GENERAL DISTRIBUTION

WEST VIRGINIA
DIVISION OF CORRECTIONS
& REHABILITATION

NUMBER: 410.00

EFFECTIVE DATE: 04 August 2026

SUBJECT: HEALTH CARE SERVICES IN PRISONS AND COMMUNITY CORRECTIONS FACILITIES

POLICY DIRECTIVE

PURPOSE:

To provide policy and procedure ensuring inmates have unimpeded access to a continuum of health care services so that their health care needs, including prevention and health education, are met in a timely and efficient manner; to ensure health services are provided in a professionally acceptable manner including the requirement that all staff be adequately trained and qualified and can demonstrate competency in their assigned duties; and to ensure health care services are evaluated and continually improved.

REFERENCE:

WV Code §§25-4-7 and 28-1-2; National Commission on Correctional Health Care (NCCHC) Standards; and ACA Expected Practices:

- 5-ACI-2A-03,
- 5-ACI-6A-01, 03 through 05, 07 through 11, 17 through 22, 25, 27, 40 through 41, and 43,
- 5-ACI-6B-01 through 04, 07 through 12,
- 5-ACI-6C-02 through 06, 10 through 11, and 15,
- 5-ACI-6D-01 through 10,
- 5-ACI-6E-02 through 04; and
- 2-CO-4E-01.

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject including DCR Policy Directive 410.00, dated 07 October 2022.

APPLICABILITY:

All prisons and community corrections facilities within the Division of Corrections and Rehabilitation (DCR). This Policy is available for general distribution.

DEFINITIONS:

Health Care Professional: As provided by the American Correctional Association (ACA), staff who perform clinical duties, such as health care practitioners, nurses, licensed professional counselors, social workers, and emergency medical technicians in accordance with each health care professional's scope of training and applicable licensing, registration, certification, and regulatory requirements.

Infirmary: A specific area within an institution, separate from other housing areas, where inmates are admitted for skilled nursing care under the supervision and direction of a health care practitioner/provider.

POLICY:

I. Comprehensive healthcare, including, but not limited to, medical, mental health, dental, optometry, auditory, pharmaceutical, and diagnostic services, is provided to all offenders in the care and custody of Division of Corrections and Rehabilitation (DCR) through a contractual agreement with a vendor. The standard of care complies with National Commission on Correctional Health Care (NCCHC) standards and prevailing professional practices.

II. Each facility has a designated health authority with responsibility for ongoing health care services pursuant to a written agreement, contract, or job description. The health authority may be a physician, health services administrator, or health agency. When the health authority is other than a physician, final clinical judgements rest with a single, designated, responsible physician. The health authority is authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program. The Health Services Administrator (HSA) is designated as the health authority. The responsibilities of the HSA include:

A. Establish a mission statement that defines the scope of health care services.

B. Establish measurable goals and objectives that are reviewed at least annually and an internal system for assessing the achievement of goals and objectives and document the findings. Program changes are implemented, as necessary, in response to findings.

C. Develop mechanisms, including written agreements, when necessary, to assure that the scope of services is provided and properly monitored.

D. Develop a facility's operational health policies and procedures and review at least annually and revise if necessary.

E. Identify the type of health care staff needed to provide the determined scope of services.

F. Establish systems for the coordination of care among multidisciplinary health care providers.

G. Develop a system of documented internal review of health care services and quality management program. The necessary elements include:

1. A multidisciplinary quality improvement committee.

2. Collecting, trending, and analyzing data combined with planning, intervening, and reassessing.

3. Evaluating defined data, which will result in more effective access, improved quality of care, and better utilization of resources.

4. Onsite monitoring of health service outcomes on a regular basis through:

   a. Chart reviews by the responsible physician or his/her designee, including investigation of complaints and quality of health records.

   b. Review of prescribing practices and administration of medication practices.

   c. Systematic investigation of complaints and grievances.

   d. Monitoring of corrective action plans.

5. Reviewing all deaths in custody, suicides or suicide attempts, and illness outbreaks.

6. Implementing measures to address and resolve important problems and concerns identified (corrective action plans).

7. Reevaluating problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired results.

8. Incorporating findings of internal review activities into the organization's educational and training activities.

9. Maintaining appropriate records (i.e., meeting minutes) of internal review activities.

10. Issuing a quarterly report to the HSA and superintendent of the findings of internal review activities.

11. Requiring a provision that records of internal review activities comply with legal requirements on confidentiality of records.

III. At the time of admission/intake all inmates are informed about procedures to access health services, including any copay requirements, as well as procedures for submitting grievances. Medical care is not denied based on an inmate's ability to pay. This information is communicated orally and in writing and is conveyed in a language that is easily understood by each inmate. The information is translated into those languages spoken by significant numbers of inmates. When a literacy or language problem prevents an inmate from understanding written information, a staff member or translator assists the inmate.

IV. There is a process for all inmates to initiate requests for health services on a daily basis. Each facility provides a secure collection point for health service request forms. These requests are triaged daily by qualified health care professionals. A priority system is used to schedule clinical services. Clinical services are available to inmates in a clinical setting at least five (5) days a week and are performed by a health care practitioner or other qualified health care professional. Health care request forms are readily available to all inmates.

V. Health care services are provided by qualified health care staff whose duties and responsibilities are governed by written job descriptions, contracts, or written agreements approved by the HSA. All professional staff comply with applicable state and federal licensure, certification, or registration requirements. Verification of current credentials and job descriptions are on file in the facility.

A. When facilities do not have qualified health care staff available, health-trained personnel coordinate the health delivery services in the facility under the joint supervision of the responsible health authority and the superintendent.

B. A documented peer review program for all health care practitioners/providers. Additionally, an external peer review program for physicians, mental health professionals, and dentists is implemented with the review conducted no less than every year.

C. Each facility uses a health care staffing analysis to determine the essential positions needed to perform the health services mission and provide the defined scope of services. A staffing plan is developed and implemented from this analysis. There is an annual review of the staffing plan by the HSA to determine if the number and type of staff is adequate.

VI. Clinical decisions are the sole province of the responsible health care practitioner and are not countermanded by non-clinicians.

VII. Continuity of care is required from admission to transfer or discharge from the facility, including referral to community-based providers, when indicated. Inmate health records should be reviewed by the facility's qualified health care professional upon arrival from outside health care entities including those from inside the correctional system.

VIII. Inmates who need health care beyond the resources available in the facility, as determined by the responsible health care practitioner, are transferred under appropriate security provisions to a facility where such care is available. A written list of referral sources including emergency and routine care is maintained by the HSA. The list is reviewed and updated annually.

IX. A written individual treatment plan is required for inmates requiring health care supervision including chronic and convalescent care. This plan includes directions to health care and other personnel regarding their roles in the care and supervision of the inmate and is developed by the appropriate health care practitioner for each inmate requiring a treatment plan.

A. There is a plan for the treatment of inmates with chronic conditions such as hypertension, diabetes, serious mental illness and other diseases that require periodic care and treatment. The plan must address the monitoring of medications, laboratory testing, chronic care clinics, health record forms, and frequency of specialist consultation and review.

B. Exercise areas are available to meet exercise and physical therapy requirements of individual inmate treatment plans.

X. There is a written plan for access to twenty-four (24) hour emergency medical, dental, and mental health services availability that includes:

A. On-site emergency first aid and crisis intervention.

B. Emergency evacuation/transport of the inmate from the facility.

C. Use of an emergency medical vehicle.

D. Use of one or more designated hospital emergency rooms or other appropriate health facilities.

E. Emergency on-call or available twenty-four (24) hours per day, physician, dentist and mental health professional services when the emergency health facility is not located in a nearby community.

F. Security procedures ensure the immediate transfer of inmates, when appropriate.

G. Emergency medications, supplies and medical equipment.

XI. The principle of confidentiality applies to inmate health records and information about an inmate's health status. The active health record is maintained separately from the confinement case record. Access to the health record is in accordance with state and federal law.

A. To protect and preserve the integrity of the facility, the HSA shares with the superintendent information regarding an inmate's medical management.

B. The circumstances are specified when correctional staff should be advised of an inmate's health status. Only that information necessary to preserve the health and safety of an inmate, other inmates, volunteers, visitors, or the correctional staff is provided. Information provided to correctional/classification staff, volunteers, and visitors addresses only the health needs of the inmate as it relates to housing, program placement, security and transport.

C. The release of health information complies with the Health Insurance Portability and Accountability Act (HIPAA), where applicable, in a correctional setting.

XII. The method of recording entries in health records, the form and format of the records, and the procedures for their maintenance and safekeeping are approved by the HSA. The health record is complete and made available to and is used for documentation by all practitioners.

A. The health record file (paper and/or electronic) contains the following items filed in a uniform manner:
- Inmate identification on each sheet.
- A completed receiving screening form.
- Health appraisal data forms.
- Mental health screenings and evaluations.
- A problem summary list.
- A record of immunizations.
- All findings, diagnoses, treatments, and dispositions.
- A record of prescribed medications and their administration, if applicable.
- Nonemergent health care request (sick call) encounter documentation.
- Laboratory, x-ray, and diagnostic studies.
- The place, date, and time of health encounters.
- Health services reports (e.g., emergency department, dental, mental health, telemedicine, or other consultation).
- An individualized treatment plan, when applicable.
- Progress reports.
- Results of specialty consultations and off-site referrals.
- A discharge summary of hospitalization and other termination summaries.
- A legible signature (includes electronic) and the title of the provider (may use ink, type, or stamp under the signature).
- Consent and refusal forms.
- Release of information forms.

B. Inactive health record files are retained as permanent records in compliance with the legal requirements of the jurisdiction. Health record information is transmitted to specific and designated physicians or medical facilities in the community upon written request or authorization of the inmate.

XIII. Health care encounters, including medical and mental health interviews, examinations, and procedures should be conducted in a setting that respects the inmates' privacy. If telehealth is used for inmate/patient encounters, the plan includes policies for patient consent, confidentiality/protected health information, documentation, and integration of the report of the consultation into the primary health care record.

XIV. Informed consent standards in the jurisdiction are observed and documented for inmate care in a language understood by the inmate.

A. When health care is rendered against the inmate's will, it is in accordance with state and federal laws and regulations. Otherwise, an inmate may refuse, in writing, medical, dental, and mental health care. If the inmate declines to sign the refusal form, it must be signed by at least two (2) staff witnesses. The form then must be sent to medical and reviewed by a qualified health care professional. If there is concern about decision-making capacity, an evaluation is done, especially if the refusal is for critical or acute care.

B. When a refusal involves treatment for a serious mental illness, a qualified clinician shall evaluate the inmate's decision-making capacity to refuse. Additionally, a qualified professional must assess the risk of serious harm to self or others. If there is a risk of serious harm identified, involuntary medication use (DCR Policy Directive 410.05) and a mental hygiene commitment petition (DCR Policy Directive 410.19) must be considered. Any decision not to proceed with these interventions requires a written justification.

XV. Inmates are provided access to infirmary care either within the correctional setting or off site. If infirmary care is provided onsite, it includes, at a minimum, the following:

A. Definition of the scope of infirmary care services available.

B. A physician on call or available twenty-four (24) hours per day.

C. Health care personnel with access to a physician or a registered nurse and are on duty twenty-four (24) hours per day when patients are present.

D. All inmates/patients are within sight or sound of a staff member.

E. An infirmary care manual that includes nursing care procedures.

F. Compliance with applicable state statutes and local licensing requirements.

XVI. In medical housing units and infirmaries, the following are available for acceptable levels of inmate hygiene:

A. Operable washbasins with hot and cold running water at a minimum ratio of one basin for every twelve (12) occupants, unless state or local building or health codes specify a different ratio.

B. Sufficient bathing facilities to allow inmates to bathe daily.

C. Access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance. Toilets are provided at a minimum ratio of one for every twelve (12) inmates in male facilities and one for every eight (8) inmates in female facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets. These ratios apply unless state or local building or health codes specify a different ratio.

XVII. If female inmates are housed, access to pregnancy management is specific as it relates to the following: pregnancy testing, routine and high-risk prenatal care, management of the chemically addicted pregnant inmate, and postpartum follow-up. Unless mandated by state law, birth certificates/registry does not list a correctional facility as the place of birth. Where nursing infants are allowed to remain with their mothers, provisions are made for a nursery, staffed by qualified persons, where the infants are placed when they are not in care of their mothers.

XVIII. Emergent (life threatening), urgent (interferes with normal daily activities, e.g., toothache), and routine (not of immediate attention) dental care is provided to each inmate under the direction and supervision of a licensed dentist. There is a defined scope of available dental services with related timeframes. Dental examination and treatment include the following:

A. Appropriate uniform dental record using a numbered system such as the Federation Dental International System.

B. A medical history, current medications.

C. Current vital signs prior to invasive procedure.

D. Appropriate radiographs.

E. Periodontal Screening and Recording (PSR) or a recognized periodontal health assessment.

F. Priority of treatment.

G. Treatment provided within acceptable designated timeframes by priority.

H. Consultation and referral to appropriate specialists is provided when medically necessary.

I. A defined scope of available dental services upon admission, which includes the following:

1. Dental screening upon admission (but no later than 7 calendar days) by a qualified health care professional or health trained professional.

2. Oral hygiene, oral disease education and self-care instruction are provided by qualified health care personnel within thirty (30) calendar days after admission.

3. Dental intake assessment by a dentist within thirty (30) days of admission to assess dental pain, infection, disease, or impairment of function and establish the overall dental/oral condition.

XIX. Each inmate receives an eye screening and visual acuity assessment as part of his/her initial health assessment as well as at periodic physical examinations. Inmates identified as requiring visual care are referred to a qualified optometrist for evaluation. Inmates with a previous diagnosis of glaucoma or other eye disease will be referred to a qualified optometrist or ophthalmologist. Inmates, fifty (50) years of age or older, and inmates with diabetes, severe vascular hypertension, or severe lipid disorders (suspected or confirmed) will have an annual examination by an optometrist. An inmate will be provided with one (1) pair of safety eyeglasses when an optometrist/ophthalmologist determines corrective lenses are medically necessary.

XX. An ongoing program of health education and wellness information is provided to all inmates.

XXI. Non-emergency inmate transfers require the following:

A. Summaries, originals, or copies of the health record accompany the inmate to the receiving facility; health conditions, treatments, and allergies are included in the record.

B. Health record confidentiality to be maintained.

C. Determination of suitability for travel based on medical evaluation, with particular attention given to communicable disease clearance.

D. Written instructions regarding medication or health interventions required en route for transporting officers separate from the medical record.

E. Specific precautions to be taken by transportation officers, including universal precautions and the use of masks and/or gloves.

F. A medical summary sheet is required for all inter and intra-system transfers to maintain continuity of care. Information included does not require a release of information form.

XXII. All intra-system transfer inmates receive a health screening by qualified health care personnel, which commences on their arrival at the receiving facility. All findings are recorded on a screening form approved by the Health Services Administrator (HSA). At a minimum, the screening includes the following:

A. Inquiry into:
- Whether the inmate is being treated for a medical or dental problem.
- Whether the inmate is presently on medication.
- Whether the inmate has a current medical or dental complaint.

B. Observation of:
- General appearance and behavior.
- Physical deformities.
- Evidence of abuse or trauma.

C. Medical disposition of inmates:
- Cleared for general population.
- Cleared for general population with appropriate referral to health care service.
- Referral to appropriate health care services for emergency treatment.

XXIII. The conditions for periodic health examinations are determined by the health authority. Notwithstanding, inmates who are in the continuous custody of the DCR for twelve (12) months or more regardless of the facility are provided an annual physical examination.

XXIV. When an inmate is received directly from the community to a correctional facility other than a jail or short-term holding facility (such as a diagnostic unit or facility housing young adult offenders) the following shall occur:

A. An intake health screening commences upon the inmate's arrival at the facility and is performed by qualified health care personnel. All findings are recorded on a screening form approved by the HSA and includes at least the following:

1. Inquiry into:
   - Any past history of serious infectious or communicable illness, and any treatment or symptoms (e.g., a chronic cough, hemoptysis, lethargy, weakness, weight loss, loss of appetite, fever, night sweats that are suggestive of illness), and medications.
   - Current illness and health problems, including communicable diseases and mental illness.
   - Dental problems.
   - Use of alcohol and other drugs, including type(s) of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of any problems that may have occurred after ceasing use (e.g., convulsions).
   - The possibility of pregnancy and history of problems (females only).
   - Other health problems designated by the responsible physician.
   - Any past history of mental illness, thoughts of suicide or self-injurious behavior attempts.

2. Observation of the following:
   - Behavior, including state of consciousness, mental status, appearance, conduct, tremor, and sweating.

- Body deformities, ease of movement, and so forth.
- Condition of the skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, recent tattoos and needle marks, or other indications of drug abuse.

3. Medical disposition of the inmate:
   - General population
   - General population with prompt referral to appropriate health care service.
   - Referral to appropriate health care service for emergency treatment.

B. Inmates who are unconscious, semiconscious, bleeding, or otherwise obviously in need of immediate medical attention, are referred. When they are referred to an emergency department, their admission or return to the facility is predicated on written medical clearance. Written procedures and screening protocols are established by the responsible physician in cooperation with the facility superintendent.

C. A comprehensive health appraisal is completed by qualified health care personnel within seven (7) days after arrival at the facility. If there is documented evidence of a health appraisal and evidence of review by qualified staff within the previous ninety (90) days, a new health appraisal is not required except as determined by the HSA. Health appraisal data collection and recording includes the following:

1. A uniform process as determined by the HSA.

2. Documentation of review of the earlier receiving screening.

3. Recording of height, weight, pulse, blood pressure, and temperature by qualified health personnel.

4. Collection of additional data to complete the medical, dental, mental health, and immunization histories by qualified health personnel.

5. Medical examination, including review of mental and dental status by qualified health personnel.

6. Laboratory and/or diagnostic tests to detect communicable disease, including venereal disease and tuberculous.

7. Other tests and examinations as appropriate.

8. Development and implementation of treatment plan, including recommendations concerning housing, job assignment, and program participation.

9. Initiation of therapy, when appropriate.

10. Review of the results of medical examination, tests, and identification of problems by a physician or mid-level practitioner, as allowed by law.

XXV. Medical or dental adaptive devices (eyeglasses, hearing aids, dentures, wheelchairs, or other prosthetic devices) are provided when medically necessary, as determined by the responsible health care practitioner.

XXVI. Withdrawal management is done only under medical supervision in accordance with local, state, and federal laws. Withdrawal management from alcohol, opiates, hypnotics, stimulants, and sedative hypnotic drugs is conducted under medical supervision when performed at the facility or is conducted in a hospital or community treatment center. Specific guidelines are followed for the treatment and observation of inmates manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs. Inmates experiencing severe, life-threatening intoxication (an overdose) or withdrawal are transferred under appropriate security conditions to a facility where specialized care is available.

XXVII. Proper management of pharmaceuticals includes the following provisions:

A. A formulary is available and a formalized process for obtaining non-formulary medications.

B. Prescription practices, including requirements that medications are prescribed only when clinically indicated as one facet of a program of therapy, and a prescribing provider reevaluates a prescription prior to its renewal.

C. Procedures for medication procurement, receipt, distribution, storage, dispensing, administration, and disposal.

D. Secure storage and perpetual inventory of all controlled substances, syringes, and needles.

E. The proper management of pharmaceuticals is administered in accordance with state and federal law.

F. Administration of medication by persons properly trained and under the supervision of the health authority.

G. Accountability for administering or distributing medications in a timely manner and according to physician orders.

XXVIII. There is consultation between the superintendent or designee and the responsible health care practitioner, or designee, prior to taking action regarding chronically ill, physically disabled, geriatric, seriously mentally ill, or developmentally disabled inmates in the following areas:

- Housing assignments.
- Program assignments.
- Disciplinary measures.

- Transfers to other facilities.

When immediate action is required, consultation to review the appropriateness of the action occurs as soon as possible, but no later than seventy-two (72) hours.

XXIX. All health care staff in the facility are trained in the implementation of the facility's emergency response plans. Health care staff are included in facility emergency drills, as applicable.

XXX. Designated correctional staff and all health care staff are trained to respond to health-related situations within a four (4) minute response time. The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with the superintendent and includes instruction on the following:

A. Recognition of signs and symptoms, and knowledge of action required in potential emergency situations.

B. Administration of basic first aid.

C. Certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization.

D. Methods of obtaining assistance.

E. Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal.

F. Procedures for inmate transfers to appropriate medical facilities or health care providers.

G. Suicide intervention.

XXXI. Equipment, supplies and materials for health services are provided and maintained as determined by the HSA. There is a plan for the management of biohazardous waste and the decontamination of medical and dental equipment.

XXXII. First aid kits are available in designated areas of the facility based on need and an automatic external defibrillator is available for use at the facility. The HSA approves the contents, number, location, and procedures for monthly inspection of the kit(s) and develops written procedures for use by nonmedical staff.

XXXIII. Any students or interns delivering health care in the facility, as part of a formal training program, only work under staff supervision commensurate with their level of training. There is a written agreement between the facility and the training or educational facility that covers the scope of work, length of agreement, and any legal or liability issues. All requirements of Policy Directive 154.00 will be followed, and students/interns agree in writing to abide by all facility policies, including those relating to the security and

confidentiality of information. DCR does not use volunteers in the delivery of health care.

XXXIV. The HSA meets with the superintendent monthly and submits reports on the health services system and health environment and plans to address issues raised.

XXXV. Unless prohibited by state law, inmates (under staff supervision) may perform familial duties commensurate with their level of training. They may provide support for activities of daily living and comfort, companionship and general assistance. They are not to provide direct patient care services. Accordingly, they do not provide personal hygiene care, bathing/showering, or assistance with toileting.

XXXVI. In accordance with WV Code §15A-4-13a, no funds authorized or appropriated by state law may be expended, directly or indirectly, for any medical procedure that the DCR Commissioner, or his/her designee or agent, after consulting with a medical professional determines is not medically necessary for any individual who is the custody of DCR.

A. As defined in state code and for the purposes of this section, "medical procedure" includes health care services or products, surgery, in-patient or out-patient treatment or the prescribing or dispensing of drugs or biologicals for the purpose of treating an illness, injury, disease, condition, or the symptoms thereof.

B. As defined in state code and for the purposes of this section, "medically necessary" means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose, or treat an illness, injury, or disease, or any symptoms thereof to include the provision of contraception by means of dispensing drugs or medical procedures, that are necessary and that are provided in accordance with generally accepted standards of medical practice; clinically appropriate with regard to type, frequency, extent, location, and duration; not provided primarily for the convenience of the patient or provider of health care; required to improve a specific health condition of a patient or to preserve the existing state of health of the patient; and the most clinically appropriate level of health care that may be safely provided to the patient.

XXXVII. There is a process by which the individuals designated by the inmate are notified in case of serious illness, serious injury, or death, unless security reasons dictate otherwise. If possible, permission for notification is obtained from the inmate.

ATTACHMENT(S):

None.

APPROVED SIGNATURE: _____ 07/07/2026

David L. Kelly, Commissioner **Date**