pre-sentence detainees indefinitely, and juveniles up to limits prescribed by Minnesota statute and commissioner approval.
Class IV Facility	Jail Annex (Annex) – means a minimum-security adult detention facility used to confine sentenced inmates for a time not to exceed one full year per conviction and/or pre-sentenced detainees indefinitely.
Class V Facility	Adult Detention Facility (ADF) – means a secure detention facility used to detain adult pretrial and pre-sentenced detainees indefinitely.
Class VI Facility	Adult Correctional Facility (ACF) – means a facility used to confine sentenced inmates for a time not to exceed one full year per conviction.

(Note: Rules governing children’s residential facilities are contained in MN Rules Chapter 2960.)

## Appendix C

### Essential Local Public Health Activities: Local Public Health’s Role in Correctional Health

- Assure an adequate local public health infrastructure**
- Promote healthy communities and healthy behaviors**
- Prevent the spread of infectious diseases**
- Protect against environmental health hazards**
- Prepare for and respond to disasters, and assist communities in recovery**
- Assure the quality and accessibility of health services**

#### Assure an adequate local public health infrastructure.

Essential Local Public Health Activities	Application to Correctional Health
<ul style="list-style-type: none"> <li>➤ Assess and monitor community health needs and assets on an ongoing basis.</li> <li>➤ Work with community members and key community partners, including communities of color, tribal representatives, and people with special needs, to identify community health and prevention priorities.</li> <li>➤ Every five years, develop an action plan with evaluation measures and recommended policy options to put essential local activities in place and address local priorities.</li> <li>➤ Convene community members and key community partners (including communities of color, tribal representatives, and people with special needs) to build community collaborations, determine roles, identify and leverage community assets/resources and participate in research that benefits the community, as resources allow.</li> <li>➤ Advocate for policy changes needed to improve the health of populations and individuals.</li> <li>➤ Lead or participate in community efforts that support and encourage physical, economic, and social health.</li> <li>➤ Designate, recruit, train and retain local public health staff.</li> <li>➤ Recruit local public health staff who reflects the cultures and ethnicities of the community.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Include the correctional population in the community assessment and action planning process:               <ul style="list-style-type: none"> <li>○ What information is available regarding the health problems of incarcerated individuals in the correctional population?</li> <li>○ What are the health problems of the correctional population?</li> <li>○ Are there health needs that are not being met? Who could best provide these services?</li> <li>○ What is the appropriate allocation of resources to address those needs?</li> <li>○ Would county resources be better utilized by providing prevention education to the correctional population?</li> </ul> </li> <li>➤ Work with community partners and stakeholders to develop strategies for programs to meet the multiple health needs of the correctional population, including appropriate placement at release.</li> <li>➤ Provide nursing students an overview of Correctional Health during PH clinicals.</li> </ul>

\* Correctional population includes incarcerated, detainees, juveniles, night residents

## Promote healthy communities and healthy behaviors.

Essential Local Public Health Activities	Application to Correctional Health
<ul style="list-style-type: none"> <li>➤ Engage the community on an on-going basis to promote healthy communities and behaviors through activities including, but not limited to: a) assessment, prioritization and developing actions plans; b) coalition building; c) community readiness; d) empowerment; and e) decision-making.</li> <li>➤ Based on community assessment, resources, and capacity:               <ul style="list-style-type: none"> <li>○ Develop action plans to promote healthy communities and healthy behaviors; and</li> <li>○ Conduct evidence-based, culturally sensitive programs, and disseminate information on services and resources to promote healthy communities and healthy behaviors. (Healthy communities and healthy behaviors include issues such as physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STDs, mental health, maternal and child health, and/or the prevention of injury and violence.)</li> </ul> </li> <li>➤ Inform and educate different audiences, such as the public, providers, and policy leaders, about healthy communities and population health status.</li> <li>➤ Support the development and enforcement of policies, and encourage cultural norms, that promote healthy communities and healthy behaviors.</li> <li>➤ Participate in local decisions about community improvement and development, to promote healthy communities and healthy behaviors.</li> <li>➤ Promote optimum quality of life across the lifespan, such as healthy growth and development, healthy aging, and the effective management of chronic diseases.</li> <li>➤ Identify and address the needs of vulnerable populations, such as: high-risk pregnant women, mothers, and children; the frail elderly; persons with mental illness; and people experiencing health disparities.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Based on community assessment, resources, and capacity, work with community partners and stakeholders to develop action plans to promote healthy behaviors such as physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS, sexually transmitted infections, mental health, maternal and child health, and the prevention of injury and violence in the correctional population.</li> <li>➤ Inform and educate county boards, community health boards, sheriffs, and other community partners about the health status and health risks of the correctional population.</li> </ul>

## Prevent the spread of infectious diseases.

Essential Local Public Health Activities	Application to Correctional Health
<ul style="list-style-type: none"> <li>➤ Work with providers and other community partners to facilitate disease reporting and address problems with compliance.</li> <li>➤ Assess immunization levels and practice standards in the community and promote and/or provide age-appropriate immunizations.</li> <li>➤ Assess infectious disease risks in the community, inform the community about those risks and assure appropriate interventions.</li> <li>➤ Based on disease surveillance information, develop strategies and plans to detect and respond to infectious disease problems and outbreaks in the community.</li> <li>➤ Assist and/or conduct infectious disease investigations with the MDH.</li> <li>➤ When data indicates an imminent outbreak or epidemic of infectious disease, implement appropriate local disease control programs, including but not limited to mass treatment clinics, mass immunization clinics, and isolation and quarantine.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Conduct ongoing surveillance for infectious diseases, including tuberculosis, hepatitis, AIDS/HIV, sexually transmitted infections.</li> <li>➤ Conduct Mantoux testing on all inmates incarcerated more than 14 days.</li> <li>➤ Work with local physicians on the treatment and follow-up of positive TB testing.</li> <li>➤ Assure follow-up continues upon release.</li> <li>➤ Detect and respond to infectious disease problems and outbreaks in the inmate population, including hepatitis, AIDS/HIV, sexually transmitted infections, pediculosis, scabies, Methicillin-resistant <i>Staphylococcus Aureus</i> (MRSA).</li> <li>➤ Assure isolation and separation policies and procedures are in place.</li> <li>➤ Assure that reportable infectious diseases occurring in correctional setting are reported in a timely and accurate manner.</li> <li>➤ Immunize correctional population as appropriate.</li> <li>➤ Conduct testing and follow-up for sexually transmitted infections.</li> </ul>

## Protect against environmental health hazards.

Essential Local Public Health Activities	Application to Correctional Health
<ul style="list-style-type: none"> <li>➤ Provide the public and policy leaders with information on health risks, health status, and environmental health needs in the community, as well as information on policies and programs regarding environmental health threats to humans.</li> <li>➤ Identify the federal, state, tribal or local agencies with regulatory authority and bring people together to address compliance with public health standards.</li> <li>➤ Develop public health nuisance policies and plans, and assure enforcement of public health nuisance requirements.</li> <li>➤ Monitor the community for significant and emerging environmental health threats, and develop strategies to address these threats.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Provide consultation regarding environmental health hazards in the correctional setting for issues such as methamphetamine contamination, sharp disposals, storage and use of chemicals, blood and body fluid exposures.</li> <li>➤ Provide follow up/enforcement for OSHA regulations.</li> </ul>

**Prepare for and respond to disasters, and assist communities in recovery.**

<b>Essential Local Public Health Activities</b>	<b>Application to Correctional Health</b>
<ul style="list-style-type: none"> <li>➤ Provide leadership for public health preparedness activities in the community by developing relationships with community partners at the local, regional, and state levels.</li> <li>➤ Conduct or participate in ongoing assessments to identify potential public health hazards and the community’s capacity to respond.</li> <li>➤ Develop and periodically review a plan to respond to all potential public health threats.</li> <li>➤ Conduct activities to detect patterns of unusual events, and implement appropriate actions.</li> <li>➤ Participate in activities during a drill or actual emergency.</li> <li>➤ Make sure staff are trained and prepared to respond to public health emergencies.</li> <li>➤ Develop and implement a system to provide timely, accurate and appropriate information, in a variety of languages and formats, to elected officials, the public, the media, and community partners in the event of a public health emergency.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Assist with the development of emergency policies, procedures, and plans.</li> <li>➤ In collaboration with correctional staff, develop and participate in preparedness exercises, such as tabletops and drills.</li> <li>➤ Assure that public health staff who work in correctional settings are trained in emergency polices and procedures.</li> </ul>

**Assure the quality and accessibility of health services.**

<b>Essential Local Public Health Activities</b>	<b>Application to Correctional Health</b>
<ul style="list-style-type: none"> <li>➤ Identify gaps in the quality and accessibility of health care services.</li> <li>➤ Based on the on-going community assessment, inform and educate the public and providers about the quality and accessibility of health care services in the community.</li> <li>➤ Lead efforts to establish and/or increase access to personal health services, including culturally competent preventive and health promotion services, as identified in the planning process.</li> <li>➤ Promote activities to help people in the community find the health services they need.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Advocate to policy makers regarding the need for and benefit of providing preventive services in correctional settings.</li> <li>➤ Work with federal and state health and corrections agencies on the development of legislation and rules that affect the health of the correctional population (MA reimbursement, medication purchasing).</li> <li>➤ Facilitate coordination between the correctional, public health, human services, and medical care systems to assure continuity of medical, dental and mental health services (including medications) upon release.</li> </ul>

## Appendix D

### Summary of Issues Reported By Correctional Health Nurses at Regional Meetings August 2005

#### Health Issues

##### 1. Methamphetamine (Meth) Use

- For many jails, number one issue; an “epidemic of meth”
- Takes 4 –6 weeks to withdraw from meth (as compared to 5-7 days for alcohol)
- Often come in violent, difficult to detox
- Debilitating, permanent irreversible brain damage in long term users
- No end in sight

“70 – 80% of our population is there because of meth”

“In the Chemical Dependency assessment at jail, 9 out of 10 mention meth”

“If you don’t know how to cook meth when you come to jail, you’ll know when you leave here”

##### 2. Mental Illness

- Dramatic increase in number of mental health issues and psychiatric conditions
- Increase in the number of inmates who are persistently and severely mental ill
- Lack of mental health services
- Lack of mental health providers
- Psychiatrists basically manage medications, no psychological counseling services for mentally ill inmates
- No place to place persistently and severely mentally ill – hospital won’t take, detox inappropriate (special concern with Willmar’s impending shutdown)

“Mentally ill inmates are sent back into the community and being discharged to the street”

“No place wants inmates who are psychotic “

“We need a unit for inmates with mental illness.”

##### 3. Dental Needs

- Severe lack of dental providers who will see inmates
- Very limited access to dental services
- Dental services provided for severe pain and abscesses only
- Extraction only – no restorative services (one county reports their cost of an extraction is \$189 plus cost of deputy)
- Meth users often come in with teeth broken off at the gum line; the standard for “meth mouth” is extraction
- Access to oral surgeons (one county reported that there is only one dentist in town who will see inmates for regular services; an extraction requires a referral to an oral surgeon located in the nearest large city, which involves transportation and security costs as well)

##### 4. Chronic Conditions and Medical Issues

- Increasing number of inmates with serious medical issues (for example, diabetes, hypertension, kidney failure, cancer)

- Increased need for disease management ranging from dialysis three times a week to complicated insulin regimes
- Dramatic increase in the demand for diabetes management, particularly with American Indian inmates
- Inmates with major medical problems that result in huge medical bills

## 5. Infectious Diseases

- Increase in number of inmates with infectious diseases
- Increase in numbers of positive Mantoux (TB treatments are often complicated by the fact that a person needs to have a good liver to take INH [TB meds] and inmates with chronic alcohol use often do not have good livers)
- Increase in hepatitis (similar situation for the TB meds; inmates with hepatitis often also do not have good livers)

## 6. Chemical Use/Abuse

- Chronic, regular alcohol usage very high among inmates (correctional health nurses report seeing inmates who are actually undiagnosed FAS/FAE)
- Multiple chemical use – heroin, cocaine, alcohol, meth, ecstasy - don't know how to treat
- Need to detox in correctional setting because crisis unit will often not take them – need protocols

## Correctional Health Infrastructure

### 1. Escalating Costs of Correctional Health Programs and the Need for Cost Containment in the Face of Increasing Needs

- Payment issues: Who pays?
- MA reimbursement cut off day after enter jail;
- Need to limit county responsibility for medical costs to MA rates rather than full costs for hospitalization
- VA reimbursement has also been cut off as of August 1

### 2. Medication Costs

- Huge increase in the number of medications for inmates
- Dramatic increase in number of inmates on psychotropic medications
- Skyrocketing costs of psychotropic drugs
- Costs of diabetes drugs
- The recommendation for people on psychotropic medications is that they need to have their lab values checked every three months; this is not happening

“Increase in psychiatric conditions – half of our inmates are on psychotropic meds”  
 “We had an inmate with AIDS whose medications cost \$3500 per month.  
 We spent over \$100,000 on one inmate.”  
 “Many of our inmates have 6-12 medications.”

### 3. Medication Administration

- Accountability and legal responsibility: one county reported that they only do medication administration training and Mantoux tests; the jailer is making medical decisions. What is there accountability in this situation?

- Medication administration is a nursing function delegated under whose license? Who is responsible for assuring that the right medication is administered in the right dose at the right time to the right inmate?
- Medication issues take up so much time. “I spend all day making calls”
- Cannot have a stock of medication in the jail; this is problematic, especially for larger jails
- Inmates present with medications prescribed prior to incarceration: some are medications not allowed in the jail. Inmates also often come in with medications outdated, may not have been seen by physician in a year. They see a local doctor, who then prescribes different medications
- Medication errors and charting issues
- Who teaches medication administration; correctional health nurses need a standardized medication administration training curriculum
- Jails needs data systems that are usable and can track pharmaceutical costs

#### **4. Entitlement Culture**

- Changing cultural expectation of inmates: entitled “to be cared for”
- Inmates smarter about the law – prisoners’ savvy – “You have to take care of me.”
- Inmates constantly threaten litigation; real fear of being sued (For example, an existing lawsuit over an inmate’s constitutional right to narcotics)

“Providers are afraid of getting sued so they do things they wouldn’t do for their own kids.”  
 “Make everybody happy and avoid law suits”

#### **5. Lack of Release/Discharge Planning**

- Many released inmates need help with their medications; they cannot (and often do not) follow-up with their medications
- Many released inmates need supervised living situation because these folks cannot manage by themselves
- There is a state law that requires that if an inmate is diagnosed mentally ill and in jail for >90 days, they must have a discharge plan
- Counties are trying to work in this area; Stearns has a program, Douglas bartered for the services of a social worker to work with inmates

“Inmates have no housing when they get out – we just get them back.”  
 “We need to stop the revolving door”

#### **6. Changing Jail Populations**

- Higher proportion of American Indian, Mexican, Laotian population
- Many more women in the jails (related to meth use)
- Younger, not local, involving meth
- Elderly alcoholics – (70’s – 91 years old)

#### **7. Practice Issues**

- Lack of support for correctional health nurses; need a structure to support nurses in independent setting
- Need practical standards for care
- Security and staff safety issues
- Roles – who is responsible for what?
  - Who has medical authority over inmate?

- What is public health authority in the jail?
- Security function versus health functions
- Control of jail health record?
- Responsibility for health care during furlough

This is a summary of discussions with correctional health staff at the following regional correctional health meetings:

- Southeast (Rochester), March 15, 2005
- Metro (Roseville), March 15, 2005
- Northwest (Bemidji), April 1, 2005
- Central (St. Cloud), March 29, 2005
- Southwest (Montevideo), March 16, 2005
- Northeast (Grand Rapids), March 17, 2005

“Correctional health nursing is different from other area of nursing practice. It requires clear boundaries, the ability to say no, someone firm, the ability to discern lying and manipulation.”  
Why do you practice correctional health nursing? “I get to assess the whole person, not just use my skills.”

## Appendix E

### Eligibility for Minnesota Health Care Programs

In general, people who reside in a secure correctional facility are ineligible for Minnesota public health care programs during the time they are incarcerated. However, Minnesota health care programs eligibility rules are somewhat different in each of the three programs as described below. All inmates scheduled for release from a correctional facility may apply for a Minnesota health care program 45 days before their release date. The county agency may determine eligibility prior to the inmates release and, if found eligible, coverage will begin on the date the inmate is released.

Following is a brief description of how incarceration affects eligibility in each of the three Minnesota health care programs.

#### Medical Assistance (MA)

- Persons residing in a secure correctional facility are not eligible for MA regardless of their age.
- A person who is serving a sentence but participating in a work release program while living in the **community** may be eligible for MA. These individuals may be residing in their own home (even when subject to electronic monitoring), half-way house, or other non-secure residence. (A person approved for work release from prison by the Commissioner of the Department of Corrections but who resides at the county jail or a person serving a sentence at a county jail, approved for daily work release but who must return to the county jail or other secure corrections facility when not working is not eligible for MA).
- Persons who are enrolled in MA at the time they become incarcerated are terminated beginning the first month that the county agency can give them ten day notice of termination.

#### General Assistance Medical Care (GAMC)

Persons residing in a secure correctional facility are not eligible for GAMC unless:

- Detainment will be for no more than 12 months in a county correctional or detention facility, or the person is an inpatient in a hospital on a criminal hold order;  
AND
- The person was enrolled in GAMC at the time of detention or admission to the hospital on a criminal hold order;  
AND
- The person is otherwise eligible for GAMC.

#### MinnesotaCare

- Persons who reside in adult correctional facilities are ineligible for MinnesotaCare regardless of their age.
- Persons who are enrolled in MinnesotaCare at the time they become incarcerated continue to be eligible for MinnesotaCare until their next eligibility renewal.

## Appendix F

### Discharge Planning For Serious and Persistent Mental Illness (SPMI)

(From First Special Session Chapter 4, HF139 (HHS omnibus bill) Article 2, Section 18)

The commissioner of corrections shall develop a model  
102.3 discharge planning process for every offender with a serious and  
102.4 persistent mental illness, as defined in section 245.462,  
102.5 subdivision 20, paragraph (c), who has been convicted and  
102.6 sentenced to serve three or more months and is being released  
102.7 from a county jail or county regional jail.  
102.8 An offender with a serious and persistent mental illness,  
102.9 as defined in section 245.462, subdivision 20, paragraph (c),  
102.10 who has been convicted and sentenced to serve three or more  
102.11 months and is being released from a county jail or county  
102.12 regional jail shall be referred to the appropriate staff in the  
102.13 county human services department at least 60 days before being  
102.14 released. The county human services department may carry out  
102.15 provisions of the model discharge planning process such as:  
102.16 (1) providing assistance in filling out an application for  
102.17 medical assistance, general assistance medical care, or  
102.18 MinnesotaCare;  
102.19 (2) making a referral for case management as outlined under  
102.20 section 245.467, subdivision 4;  
102.21 (3) providing assistance in obtaining a state photo  
102.22 identification;  
102.23 (4) securing a timely appointment with a psychiatrist or  
102.24 other appropriate community mental health providers; and  
102.25 (5) providing prescriptions for a 30-day supply of all  
102.26 necessary medications.

## Appendix G



Phone: 651-642-0200 Fax: 651-642-0223

### Health Services Unit MENTAL HEALTH RELEASE PLAN

Offender Name:	OID:	MCF:
DOB:	SSN:	Veteran Status:
MH Release Planner:		Release Date:
		Release Type: Supervised
Expiration Date:	Conditional Release Date:	Transportation upon release to be provided by:

Agency/Contact Name	Address/ Phone/ Fax/ Plan
Community Corrections Agent:	
MN Department of Economic Assistance - MA Financial Worker:	
Community Social Worker:	
Financial Benefits – Social Security Claims Representative:	
Housing Placement: Private Residence	
Outpatient Psychiatrist:	

Outpatient Psychology:			
Community Treatment Program: SO/CD/MI-CD			
.			
Additional Community Supports: Friends/Family			
	Diagnosis: Axis I: Axis II: Axis III: Axis IV: Axis V GAF:		
<b>Current Medications:</b>	<b>Dosage:</b>	<b>Frequency:</b>	<b>Ordered By:</b>

**Prevention Plan**

Attend all Psychiatric and therapy appointments.  
Take your medication as prescribed.  
Follow the conditions of your parole and keep your parole agent informed of your activities (Mental health treatment, changes in housing, employment, etc).  
Do not associate with people who do not support your sobriety.  
Work closely with your county caseworker, corrections agent, and mental health professionals in problem solving and managing your mental health.  
Attend weekly support and therapy groups.  
Do not use alcohol or drugs.  
Build a support network with family and friends.  
Participate in weekly self-help groups focusing on MI/ C.D. issues.  
Contact your County Social Worker and request assistance with housing if you become homeless.  
Follow all the rules and expectations of your housing authority.

**I have read and understand this treatment plan.**

Offender Signature:

Date:

Release Planner Signature:

Date:

## Appendix H

### Minnesota Innovations in Service Delivery

	<b>What are some successes or innovations that your health department has experienced in your correctional health program?</b>
Carver	Hep B Vaccine Program for Inmates University of Minnesota Nursing Students Survey identifying Health Education priorities Consistency in staffing, nursing and clerical
Meeker	Continuity in presence of same jail nurse & MD Good cooperation between medical & corrections staff. Improved communication between med. & correction staff. Improvement in teaching in some areas - e.g. LTBI, TB, STD's, pregnancy prevention.
Sibley	New tracking system for Mantoux and health appraisals
Inter Co. Nursing Service	Use one clinic that has two physicians who have experience with prison populations One physician will make visits to the jail Psych unit will also send staff to jail
Hubbard	"Keeping inmates out of the clinic" was used as a way to get time out of the jail setting.
Goodhue	Doctor comes to the facility 2x per week Having x-ray come to the jail for chest x-rays, etc. has helped not having to transport detainees to local clinic
Itasca	Full time position Unit dosing for meds
Polk	Electronic/computerized documentation system at jail nurse training with state & local jail health group
Stearns	Monthly meetings with jail Admin. To discuss issues Release Advance Planning Team Adding public health to the criminal justice coordinating committee Priority inmate reporting process Primary nursing for difficult inmates.
Wadena	Use of PH Doc Jail Health Software to secure the health data & efficiency in charting
Mille Lacs	We almost had a contract with the local mental health facility to assess our inmates. Increasing the nurse time to 40 hrs/week (92 bed facility) decreased the number of visits to Dr. office.
Douglas	Improved medication management and delivery for staff and inmates.
Isanti	Partnering with 5 county mental health & their nurse practitioner for MH assessments & medication monitoring, but time is very limited.
Pine	Updated policies and procedures for jail health. Increase in staff trainings. Jail nurses assisted in security auto D-fib machine for deputies and county courthouse. Improved medication administration system and procedures. Increase in weekly hours for jail nurse in order to meet increased need.
Scott	TB tracking; assisted writing policies, procedures, and protocols
Houston	Standing orders; nursing assessment; pharmacy set up bubble medication packs

Anoka	1. Utilizing PHNs and Disease Prevention and Control staff to assist with completion of 14-day health assessments. 2. D/C planning for pregnant women with referral to public health nurses. 3. Establishing periodic mental health meetings with Mercy Hospital. 4. Utilizing professional consultation and training from select contracted vendors. 5. Obtaining statutory language to allow M.A. rate payments for medical services. 6. Utilizing outside consultant for QA/QI efforts to improve data collection and reduce medical administration errors by non-medical staff. 7. Use of accreditation standards and recommended policies from National Commission on Correctional Health Care – also acts as a benchmark for our department QA/QI initiative. 8. Over the counter meds available for purchase through canteen and from med cart. 9. Instituting additional contract for nursing services from private vendor to supplement or cover shifts due to staff turnover, and use of FTO. 10. Utilizing PHNs to assist with completion of 14-day health assessments & TD screening. OTC meds available for purchase through canteen & from med cart.
Olmsted	All staff are PHN/RN who do only correctional health & have a highly developed team practice. Mental health team (nurses, psychologist, social worker, psychiatrist NP). Excellent pharmaceutical supply & delivery system. First rate health care. No suicides in history of facility. Support of county administrator to provide health services. Good relationship w/community resources to make referrals and do discharge planning.
Ramsey	Partnering with other sections in our health department to provide STI screening and Family Planning within the facilities. Contracting for on-site services, e.g. x-ray, dialysis. Regional Correctional Health meetings, sharing of information. Coordination of Health Services between Community Corrections and Sheriffs Departments. Successful partnerships between Health Service and Security staffs.
Rice	Public Health & Rice Co. social services staff offer a parenting education program for jail residents. Most attendees are men and the program has been well received.
McLeod	We have an excellent working relationship with correctional staff. We teach the inmates that medical care is available when it is urgent/emergent. The implementation of co-pays for OTC meds and sick call to the nurse has eliminated much of the unnecessary/time consuming consults to inmates who are really not ill.
Washington	Increasing effectiveness in discharge planning. Our county has a multi disciplinary group that meets with 2 months. We have been meeting for 2-3 years & we have improved communication with court & social services. This is especially important with the mentally ill population who need meds.
Winona	The county sheriff, jail administrator and other lead staff requested public health nurse input to new detention facility for nursing visit needs. They also consulted CHS/PHNs for supplies and equipment.
Dakota	1. Reducing medication costs by use of a formulary for mental health (psychotropic) medications. 2. Good coordination with sheriffs department for care of high cost, high medical needs of inmates. 3. Updating medical policies/protocols. 4. Closing down the medical unit at lunch time so nurses can get off the unit together and be assured a lunch break.
Beltrami	Hired Nurse Practitioners with specialty in mental health, part-time. This has decreased outside trips and provided expanded health services and health management. PHNs have been trained and complete CD assessments.

Source: Local Public Health Department Survey Responses

# Appendix I

## Correctional Health Resources

### Minnesota Resources

#### **MN Chapter of American Correctional Health Services Association**

Jeanne Schumacher 651-430-7935, [Jeanne.schumacher@co.washington.mn.us](mailto:Jeanne.schumacher@co.washington.mn.us)

Jeff Allen, 651-266-1424, [jeff.allen@co.ramsey.mn.us](mailto:jeff.allen@co.ramsey.mn.us)

Offers training for medication administration curriculum, Medications Delivery Curriculum for Detention and Corrections Officers

#### **Minnesota Department of Corrections**

Inspection and Enforcement Unit, Telephone: 651-643-3447

Sample Policies and Procedures for jails

#### **Minnesota Department of Corrections**

Policy and Instructions Manual for Prisons web site:

[http://www.doc.state.mn.us/DOcpolicy2/html/DPW\\_toc.asp](http://www.doc.state.mn.us/DOcpolicy2/html/DPW_toc.asp)

#### **Minnesota Department of Health**

Infectious disease and environmental health information and resources

<http://www.health.state.mn.us/>

### National Resources

#### **American Correctional Association**

<http://www.aca.org/>

#### **American Correctional Health Services Association**

<http://www.achsa.org/index.cfm>

#### **American Nurses Association**

Scope and Standards of Nursing Practice in Correctional Facilities

<http://www.statepen.org/ana.htm>

#### **Centers for Disease Control and Prevention**

##### **Correctional Health**

<http://www.cdc.gov/nchstp/od/ccwkg/default.htm>

#### **Massachusetts Public Health Association**

A Public Health Model for Correctional Health Care

<http://www.mphaweb.org/hccc.html>

#### **National Commission on Correctional Health Care**

Phone: (773) 880-1460 Email: [ncchc@ncchc.org](mailto:ncchc@ncchc.org)

URL: <http://www.ncchc.org>

#### **University of Texas Medical Branch: Correctional Managed Care/Digital Medical Services**

<http://www.utmb.edu/cmc/Services/Digital/Default.asp>







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**Revised Report  
April 2006**