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**Subject:** DRAFT HS Core Responsibility Package  
**Attachments:** HS Core Resp Package - Table of Contents - 2021 February 28.docx; Health Services - Core Responsibility - 2021 February 28.pptx; HS Core Responsibility - Rationale and Background - 2021 February.docx; NHQ Health Services - Priorities Poster - 2021 February 21.docx; HS Thematic Priorities - Summary - 2021 February 28.docx; HS Commitments - Summary - 2021 February 28.docx; CR and Program - Descriptions - 2021 Feb 28.docx; PIP NEW - Health Services - 2021-02-28.docx; Logic Model - Combined - 2021-02-28.pptx

Hello All,

Hoping this will provide some respite from COVID related work as I am seeking your valuable feedback on some documents from a HS corporate way forward. These documents incorporate information on all your projects and I am looking for confirmation and suggestions.

In the fall of 2020, we began the revision and combining of the logic model for the three health services programs in the Corporate Reporting framework, updated our ongoing commitments and developed a thematic priorities document. As part of the process, we identified the need for change in the CSC Corporate Reporting framework to reflect the changes in Health Services by combining the current programs (P4, P5 and P21) within health services and establishing a new core responsibility. *Feedback from HS Managers at NHQ has been included.*

We have drafted a presentation and rationale document for the new Core Responsibility, and put this together as package with the revised logic model, combined performance information profile, and the new thematic priorities and commitments documents.

I would like to **request your input** on the **draft** of the Core Responsibility Package *in advance of sending to the ACHS and putting forward to HSET.*

As this is currently in draft, I request that the documents are not distributed any further at this time.

Would it be possible to provide your feedback by **Wednesday March 24, 2021**?

If you would like I can arrange for a MS teams discussion in the week of March 22 after you have had a chance to review.

Thank you for your anticipated feedback. Hope you have a great weekend!

With thanks,  
Manjeet

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# Health Services – A New Core Responsibility

DRAFT – For discussion purposes only

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# CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.



## Health Services – A New Core Responsibility Background & Rationale

FEBRUARY, 2021

DRAFT

# Health Services – A New Core Responsibility

## Background & Rationale

### Introduction

Health governance in prisons has been the focus of national and international reviews and investigation for more than a decade (WHO, 2010, 2020; Thomas, 2010). The Health Services governance within CSC underwent significant changes since the Health Services Sector was established in 2007. In response to the recommendations of the Office of the Corrections Investigator in 2008, a review of alternative models for the provision of health care to federal offenders was undertaken (Jim Thomas, 2010). Recognizing that there is a continuum of alternative models for the governance of health care in prisons (Thomas, 2010), CSC subsequently implemented a “virtual transfer” of all health services to CSC National Health Service with the transfer of mental health professionals in institutions in 2013 and treatment centres in 2014. Thomas suggested that “In essence, this option is as close as CSC could come to transferring health services to a national health authority without actually doing so” (Thomas, 2011, p. 11). The establishment of Health Services as a new core responsibility within the overall CSC departmental framework is the next step in the transfer to a National Health Service within CSC.

Within the context of providing Health Services within a correction environment, the Nelson Mandela rules<sup>1</sup> outline the principles for health service professionals with the overall prison environment. These rules focus on the clinical independence of health professionals and on patient-centered care. Health services is provided because there is a patient need that may or may not be related to the broader correctional goal or outcome (e.g. rehabilitation or criminogenic risk). Health professionals must be able to provide services without any undue influence or any real or perceived “dual loyalties”. The only consideration for health professionals should be what is in the best interest of the patient’s mental and physical health needs. Health services needs to be distinct and unique within the organization to ensure a clear separation of the care from the custody roles. The full transfer to a CSC National Health Services puts health in the driver’s seat for health decisions, and prevents health decisions from being influenced by the greater institutional structure (e.g. OT costs, security, etc.).

Establishing Health Services as a new core responsibility within the CSC will clearly separate the Health Services role as care providers from CSC’s custody role. This is necessary to effectively achieve Health’s mandate outlined in the Corrections and Conditional Release Act to “provide every inmate with (a) essential health care; and (b) reasonable access to non-essential health care” in alignment with “professionally accepted standards”. Though Healthcare may contribute to CSC’s overall mission to support reintegration and contribute to safer communities, the ultimate objective for health services is the provision of health care to inmates. There is a need to clearly separate the responsibilities for care from the custody responsibilities within CSC. The focus on providing an integrated clinically independent patient-centre model of health care and a clear separation of Health Services from the custodial responsibilities is required to achieve this mandate. The recent revisions to the CCRA equips CSC with the legislation to reinforce the requirements for clinical independence and autonomy of health care professionals, patient advocacy, and allows for the designation of health care units. Our stakeholders recognize and call for independence in health services. This independence will focus health services’ governance performance on key health objectives, outcomes and accountabilities. The proposal for Health Services to establish a new and separate Core Responsibility within CSC is a natural progression, from the governance changes that were first initiated in 2007; to the changes in the legislation that took effect in 2019. A

<sup>1</sup> The Nelson Mandela rules are noted in relation to CSC Health Services.

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new Core Responsibility will result in a strong, integrated and focussed mandate for the Health Services Sector moving forward in 2022-2023 that will clearly articulate the role for Health Services within CSC.

**Health Services in Prisons – A Question of Governance**

**The Nelson Mandela Rules**

The United Nations Standard Minimum Rules for the Treatment of Prisoners, also known as the Nelson Mandela Rules, outline the rules for prisons (UNODOC, 2015). The Nelson Mandela rules include those related to health services, among which include:

- “...Health care for prisoners is a state responsibility [, and] prisoners should enjoy the same standards of health care available in the community”. (Rule 24, UNODOC, 2015, p. 8)
- “Health care services should be organized ... [with] general public health administration ... that ensures continuity of treatment and care...” (Rule 24, UNODOC, 2015, p. 8)
- “Every prison shall have ... a health-care service for prisoners ... with particular attention to ... special health-care needs or with health issues that hamper their rehabilitation” (Rule 25, UNODOC, 2015, p.8).
- “Health care service[s] shall consist of an interdisciplinary team with sufficient qualified personal acting with full clinical independence...” (Rule 25, UNODOC, 2015, p. 9).
- “Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.” (Rule 27, UNODOC, 2015, p. 9)
- Health-care professional must document and report any signs of torture or other cruel, inhuman or degrading treatment or punishment (Rule 34, UNODOC, 2015, p. 11).
- “Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures..., and report ... any sanctions or restrictive measures that have any adverse effect ... on physical or mental health, and have the authority to review and recommend changes” (Rule 46, UNODOC, 2015, p. 14).

**Health Services in Prisons - Governance**

The issue of who should be responsible for the provision of health services in prisons has been a focus both nationally and internationally for more than a decade (WHO, 2010, 2020). There are a range of alternative models/ approaches (e.g. Finland, Portugal, England – WHO 2020; Jim Thomas, 2010). These range from the complete transition of the responsibility or governance for health services in prisons from corrections/prisons authorities (e.g. justice ministries) to health authorities (e.g. health ministries) to a continuum of variations of the transition. Though there does not appear to be one “right” approach, there are several key similarities and considerations in the analysis of governance transition (WHO 2020).

The rationale for integrating correctional health services with public health or health ministries was linked to concerns for human rights (e.g. different systems will result in inherently unequal service provisions), lack of quality health in prisons, recruitment and retention, and threats to the professional roles of health staff (WHO, 2010; Thomas 2010). Thomas (2010) suggested that the separation of HS from operations would strengthen the HS voice and influence in a correctional setting, ensure that security measures were instituted in ways that minimized harm to patient, address recruitment and retention challenges, and reduce isolation from other health professionals, ties and communities of health peers. The benefits of transferring to health authorities would provide a level of care equivalence, integrate training and research, prevent isolation of health professions, solves difficulties in recruiting, contribute to integrated delivery of health care services, and clearly establish role of health professionals (Thomas, 2010; WHO 2010).

Across the 3 countries reviewed in the WHO 2020 summary, there were a number of similarities “that seem to be crucial for successful improvement” (WHO, 2020, p. 29). These include the establishment of partnerships,

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using workforce standards and national approaches that ensure equivalence of care, qualifications and training, “the need to guarantee the independence of staff” (WHO, 2020, p. 29), and the use of practices (e.g. technology) to support continuity of care, transfer of health information, health status evaluations and monitoring. With regard to clinical independence, “there was a perception among health-care staff that the transition had enabled them to give as much consideration to the interested of the people in prison living with a disease as to the requirements of justice and prison security.” (WHO, 2020, p. 29).

The overall conclusion was that there was “no unique ideal governance model for prison health” (WHO, 2020, p. 31). The recommendations for the key principles were “equivalence of care, clinical independence, respect for human rights and continuity of care” (WHO, 2020, p. 31). Organizations were encouraged to take baseline assessments of infrastructure and processes, to have a functional, integrated health information systems and that there should be careful planning, that includes staffing issues, for transitions in governance (WHO, 2020).

**Brief Review of Examples from Other Jurisdictions – What have other jurisdictions done? Did it work?**

**WHO Reports – Other countries**

**Finland**

Health services in Finland are provided by the Unit for Prisoners’ Health Services (VTH), in the Finnish Institution for Health and Welfare under the Ministry of Social Affairs and Health. Clinics and hospitals operate in prisons (WHO, 2020). The Criminal Sanctions Agency under the Ministry of Justice manages and operates the prison system. The Unit for Prisoners’ Health Services is autonomous with its own budget, staff, rules and Board. Rules are compatible with the Institute of Health and Welfare. Strategic tripartite negotiations between government agencies and cooperative meetings among prison health care units. Supervisory authority for health and welfare provides organizational supervision and there is a regional licencing agency. Though there is no publicly available data, the perception is the quality of care had improved, and it has been easier to recruit staff (WHO, 2020).

**Portugal**

Prison health in Portugal is the joint responsibility of the DGRSP under the Ministry of Justice and the Ministry of Health. Health care services and products are provided by CCGCS, part of DGRSP. They provide all primary health care and some specialized care, and all prisons have health services and nursing care available. Some have psychiatry, psychology and dentistry. Specialized care that cannot be delivered through prison health is provided by Portuguese National Health Service. It is a mixed system where DCRSP is the main provider and PNHS supplements the system (WHO, 2020). There is a collaborative approach, whereby protocols were established for early detection and treatment of TB, and a synergy of protocols was used to gain access to ID appointments. A standardized provision of care is ensured with respect for the autonomy and clinical independence, and support for the continuity of care (e.g. communication). Collaborative agreements made to improve health status, and had impacts on specific workflow (e.g. appointments in prison units improved well being and dignity) through successful partnerships (WHO, 2020).

**England**

The responsibility for prison health care in England was transferred from the Ministry of Justice to the Department of Health in 2006 and published a review of evidence in 2016 (WHO, 2020). Prison health services are funded by Department of Health and Social Care, and services are commissioned from health care providers (e.g. community – hospital trusts, or private health-care provider companies) and are delivered in a justice setting. Agreement between Her Majesty’s Prison and Probation Services, Public Health England and National Health Service England are in place (2013, 2015) and expanded to include the Ministry of Justice and DHSC (2018) – responsibility for oversight and management by the National Prison Healthcare Board and a local delivery boards. NICE standards. The benefits noted a “greater transparency, evidence-based assessment of needs, tackling professional isolation, improving quality of care, and integration of prison populations into wider

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public health programmes” (WHO, 2020, p. 27). In the 2016 review of evidence, “a significant improvement in the commissioning and provisions of health care, leading to better health outcome for people in prison” (WHO, 2020, p. 27) and notes limited data. There is a challenge noted for continuity of care and a good practice was noted for the national partnership approach based on public health principles, and transparency (WHO, 2020).

**Alberta**

Alberta Health Services provides services to inmates in provincial correctional centres through correctional health teams to “improve the overall health of inmates by providing care, support, treatment, referrals and mental health and addictions counseling” (Neilsen, 2017). The Lethbridge Correctional Centre team includes a “diverse group of health professionals” including “RNs, LPNs, a Registered Psychiatric Nurse, a service worker, admin support”, a psychologist, an addictions counselor, pharmacy team from Edmonton, other provincial specialists as needed, and a doctor (twice a week) and weekly dental/other health care provider clinics. Telehealth is used to provide services as well (Neilsen, 2017). It was noted that the security aspect was the biggest difference (Neilsen, 2017).

**Nova Scotia**

After twelve years, the benefits of integrating the health care in provincial corrections with the public health system are evident, particularly in the area of infectious diseases (Webster, 2013).

**British Columbia**

The BC Mental Health and Substance Use Services, an Agency of the Provincial Health Services Authority, assumed responsibility for the health care services in the provincial correctional centres in British Columbia in October, 2017 (Pelletier, MacFarlane & Sharfi, 2018). Services provided include “primary medical and nursing care, mental health and substance use services, urgent care and basic emergency response, selected public health services, urgent dental care, health-related discharge planning, pharmacy services, laboratory and x-ray imaging, coordination of specialized services and occupational first aid” (Pelletier, MacFarlane & Sharfi, 2018, slide 12). The plan was to deliver services equivalent with those in the community, the responsibility for services will remain autonomous from corrections, integration of services with other health authorities to promote transition and continuity of care, and collaboration between health service and corrections. Staffing, upgrades to facility and equipment and policy reviews, risk assessments and evaluation methods, communication and change management and legal agreements were undertaken. There was a focus on the partnership with BC Corrections. Some of the key achievements included the use of virtual health (e.g. telemedicine), opiate agonists therapy (OAT), transitions in care and the staff and culture (Pelletier, MacFarlane & Sharfi, 2018).

**The Stakeholder Perspective – An Organizational Risk**

CSC has been criticized on its ability to maintain clinical independence and avoid mixed or “dual loyalties”.

**OCI – Clinical Independence and Prison Health Care Governance**

The OCI continues to raise concerns with the “clinical independence and the mixed or ‘dual loyalties’ that health care providers constantly face working in a correctional health care context” (OCI, 2018, p. 17; OCI, 2017; OCI, 2019). Some examples of dual loyalties that health professionals face in CSC include fitness to participate assessments, involvement in restraints, the formulary, consent to treatment and post-use of force assessments (OCI, 2018). The need for health professionals to be free from any “undue interference with the task of advocating and protecting the physical and mental of inmate patients” (OCI, 2018, p.17) continues to be emphasized, and that health care needs to be provided with “undivided loyalty to their patients”, and “unrestricted clinical independence” (Pont et al., 2018; OCI, 2018). The OCI goes on to state that: “These areas are not as well-articulated, grounded or protected in CSC health care administration, policy and governance structures as they should be”(OCI, 2018, p. 17). As CSC health staff do not report to a Health Ministry, the OCI

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suggests that there is a need for an even more “robust accountability and rigorous oversight” (OCI, 2018, p.18) to ensure clinical independence and autonomy. Examples of role conflicts (e.g. population movement and clinic hours and medical escorts determined by staffing levels) are also highlighted and suggested to be regular occurrences (OCI, 2018). A review of CSC policies in relation to the Nelson Mandela results was recommended in 2016-2017. More recently, the OCI indicated that “The fact of the matter is that CSC’s Health Services is not fully independent from CSC operations. At the very least, full clinical independence would require prison health care staff to be employed by the provincial health body or the national health authority” (OCI, 2020, p. 11).

The view that dual loyalties impacts health service delivery within CSC is an organizational risk. In CSC, we are working to mitigate risks by reviewing and revising policies, promoting a patient-centered, safety and quality improvement culture, and enhancing the health services model in line with community and professional standards.

**Legislation**

**HS Mandate – The Hub**

In accordance to the Corrections and Conditional Release Act, the Correctional Service of Canada is legislatively mandated to provide essential health care to inmates and reasonable access to non-essential health care, in keeping with professional standards ([The Hub](#)).

**Professional Autonomy and Clinical Independence of Health Care Professionals**

In line with international standards (i.e. the Nelson Mandela Rule), one of the key tenets for the delivery of health services to offenders is the clinical autonomy and independence of health care professional to provide health services with out any undue influence. The principle became enshrined in legislation with recent amendments to the CCRA, and clearly affirmed CSC’s responsibility support the professional autonomy and clinical independence of registered health care professionals.

The legislation states: “86.1 When health care is provided to inmates, the Service shall (a) support the **professional autonomy and the clinical independence** of registered health care professionals and **their freedom to exercise, without undue influence, their professional judgment in the care and treatment of inmates;** ... and (c) promote **decision-making that is based on the appropriate medical care, dental care and mental health care criteria.**” (bold added, [Corrections and Conditional Release Act - S.C. 1992, c. 20 \(Section 86.1\)](#) )

A Policy Bulletin issued on November 30, 2019 provided direction for registered health professionals to exercise, without undue influence and within professionally accepted standards their professional judgement in the care and treatment of inmates.

**Patient Advocacy and Patient Centred-Care**

A second, and no less important, principle is the role of health care providers as patient advocates, and provide patient-centred care. Recent amends to the CCRA legislation in introduced patient advocacy and patient-centered care as both a service and a fundamental role for all health professionals.

The legislation indicates that “86.1 When health care is provided to inmates, the Service shall ... (b) support those registered health care professionals in their promotion, in accordance with their respective professional code of ethics, of **patient-centred care and patient advocacy;**...” (Bold added, [Corrections and Conditional Release Act - S.C. 1992, c. 20 \(Section 86.1\)](#)).

The legislation goes on to outline more specific patient advocacy roles and responsibilities. It states, “89.1 The Service shall provide, in respect of inmates in penitentiaries designated by the Commissioner, access to **patient**

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**advocacy services** (a) to support inmates in relation to their health care matters; and (b) to enable inmates and their families or an individual identified by the inmate as a support person to understand the rights and responsibilities of inmates related to health care” (bold added, Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 89.1)).

**Patient Care and Advocacy in the Structured Intervention Units**

Health Services role in patient advocacy is also evident in the care and potential impact of the Structured Interventions units. “37.1 (1) The Service shall ensure that measures are taken to provide for the ongoing monitoring of the health of inmates in a structured intervention unit. (2) The Service shall ensure that the measures include (a) a referral of the inmate’s case, within 24 hours after the inmate’s transfer into the structured intervention unit, to the portion of the Service that administers health care for the purpose of conducting a mental health assessment of the inmate; and (b) a visit to the inmate at least once every day by a registered health care professional employed or engaged by the Service.” (Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 37.1)).

Further, the legislation outlines the need to report if the SIU is having an impact on health. It states: “37.11 If a staff member or a person engaged by the Service **believes that the confinement of an inmate in a structured intervention unit is having detrimental impacts on the inmate’s health**, the staff member or person shall **refer**, in the prescribed manner, the inmate’s case to the portion of the Service that **administers health care**. Grounds for the belief include the inmate (a) refusing to interact with others; (b) engaging in self-injurious behaviour; (c) showing symptoms of a drug overdose; and (d) showing signs of emotional distress or exhibiting behaviour that suggests that they are in urgent need of mental health care. (Bold added, Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 37.11)).

The legislation also gives health services an amplifying voice for patient well being regarding placements in the SIUs as institutions have the authority to discontinue the placements. For example, “37.3 (1) The institutional head shall determine, in accordance with regulations made under paragraph 96(g), whether an inmate should remain in a structured intervention unit (a) as soon as practicable **after a registered health care professional recommends under section 37.2, for health reasons, that the inmate not remain in the unit**; (2) As soon as practicable after the registered health care professional referred to in section 37.2 has recommended, for health reasons, that the conditions of confinement be altered, the institutional head shall determine whether the inmate’s conditions of confinement in the structured intervention unit should be altered. (Bold added, Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 37.3)).

**Grievance Process/Quality of Care Reviews**

The revised legislation provided Health Services the authority to conduct quality of care reviews on deaths that are believed to occur due to natural causes. The legislation states: “19.1 (1) If a registered health care professional advises the Service in writing that the **registered health care professional has reasonable grounds to believe that the death of an inmate is from a natural cause**, the Service shall, whether or not there is an investigation under section 20, without delay, **cause a review to be conducted by a registered health care professional employed or engaged by the Service for the purpose of determining the quality of care provided to the inmate in the penitentiary**. The registered health care professional shall report on the review to the Commissioner or to a person designated by the Commissioner” (bold added, Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 19.1)).

In addition, the legislation aligns responses to health grievances with health governance. Health Services was made the decision maker for inmate grievances related to health services. The review process for inmate grievances has changed to have health perform the analysis of the issues and identify opportunities for improvements. The final approval of the response to inmate grievances related to health are authorized by health services. Health Services has been working to strengthen patient advocacy and patient centered care in

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the response to grievances, and initiating the analysis of improvement opportunities for patient centered and continuity of care.

**Health Care Units**

The legislation also provides CSC the authority to designate institutions, or parts of institutions, as Health Care Units (HCU). The legislation states: “86.2 The Commissioner may designate a penitentiary or any area in a penitentiary to be a health care unit” (Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 86.2)) and “86.3 The purpose of a health care unit is to provide an appropriate living environment to facilitate an inmate’s access to health care” (Corrections and Conditional Release Act - S.C. 1992, c. 20 (Section 86.3)).

**CSC HS Governance – A Natural Progression**

**HS Governance – The Hub**

Since September 2007, there has been integration of service delivery, line authority, and accountability of health managers within a designated CSC Health Services Sector. Accountability of managers involved in the delivery of health care services is to the Assistant Commissioner of Health Services, including: physical health services in mainstream institutions (September 2007); mental health services in mainstream institutions and in the community (April 2013); and the treatment centre services (April 2014) (The Hub).

Thomas (2010) presented a continuum of “alternative models” that ranges from the use of alternative providers of health services (i.e. non-CSC; staff employed by other health organizations) to partnership arrangements, contracted services or hybrids of the approaches. There was a distinction noted between the transfer of the delivery of services and the transfer of the responsibility for care. It was recognized that the full transfer not a realistic option for CSC (Thomas, 2010). The obstacles or limitations to a full transfer of the provision of health services to a health authority or ministry in Canada were outlined and included the multi-jurisdictional context (e.g. provincial health authorities), the “absence of National Health delivery authority” ((Thomas, 2010, p. 8), whether contracted services would provide a strong enough voice, financial considerations, continuity of care, as well as logistical, political and community reactions (Thomas, 2010). In Canada, it was recognized that there were eight different provincial health ministries/authorities with different standards were responsible for health and not all of them have taken over provincial correctional health services. It was also noted that Health Canada was not equipped to function in this role. There were also financial, issues that may be raised by employee groups and the need for an analysis of the benefits of the transfer (Thomas, 2010). Though a complete transfer to health authorities was not deemed feasible at the time, it was recommended to “not rule it out” and explore alternative models in the meantime (e.g. partnership arrangements, pilots with other jurisdictions, review CSC governance, options for delivery of specialized services; Thomas, 2010).

In the review of the governance options available to CSC along with the challenges and/or limitations, Thomas (2011) suggested that a “virtual transfer” of all health services to CSC National Health Service would “In essence, ... [be] is as close as CSC could come to transferring health services to a national health authority without actually doing so.” (Thomas, 2011, p. 11).

**Model of Health Service Delivery**

Health Services is embarking on a revision to the service delivery model within CSC. The model builds on many of the principles that are currently in place while expanding in some areas. In 2019-2020, consultations were held across all regions with health managers to inform key enhancements to CSC’s clinical model and approaches to health care. Key considerations for implementation were also discussed. Along with the changes in how we deliver services, the Sector is also adjusting its organizational structure and resource model.

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**Bill C83 Health Resource Model**

With the legislation of Bill C83 an *Act to amend the Corrections and Conditional Release Act and another Act coming into force*, several changes had significant positive impacts for Health Services namely clinical independence, patient advocacy and patient-centered care. For example, it aligns responses to health grievances with health governance, it affirms in legislation CSC’s obligation to support the autonomy and clinical independence of registered health professionals, introduces the concept of patient advocacy as both a service and a fundamental role for all health professionals, provides authority for CSC to designate institutions, or parts of institutions, as Health Care Units (HCU), along with appropriate admission and discharge processes.

In addition to legislative change, CSC health services received substantial funding to enhance key areas. This includes; the provision of 24/7 health care at all 5 regional women’s sites and men’s maximum security sites with a therapeutic range; enhancements to psychiatric services to improve early identification, diagnoses and treatment of all offenders; expansion of psychiatric services at all levels of care; expanded use of nurse practitioners; integrated health leadership at all mainstream institutions and the introduction of a patient advocacy services at select sites. Moreover, health services will implement a professional practice structure to provide leadership in adherence to professional practice standards and to facilitate continuous learning and quality improvement. Through Bill C-83 funding, CSC will also make significant investments in treatment centres to ensure the most significantly impaired patients receive high quality, safe patient care in keeping with professionally accepted standards.

**The Alternatives**

1. A New Core Responsibility for Health Services within CSC
2. Health Services delivered by Provincial Health Authorities or National Health Agency

**NEW Health Services Vision, Mission and Priorities (pending approval)**

**Health Services Vision:** Provide quality, integrated, person-centered care.

**Health Services Mission:** In collaboration with our partners, we provide a broad-range of evidence informed health services that are responsive to the diverse needs of our population through:

- Promoting family and community supports
- Professional advocacy for quality health care
- Facilitating and respecting informed individual care
- Fostering continuous learning.

**Priorities**

1. **Person-Patient Health Care Home** Strengthen the clinical model of primary care in line with professional standards of care and a focus on clinical independence and patient-centered care
2. **Patient-Centred Care For Diverse Populations** Improve capacity to provide patient-centered care with a focus on the health needs of Indigenous offenders, aging offenders, offenders with mental health needs and offenders with gender-based needs
3. **Patient Advocacy & Redress** Focus on the role of Health Services in patient advocacy to provide input and guidance on issues that impact patient-centred care, patient safety, and quality improvement
4. **Mitigating Health Impacts In A Correctional Environment** Strengthen and expand infection disease prevention, harm reduction and treatment and intervention strategies for problematic substance use and suicide/self-injury
5. **Workforce/ Workplace** Strengthen a sustainable, healthy workforce in a healthy workplace
6. **Partnerships** Strengthen internal and external partnerships & **COVID** Be responsive to the evolving priorities of the COVID pandemic to ensure the health and safety of our inmates, staff and communities

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**Resources**

Pont, J., Enggist, S. Stover, H., Williams, B., Greifinger, R., & Wolff, H. (2018, April). Prison health care governance: Guaranteeing clinical independence. American Journal of Public Health, Published Online – March 7, 2018.

Neilsen, J. (2017, June 19). Improving health behind bars: Creating better health outcomes.

Office of the Correctional Investigator. (2020). Annual Report – 2019-2020. Cat. No.: PS100E-PDF ISSN: 1493-5295.

Office of the Correctional Investigator. (2018). Annual Report – 2018-2019. Cat. No.: PS100E-PDF ISSN: 1493-5295

Office of the Correctional Investigator. (2018). Annual Report – 2017-2018. Cat. No.: PS100, ISBN: 0383-4379

Office of the Correctional Investigator. (2017). Annual Report – 2016-2017. Cat. No.: PS100, ISBN: 0383-4379

Pelletier, L., MacFarlane, A., & Sharifi, N. (2018, October). Correctional Health Services: Transition to the Provincial Health Services Authority. Presentation.

Thomas, J. (2010, December). Report on Assessment Framework for Alternative Service Delivery – CSC Response to Recommendation #16. Internal Report.

Thomas, J. (2011, September). Implementing the CSC Report on an Assessment Framework for Alternative Service Delivery – Report for CSC’s Executive Committee Meeting on October 5, 2011. Internal Report.

United Nations Office on Drugs and Crime. (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). General Assembly, adopted on 17 December 2015.

Webster, P.C. (2013). Integrating prison health into public health care: the global view. CMAJ April 16, 2013 185 (7) E283; DOI: <https://doi.org/10.1503/cmaj.109-4435>.

World Health Organization. (2020). Organizational models of prison health. Considerations for better governance. Copenhagen: WHO Regional Office for Europe; 2020. Licence: CC BY-NC-SA 3.0 IGO.

World Health Organization. Hayton, P., Gatherer, A., & Fraser, A. (2010). Patient or Prisoner: Does it matter which Government Ministry is responsible for the health of prisoners? A briefing paper for network meeting, Copenhagen, October, 2010.

World Health Organization. (2013). Good governance for prison health in the 21<sup>st</sup> century: A policy brief on the organization of prison health. ISBN 978 92 890 0050 5.

CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.



SERVICE CORRECTIONNEL CANADA

TRANSFORMONS DES VIES. PROTÉGEONS LES CANADIENS.

## Health Services Priorities – 2020-2025

**Introduction:** Health Services priorities are developed and established from a wide range sources. Some of these drivers include our knowledge of health service administration, professional and community standards, experience and expertise within the field, consultation and input from individuals receiving our services, our health service professionals and management teams, and from our commitments our internal and external stakeholders and partners. This document is intended to summarize the key priority areas for Health Services over the next 5 years and highlight some of the key commitments in these priority areas.

DRAFT





**Health Services Vision & Mission (Pending approval)**

**Health Services Vision:** Provide quality, integrated, person-centered care.

**Health Services Mission:** In collaboration with our partners, we provide a broad-range of evidence informed health services that are responsive to the diverse needs of our population through:

- Promoting family and community supports
- Professional advocacy for quality health care
- Facilitating and respecting informed individual care
- Fostering continuous learning.

**Person-Patient Health Care Home: Clinical Independence, Continuum of Care, Professional Standards<sup>1</sup>**

Health Services is embarking on an enhancement of the service delivery model within CSC. The new model builds on many of the principles that are currently in place while expanding in some areas. In 2019-2020, consultations were held across all regions with health managers to inform key enhancements to CSC’s clinical model and approaches to health care. The model will focus on the provision of care across the full continuum of service delivery from assessment to treatment and at the transition points throughout service delivery, including screening, assessment, primary, intermediate, tertiary, acute care and discharge. The model will focus on a person-patient health care home with a most-responsible provider and clinical case coordinator in line with professional standards including accreditation, documentation and information sharing. Recent amendments to the CCRA, introduced several changes that had significant positive impacts for Health Services, which include a focus on clinical independence and patient-centered care. These principles are cornerstones in the patient-person health care model.

**Continuum of Care:**

1. Improve the health services available through an emphasis on early assessment, diagnosis and direction to appropriate pathways of care. (Departmental Plan)
2. Conduct a review of Therapeutic Ranges. (OCI)
3. Implement a primary health care model of services - Patient-person medical home. (OCI)
4. Monitor release planning and incorporate health-related discharge plans as required. (Departmental Plan)
5. Quality improvement project that examines the comprehensiveness of the information shared and appropriately integrated into the community strategy. (OAG)
6. To expand capacity in each region for the assessment and treatment of FASD through the creation of clinics at the four remaining Regional Treatment Centres modelled on the clinic developed at the Regional Psychiatric Centre in Saskatoon.

**Clinical Independence**

1. Strengthen the professional autonomy and clinical independence of registered health care professionals. (Departmental Plan)

**Health Care Recruitment, Retention, Training, & Wellness**

In addition to legislative changes, CSC health services received substantial funding to enhance key areas. This includes; the provision of 24/7 health care at all 5 regional women’s sites and men’s maximum security sites with a therapeutic range; enhancements to psychiatric services to improve early identification, diagnoses and treatment of all offenders; expansion of psychiatric services at all

<sup>1</sup> See Health Information & Documentation/Virtual Care

levels of care; expanded use of nurse practitioners; integrated health leadership at all mainstream institutions and the introduction of a patient advocacy services at select sites. Moreover, health services will implement a professional practice structure to provide leadership in adherence to professional practice standards and to facilitate continuous learning and quality improvement. All of these new investments will have significant implications for HR planning, recruitment and staffing processes, and staff orientation and training.

1. Recruitment and Retention for New Resource Model - Active recruitment, Population Management & Staff Mix Reviews. (HR Plan)
2. Implement National Training Plan.
3. Workplace Wellness and Work Life Balance. (HR Plan)

#### **Patient Advocacy & Redress**

With the legislation of Bill C83 an *Act to amend the Corrections and Conditional Release Act and another Act coming into force*, several changes have significant positive impacts for Health Services including patient advocacy and patient-centered care. The legislation introduces the concept of patient advocacy as both a service and a fundamental role for all health professionals, and provides CSC the authority to designate institutions, or parts of institutions, as Health Care Units (HCU). The Health Services role in patient advocacy extends and focusses the need for input and guidance on issues that impact patient-centred care, such as MAiD, medical isolation, use of force, etc. This also includes mechanisms where health services assesses their delivery of care through different processes such as quality of care reviews and grievances.

1. Improve patient advocacy. (Departmental Plan)
2. Develop and implement Patient Advocacy Model. (OCI)
3. Convene an Ethics Roundtable on MAiD. (OCI)
4. Medical ethics expert review of health care's role in use of force and update of policy. (Audit)

#### **Health Information & Documentation / Virtual Care**

The effective use of technology to support the delivery of health services has the capacity to provide more efficient and safer care. The implementation of the National OHIS-EMR electronic medical record throughout CSC Health Services has introduced some clear advances and efficiencies. Continued efforts to streamline and expand the system to meet users' needs will support the delivery of health services at the frontline and support evidence based decision making throughout Health Services. Optimal use of the EMR and best practices for documentation is paramount for improved patient care and proper documentation according to legal and professional college requirements. CSC is also engaging in opportunities for the increased use of telehealth and videoconference, e-consults, laptops and tablets within the organization to effectively improve service delivery.

1. Increase usability/efficiency of EMR and consistent reporting capacity based on external review of CSC management of health records and EMR (includes Implementation of EMR integration of physical and mental health - OCI).
2. Improve documentation in EMR, and information sharing in OMS, via audit/feedback process and increase in clerical/administrative staff to assist in tracking and uploading necessary documentation in EMR and OMS.
3. Implementation of eMAR and RPMS.
4. Expansion of telehealth and E-consult capacities to increase virtual care activities.

**Patient-Centred Care for Diverse Populations**

Valuing and respecting diversity of individuals in delivery of health services is of utmost importance in patient-centered care. Health services focusses on providing patient-centred care with a focus on Indigenous Health, trauma-informed, aging offenders and gender-based needs.

1. Review recommendations of Fowler Report and develop guidelines for Indigenous health and wellness. (MMIWG)
2. Collaborate with Indigenous health care professionals to explore options for incorporating traditional mental and physical healing for Indigenous patients.
3. Implement the Older Persons in Custody (OPiC) Framework.
4. Collaborate with Indigenous Services Canada to implement MOU on transition of Indigenous offenders to the community.

**Harm Reduction and Mitigating Health Impacts in a Correctional Environment**

Harm reduction plays a foundational role in health service delivery, from problematic substance use to sexual health to suicide and self-injury. Consistent with the Canadian Drug and Substances Strategy, CSC has implemented a comprehensive and evidence-informed approach to address problematic substance use including OAT, PNEP, OPS, and naloxone. Suicide and self-injury prevention and intervention is essential to addressing the mental health needs of offenders within CSC. Mitigating health impacts in a correctional environment is a duty of all health professionals and requires HS input and guidance on issues that impact patient-centred care.

1. Prioritize infectious disease prevention, harm reduction and treatment. (Departmental Plan)
2. Continued implementation of Suicide prevention and intervention framework. (OCI)
3. Review of CD 843.
4. Implementation of Borderline Personality Disorder Guidelines.

**COVID**

COVID has changed the very nature of our work environment and has introduced a new and demanding priority in our day-to-day work. The constant monitoring of public health information and community transmission informs decision making to ensure the health and safety of inmates, staff and ultimately our communities. The continued review, assessment and planning for our IPC readiness and effective responses to potential outbreak situations is central to limiting the spread within our institutions and work environments. Effective communication, education, preparedness and management strategies area essential at every point in the response to this pandemic.

1. Effective and timely national management of COVID Infection, Prevention and Control measures, including contact tracing, testing, wellness checks, etc.
2. Implementation and operation of MERC and EOCs.
3. Proactive planning for the acquisition, storage and distribution of vaccines.

## Core Responsibility 4: Health Services

### Description

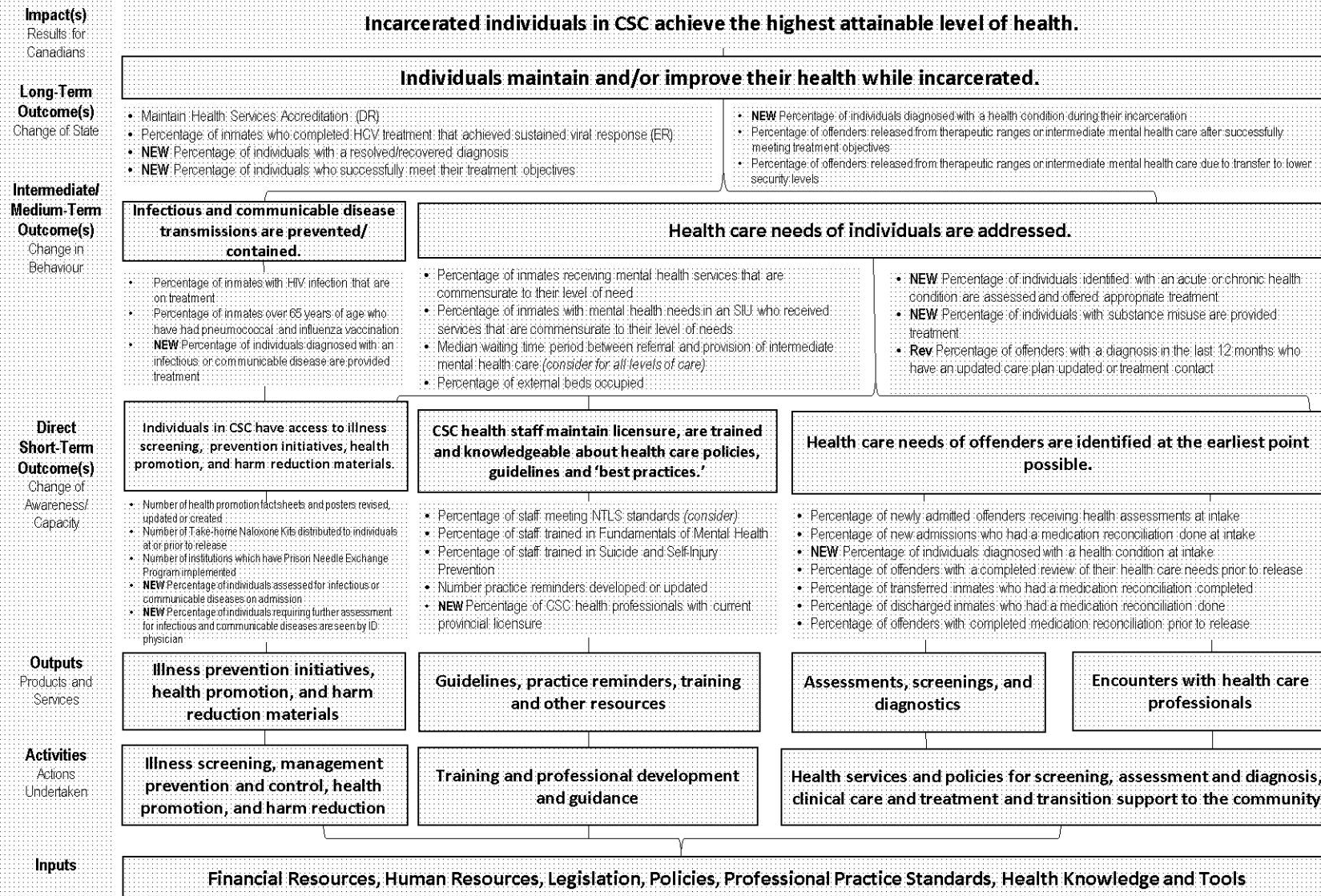
CSC provides health care to incarcerated individuals to help them achieve the highest attainable level of health. This includes screening and assessments for health needs, harm reduction services, and provision of treatments such as medications, counseling, and hospital care. Prior to release, CSC works to transfer care back to provincial and territorial health services.

### Program Description: Health Services

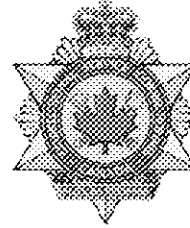
Health Services provides a broad-range of evidence-based health services in line with the diverse needs of our population. Health Services are delivered along three primary streams that form the continuum of care: Primary Care; Intermediate or Secondary Care; and Treatment Centre or Tertiary Care.

Key activities across the continuum of care include 1) illness screening, management, prevention and control, health promotion and harm reduction, 2) training and professional development and guidance 3) screening, assessment and diagnosis; 4) clinical care and treatment and 5) transition support to the community.

**DRAFT** *Final Report* **Program Review Logic Model NEW P: Health Services**

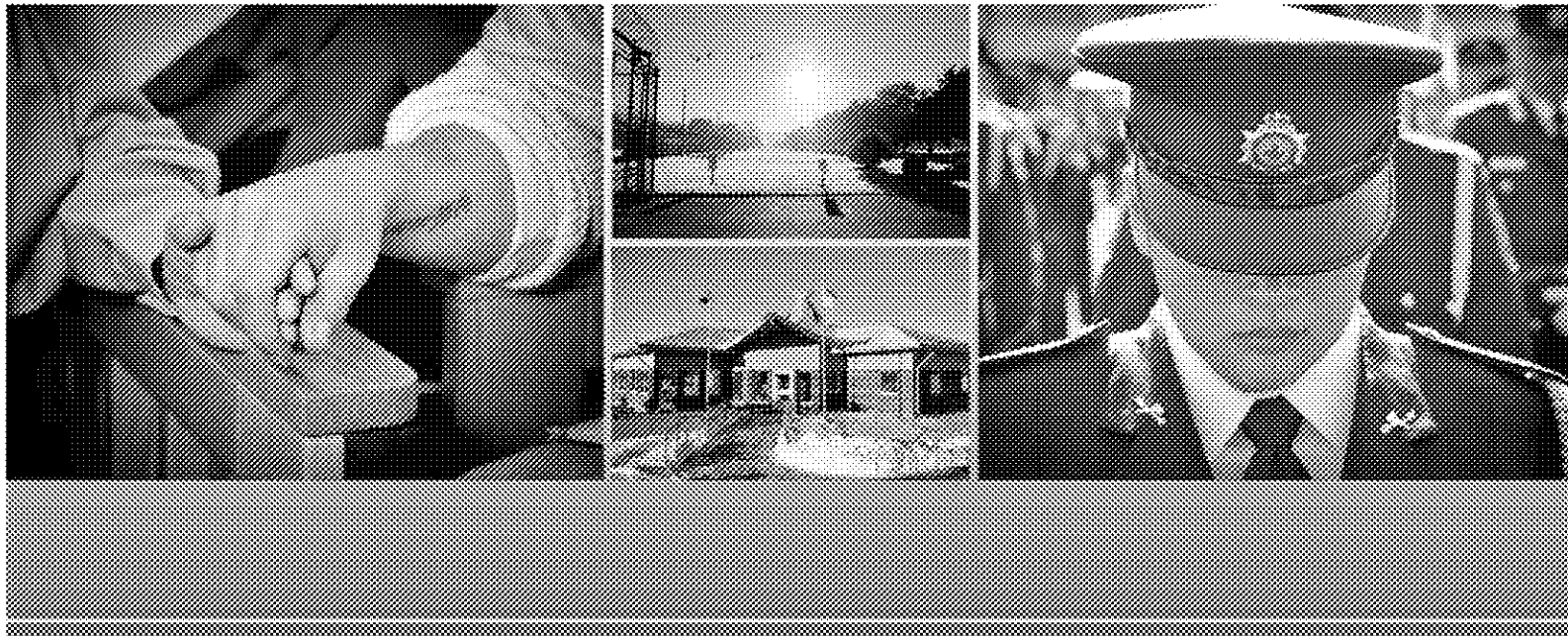


\*Also reported separately for women offenders; \*\* Health care needs of offenders are addressed in the interest of public safety where there are gaps in provincial health service delivery



# CORRECTIONAL SERVICE CANADA

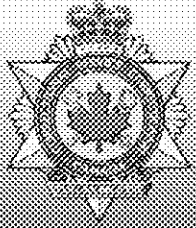
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## Health Services – A New Core Responsibility

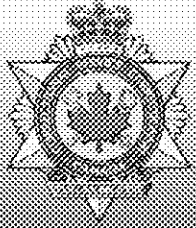
February, 2021





# Why a New Core Responsibility?

- Health Services in Prisons – A Question of Governance
  - A National and International Perspective
  - Perceptions of Health Services in CSC
- CSC Legislation & Mandate
  - Care & Custody
  - Rehabilitation
  - Safe Reintegration
- HS Mandate & Legislation
  - Mandate
  - Legislation
    - Clinical Autonomy
    - Patient Advocacy
    - Health Care Units
    - Grievance Process/Quality of Care Reviews
- CSC HS Sector Governance

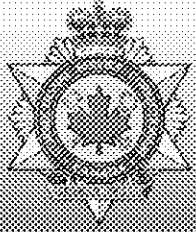


# Health Services in Prisons – A Question of Governance

- The Nelson Mandela Rules (2015) - Health Services
  - State responsibility, same standards of care as community
  - Address health care needs that impact rehabilitation
  - Full clinical independence
  - Clinical decisions may not be overruled or ignored by non-medical prison staff
  - Duty to report inhuman or degrading treatment or punishment
  - No role in disciplinary sanctions or restrictive measures
- The National/International Perspective
  - WHO – Governance Models in Prisons

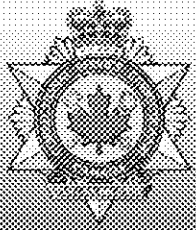
United Nations Office on Drugs and Crime. (2015). The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). General Assembly, adopted on 17 December 2015.

World Health Organization. (2020). Organizational models of prison health. Considerations for better governance. Copenhagen: WHO Regional Office for Europe; 2020. Licence: CC BY-NC-SA 3.0 IGO.



# Health Services in Prisons – A Question of Governance

- The National/International Perspective
  - International Approaches
    - Finland, Portugal, England
  - Canada - Provincial Approaches
    - Alberta
    - Nova Scotia
    - British Columbia
- “No ideal governance model for prison health” (WHO, 2020, p. 31)
- Key Principles (WHO, 2020)
  - Equivalence of care
  - Clinical independence
  - Respect for human rights
  - Continuity of care

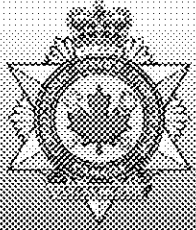


# CSC Health Service Governance - An Organizational Risk

- Perception of Health Services in CSC
  - Office of the Correctional Investigator (AR 2017-18, 2019-2020)
    - Clinical Independence
    - Dual Loyalties – fit to participate, restraints, formulary, consent to treatment, post-use of force health care assessments
    - No undue interference with the task for advocating and protecting the physical and mental of inmate patients
    - Provide health care with undivided loyalty, unrestricted clinical independence
    - “...areas are not as well-articulated, grounded or protected in CSC health care administration, policy and governance structures as they should be” (OCI, 2018, p.17)
    - Governance of health care staff – report to CSC not Health Ministry – need for robust accountability and rigorous oversight
    - Role conflicts between health care and custodial staff
    - “The fact of the matter is that CSC’s Health Services is not fully independent from CSC operations. At the very least, full clinical independence would require prison health care staff to be employed by the provincial health body or the national health authority” (OCI, 2020, p. 11)

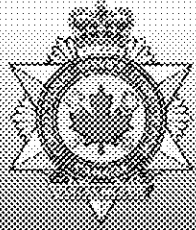
- CHRC
- Litigation Files

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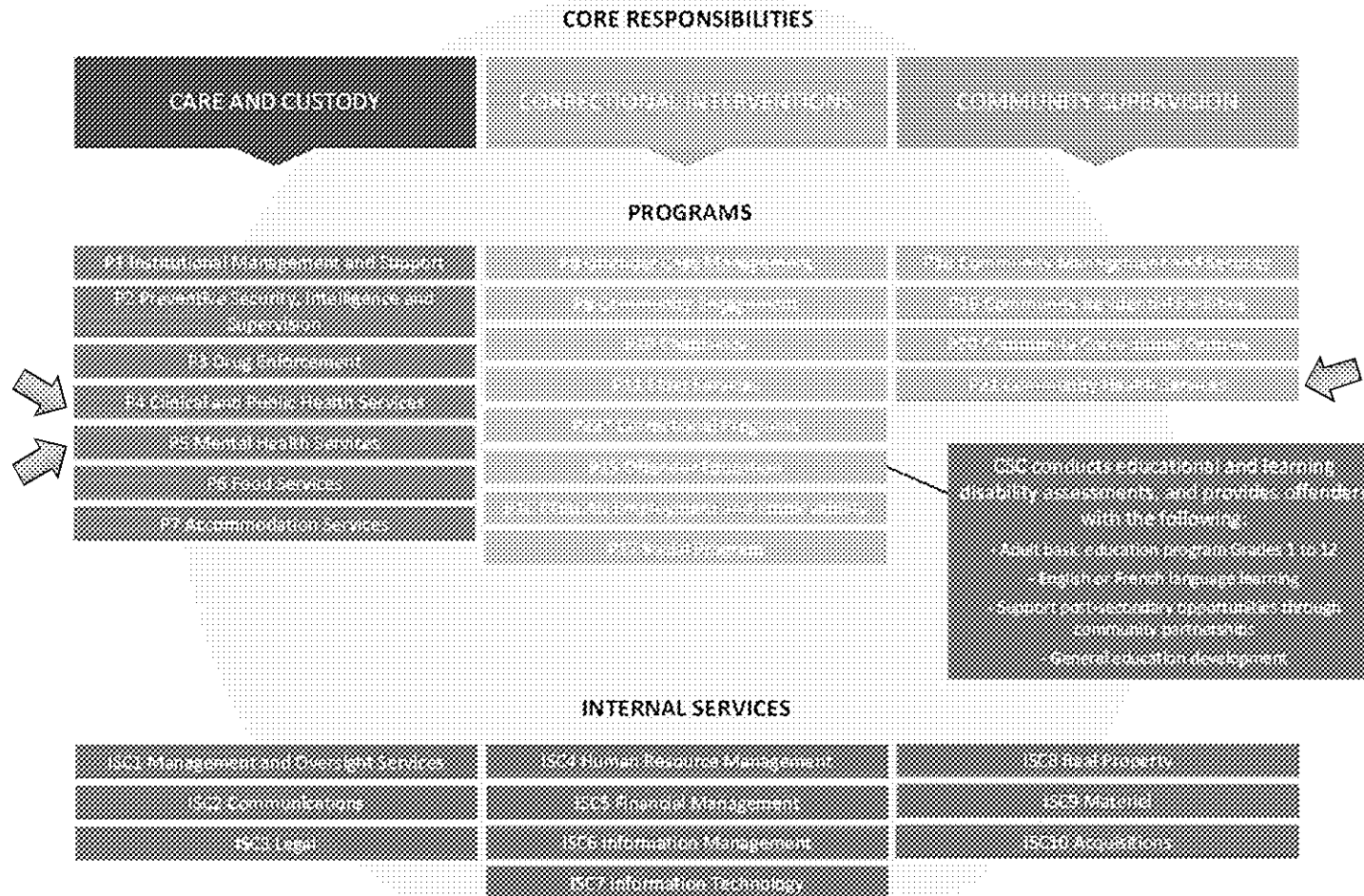
# CSC's Current Departmental Framework

- **Core Responsibility 1: Care and Custody**
  - CSC provides for the safety, security and humane care of inmates, including day-to-day needs of inmates such as food, clothing, accommodation, mental health services, and physical health care. It also includes security measures within institutions such as drug interdiction, and appropriate control practices to prevent incidents.
- **Core Responsibility 2: Correctional Interventions**
  - CSC conducts assessment activities and program interventions to support federal offenders' rehabilitation and facilitate their reintegration into the community as law-abiding citizens. CSC also engages Canadian citizens as partners in its correctional mandate, and provides outreach to victims of crime.
- **Core Responsibility 3: Community Supervision**
  - CSC supervises offenders in the community and provides structure and services to support their safe and successful reintegration into the community. Services include accommodation options, community health services, and the establishment of community partnerships. CSC manages offenders on parole, statutory release, and long-term supervision orders.



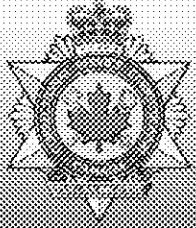
# CSC's Current Departmental Framework

## DEPARTMENTAL RESULTS FRAMEWORK



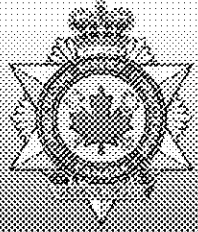
^P22 was previously represented as three separate programs:  
 -P12 Correctional Program Readiness  
 -P13 Correctional Programs  
 -P14 Correctional Program Maintenance

Legend:  
 P – Program  
 ISC – Internal Service Category



# Health Services Mandate & Legislation

- **Mandate**
  - To provide essential health care to inmates and reasonable access to non-essential health care, in keeping with professional standards.
- **Legislation**
  - Clinical Independence and Autonomy
  - Patient Advocacy
  - Health Care Units
  - Grievance Process/Quality of Care Reviews



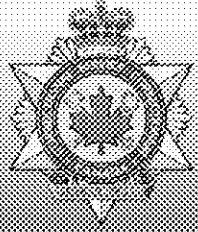
# Health Services Governance – A Natural Progression

- CSC Health Services Sector
  - Health Services Sector Established - 2007
  - Mental Health in Mainstream Institutions - 2013
  - Treatment Centres – 2014
  - Bill C83 Health Resource Model – Underway
  - Model of Health Services Delivery – Underway



# Health Services Governance – A Natural Progression

- What does Health Services needs to achieve?
  - A clear separation of the “caring” role from the “custody” role
  - No dual loyalties – real or perceived
  - Clinical independence – no undue influence
  - Clinical decisions cannot be overrule or ignored
- The Alternatives
  - Health Services in CSC provided by Provincial Health Authorities or Health Canada – staff report to Health Ministry
  - Independent HS Governance within CSC - A New Core Responsibility



# Health Services Governance – A Natural Progression

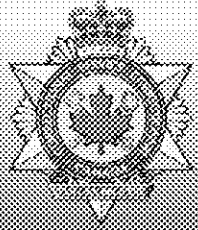
- How will a New Core Responsibility achieve the outcome?
  - Program articulates a clear separation of the “caring” role from the “custody” role
  - Clarity on the role of health professionals in the duty of care – culture of change
- Why not Provincial Health Authorities or Health Canada?
  - A future consideration - perhaps
  - Multiple provincial jurisdictions – challenging transition
  - Health Canada



# Health Services as a New Core Responsibility

- **Core Responsibility**
  - CSC provides health care to incarcerated individuals to help them achieve the highest attainable level of health. This includes screening and assessments for health needs, harm reduction services, and provision of treatments such as medications, counseling, and hospital care. Prior to release, CSC works to transfer care back to provincial and territorial health services.
- **Program Description**
  - Health Services provides a broad-range of evidence-based health services in line with the diverse needs of our population. Health Services are delivered along three primary streams that form the continuum of care: Primary Care; Intermediate or Secondary Care; and Treatment Centre or Tertiary Care.
  - Key activities across the continuum of care include 1) illness screening, management, prevention and control, health promotion and harm reduction, 2) training and professional development and guidance 3) screening, assessment and diagnosis; 4) clinical care and treatment and 5) transition support to the community.

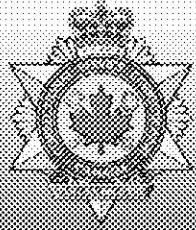




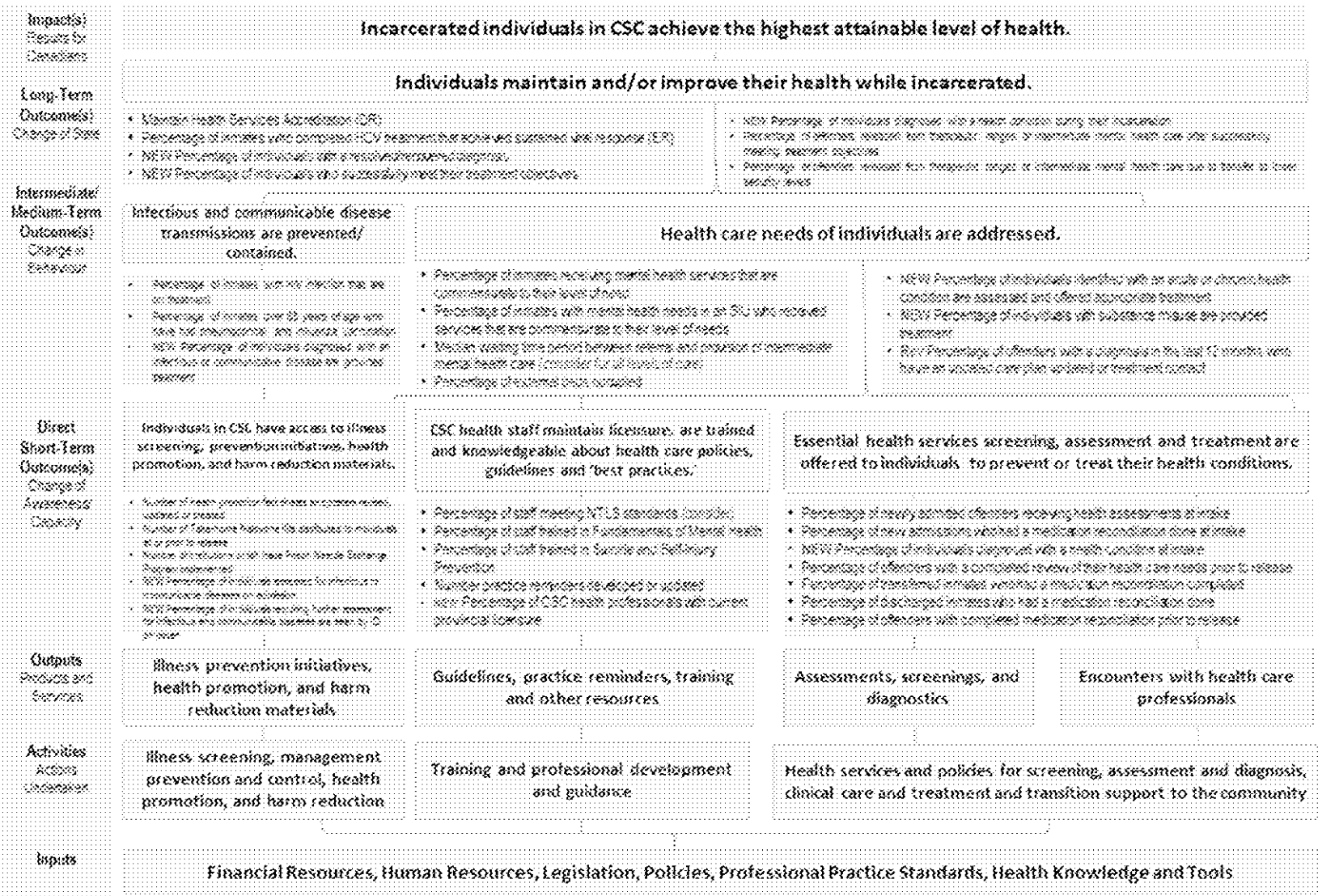
# One Step at a Time – Option 2 Combine P4 and P5 Programs

Core Responsibility 1 Care and Custody	Core Responsibility 2 Correctional Interventions	Core Responsibility 3 Community Supervision	Internal Services
P1 Institutional Management and Support	P8 Offender Case Management	P18 Community Management and Security	ISC1 Management and Oversight Services
P2 Preventive Security, Intelligence and Supervision	P9 Parole and Probation	P19 Community-Based Residential Facilities	ISC2 Communications
P3 Drug Enforcement	P10 Community Engagement	P20 Community Correctional Centres	ISC3 Legal
P4 Clinical Services and Public Health	P11 Community Engagement	P21 Community Health Services	ISC4 Human Resource Management
P5 Mental Health Services	P12 Offender Programs		ISC5 Financial Management
P6 Food Services	P13 Offender Education		ISC6 Information Management
P7 Accommodation Services	P14 OSCCA Employment and Accountability		ISC7 Information Technology
	P17 Social Programs		ISC8 Real Property
			ISC9 Material
			ISC10 Acquisitions

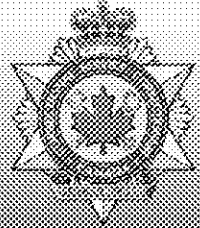
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# Health Services – Program Logic Model



\*Also reported separately for women offenders. **DRAFT - For discussion purposes only**



# Health Services – Vision, Mission & Priorities

**CSC CORPORATE PRIORITIES**

Safe management of eligible offenders during their transition from the institution to the community, and while on supervision.

Safety and security of the public, visitors, staff and offenders in institutions and the community.

Effective, culturally appropriate interventions and rehabilitation support for First Nations, Métis and Inuit offenders.

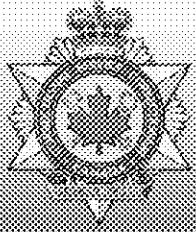
Effective and timely interventions in addressing mental health needs of offenders.

Efficient and effective management practices that reflect values-based leadership in a changing environment.

Productive relationships with diverse partners, stakeholders, citizens, groups, and others, focused to support public safety.

## HEALTH SERVICES SECTOR PRIORITIES – 2020-2025

<b>PERSON/PATIENT HEALTH CARE HOME</b> Strengthen the clinical model of primary care in line with professional standards of care, patient choice, independence and patient-centred care.	<b>PATIENTS/COMMUNITY CARE FOR DIVERSE POPULATIONS</b> Increase capacity to provide patient-centred care built on the health needs of Indigenous peoples, young offenders, offenders with mental health needs and offenders with geriatric needs.	<b>PATIENT/ADVOCACY/REGRESS</b> Focus on the role of health services in patient advocacy to provide, assist and support outcomes that improve patient-centred care, patient safety, and quality in treatment.	<b>IDENTIFYING HEALTH ISSUES/INBAYS IN A CORRECTIONAL ENVIRONMENT</b> Generation and external injection of new knowledge, best practices and evidence and integration strategies for problematic substance use and mental health issues.	<b>WORKFORCE/WORKSPACE</b> Strengthen, diversify, healthy workforce into healthy workplaces.	<b>PARTNERSHIPS</b> Strengthen, formalize and mutualize partnerships.  <b>COVID</b> Be responsible for the ongoing evolution of the COVID pandemic to ensure the health and safety of our inmates, staff and community.
<b>KEY PRIORITIES</b>					
<ul style="list-style-type: none"> <li>Enhance CSC's clinical model of primary care across the continuum of care.</li> <li>Strengthen professional autonomy and clinical independence of health care professionals.</li> <li>Ensure health care delivery in line with professional standards of care for accreditation, documentation and information sharing.</li> <li>Focus on the use of technology to support the sharing of health information, documentation and virtual care.</li> </ul>	<ul style="list-style-type: none"> <li>Build capacity for culturally safe health services by integrating Western and traditional approaches to care.</li> <li>Implement the framework for Older Persons in Custody.</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement Patient Advocacy Model.</li> <li>Support and engage in ethical reviews and discussion on issues impacting patient care (e.g. MAR, NS rule to Use of Force).</li> <li>Implement, monitor and improve the process for addressing health care-related grievances.</li> </ul>	<ul style="list-style-type: none"> <li>Continue the implementation and delivery of evidence-informed approaches to address problematic substance use including OAT, PNEP, OPS, and naloxone.</li> <li>Continue to support, implement and evaluate suicide and self-harm prevention and intervention.</li> </ul>	<ul style="list-style-type: none"> <li>Active Health Care recruitment and retention.</li> <li>Review of staffing from a population management and staff mix perspective.</li> <li>Implementation of a national training plan.</li> <li>Focus on workplace wellness and work-life balance.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor public health and community transmission information to inform decision-making.</li> <li>Review, evaluate and plan for IPC readiness and effective responses to outbreak situations.</li> <li>Effective communication, education, preparedness and management strategies in the response to the pandemic.</li> <li>Proactive planning for the acquisition, storage and distribution of vaccines.</li> </ul>
<p><b>HEALTH SERVICES VISION</b>                      Provide quality, integrated, person-centered care.</p>	<p><b>HEALTH SERVICES MISSION</b>                      In collaboration with our partners, we provide a broad range of evidence-informed health services that are responsive to the diverse needs of our population through:</p> <ul style="list-style-type: none"> <li>Promoting family and community supports</li> <li>Professional advocacy for quality health care</li> </ul>			<p>Facilitating and respecting informed individual care</p> <ul style="list-style-type: none"> <li>Fostering continuous learning.</li> </ul>	



# Health Services – Next Steps

- **Within Health Services**
  1. ASHS decision to proceed with New Core Responsibility
  2. Review and revision by NHQ Health Services
  3. Presentation and decision by HSET
  4. Review of timelines – Option 1 or Option 2
  
- **Within CSC**
  1. Consultation with AC and DGs – Finance, HR, COP, Policy
  2. Consultation with WOD, IID, Evaluation, ISBP
  3. Approval and support by Commissioner
  4. Submission to EXCOM for approval
  5. Preparation of Materials for TBS Approval
  
- **Outside CSC**
  1. Consultation with Provinces with Health Ministry providing services, Accreditation Canada
  2. Consultation with TBS



<b>CSC CORPORATE PRIORITIES</b>	Safe management of eligible offenders during their transition from the institution to the community, and while on supervision	Safety and security of the public, victims, staff and offenders in institutions and the community	Effective, culturally appropriate interventions and reintegration support for First Nations, Métis and Inuit offenders	Effective and timely interventions in addressing mental health needs of offenders	Efficient and effective management practices that reflect values-based leadership in a changing environment	Productive relationships with diverse partners, stakeholders, victims' groups, and others involved in support of public safety
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## HEALTH SERVICES SECTOR PRIORITIES – 2020-2025

<b>PERSON-PATIENT HEALTH CARE HOME</b> <i>Strengthen the clinical model of primary care in line with professional standards of care and a focus on clinical independence and patient-centered care</i>	<b>PATIENT-CENTRED CARE FOR DIVERSE POPULATIONS</b> <i>Improve capacity to provide patient-centered care with a focus on the health needs of Indigenous offenders, aging offenders, offenders with mental health needs and offenders with gender-based needs</i>	<b>PATIENT ADVOCACY &amp; REDRESS</b> <i>Focus on the role of Health Services in patient advocacy to provide input and guidance on issues that impact patient-centred care, patient safety, and quality improvement</i>	<b>MITIGATING HEALTH IMPACTS IN A CORRECTIONAL ENVIRONMENT</b> <i>Strengthen and expand infection disease prevention, harm reduction and treatment and intervention strategies for problematic substance use and suicide/self-injury</i>	<b>WORKFORCE/ WORKPLACE</b> <i>Strengthen a sustainable, healthy workforce in a healthy workplace</i>	<b>PARTNERSHIPS</b> <i>Strengthen internal and external partnerships</i> <b>COVID</b> <i>Be responsive to the evolving priorities of the COVID pandemic to ensure the health and safety of our inmates, staff and communities</i>
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**KEY PRIORITIES**

<ul style="list-style-type: none"> <li>Enhance CSC's clinical model of primary care across the continuum of care</li> <li>Strengthen professional autonomy and clinical independence of health care professionals</li> <li>Ensure health care delivery in line with professional standards of care for accreditation, documentation and information sharing</li> <li>Focus on the use of technology to support the sharing of health information, documentation and virtual care</li> </ul>	<ul style="list-style-type: none"> <li>Build capacity for culturally safe health services by integrating Western and traditional approaches to care</li> <li>Implement the framework for Older Persons in Custody</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement Patient Advocacy Model</li> <li>Support and engage in ethical reviews and discussion on issues impacting patient care (e.g. MAiD, NS role in Use of Force)</li> <li>Implement, monitor and improve the process for addressing health care related grievances</li> </ul>	<ul style="list-style-type: none"> <li>Continue the implementation and delivery of evidence-informed approaches to address problematic substance use including OAT, PNEP, OPS, and naloxone</li> <li>Continue to support, implement and evaluate suicide and self-injury prevention and intervention</li> </ul>	<ul style="list-style-type: none"> <li>Active Health Care recruitment and retention</li> <li>Review of staffing from a population management and staff mix perspective</li> <li>Implementation of a national training plan</li> <li>Focus on workplace wellness and work life balance</li> </ul>	<ul style="list-style-type: none"> <li>Monitor public health and community transmission information to inform decision making</li> <li>Review, evaluate and plan for IPC readiness and effective responses to outbreak situations</li> <li>Effective communication, education, preparedness and management strategies in the response to the pandemic</li> <li>Proactive planning for the acquisition, storage and distribution of vaccines</li> </ul>
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**HEALTH SERVICES VISION**

Provide quality, integrated, person-centered care.

**HEALTH SERVICES MISSION**

In collaboration with our partners, we provide a broad-range of evidence informed health services that are responsive to the diverse needs of our population through:

- Promoting family and community supports
- Professional advocacy for quality health care
- Facilitating and respecting informed individual care
- Fostering continuous learning.



# Health Services Commitments Summary 2020-2025

## DRAFT – For discussion purposes only

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
<b>Person-Patient Medical Home</b>					
Implementation of medical governance model and Patient-Person medical home (OCI)	2022-12-31 2017-2020	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-12-31 Update
<b>Person-Patient Medical Home: Clinical Independence</b>					
Strengthen the professional autonomy and clinical independence of registered health care professionals. (Departmental Plan)	2021-03-31 LT 2022-12-31	Ongoing	2021-03-31	DGCHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
<b>Person-Patient Medical Home: Continuum of Care</b>					
Improve the health services available through an emphasis on early assessment, diagnosis and diversion to appropriate pathways of care. (Departmental Plan)	2021-03-31 LT 2022-12-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Monitor access to mental health care for women offenders (OAG)	2017-November	Level 5 - Full implementation	HSET Biannual	DGHPP	<b>Decision:</b> Close & Monitoring <b>Mechanism:</b> PIP & Indicator development; monitoring indicator page summary; HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Review the evidence, consult with experts and pilot, if necessary, its approach to screening and triaging offenders at intake. (OAG)	2019-April	Level 5 - Full implementation	HSET Biannual	DGHPP	<b>Decision:</b> Close & Monitoring <b>Mechanism:</b> PIP & Indicator development; monitoring indicator page summary; HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Verify the validity and reliability of the Mental Health Need Scale. (Evaluation - CSC's Health Services)	2019-06-30	Complete	None	DGHPP	<b>Decision:</b> Close & NFA; decision not to amend MHNS <b>Mechanism:</b> <b>Priority:</b> N/A <b>Next BF:</b> None
Conduct a thorough review of Therapeutic Ranges by the end of 2022. (OCI)	2022-12-31	Ongoing	2021-04-30	National Senior Psychiatrist	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-04-30 Update
Patient Safety (13 flags) - sterilizing, medication storage, pharmacy review Rxs, independent double check (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Adverse Drug Reactions and Allergies (5 flags) - monitored, reported and record in medical file (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
Implementation of RTC standardization review tool, treatment centre files review and analysis (Review of Mental Health Commitments)	Completed	Level 5 - Full implementation	HSET – Biannual 2021-06-30	RDHS	<b>Decision:</b> Close & Monitoring; <b>Mechanism:</b> Note: recommendation to flag for RDs – focus on treatment planning; data worthwhile; HSET biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Continue to implement CSC's Chronic Disease Management Strategy (Evaluation - CSC's Health Services)	2020-03-31	Level 4 - Substantial Implementation	2020-09-18	DGHPP	<b>Decision:</b> Update Pending; consider whether to shift commitment - provincial differences; NMAC; standardized tools <b>Mechanism:</b> Update <b>Priority:</b> High <b>Next BF:</b> Overdue
Standardized tool for tracking of medications that are to be destroyed (7 days) (Health Canada)	2020-09-16	Complete	2020-11-30 2021-12-30	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2020-11-30 Update
Fund or expand community capacity for intensive mental health treatment for women (OCI)		Complete	None	DGHPP, RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Expand capacity of Structured Living Units for women (OCI)		Complete	None	DGHPP, RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Dental Waitlist (OCI)		Complete	HSET Biannual 2021-06-30	DGHPP, RDHS	<b>Decision:</b> Close & Monitoring; <b>Mechanism:</b> HSET biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Alternative arrangements for significantly mentally ill offenders (OCI)		Complete	None	RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Specialized complex case funding (OCI)		Complete	None	RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Monitor release planning and incorporate health-related discharge plans as required to address any identified gaps in provincial health service delivery – to resolve the challenges that sometimes arise when there are delays in the availability of provincial health professional/system to provide health care for offenders who need it. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Evidence-Informed Guidelines (9 flags) - used for improvement (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Evaluation (6 flags) - transitions evaluated and improvements, compliance with cleaning (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Communication (2 flags) - transitions evaluated and improvements (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
Amendments to Guidelines 710-2-3 (BOI)		Ongoing		COP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Policy <b>Priority:</b> Low <b>Next BF:</b> None
Work with community partners to facilitate the transfer of inmates to appropriate community housing, all palliative/terminal diagnoses to be reported and tracked nationally by the Health Services Sector (OCI)		NFA/ Ongoing	HSET Biannual  2021-06-30	DGHPP, RDHS	<b>Decision:</b> Close & Monitor <b>Mechanism:</b> HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Dedicate resource coordinate the retention and acquisition of official documentation (e.g., Health Cards, identification, birth certificates) for federal offenders prior to their release (OCI)	None noted	NFA	HSET – Biannual  2021-06-30	RDHS	<b>Decision:</b> Close & Monitor/Follow-up <b>Mechanism:</b> HSET Standing Agenda Item, Biannually <b>Priority:</b> Low <b>Next BF:</b> TBD
Mental health services - work with community partners (OCI)		NFA	2020-11-30	DGHPP, RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Improve partnerships with provincial and territorial health authorities to remove barriers to accessing health care cards. (OAG)	September 2018 and ongoing	Level 5 - Full implementation	HSET – Biannual  2021-06-30	RDHS	<b>Decision:</b> Close & Monitor/Follow-up <b>Mechanism:</b> HSET Standing Agenda Item, Biannually <b>Priority:</b> Low <b>Next BF:</b> TBD
Conduct a review of the policy pertaining to the sharing of health information with parole officers. (OAG)	2019-10-01	Level 5 - Full implementation	None	DGHPP	<b>Decision:</b> Close, refer to QI Project Consideration – GIST, Discharge Planning <b>Mechanism:</b> N/A <b>Priority:</b> Low <b>Next BF:</b> None
Quality improvement project that examines the comprehensiveness of the information shared and appropriately integrated into the community strategy. (OAG)	Begin November 2019 End December 2020	Level 5 - Full implementation	2020-12-04	DGHPP	<b>Decision:</b> Ongoing – Recommendations from report; follow up? <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2020-12-04 First Report Overdue; submitted 2021-02-18
Periodic reviews of case management files to ensure that relevant health information was shared. (OAG)	Beginning 2019-12-01	Level 3 - Preparation for implementation	2021-03-31	DGHPP, RDHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional reviews; decision regional OPIs – not tracking nationally; HSET Standing Agenda Item, Biannually <b>Priority:</b> High <b>Next BF:</b> 2021-03-31
<b>Person-Patient Medical Home: Professional Standards (Accreditation, Health Information &amp; Documentation)</b>					
Require quality improvement chart audits on a monthly basis- site/region roll up. (OAG)	2018-November	Ongoing; No follow up on MAF	HSET – Biannual  2021-06-30	RDHS	<b>Decision:</b> Close & Monitor <b>Mechanism:</b> Professional practice; integrated tool?; HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Require quality improvement chart audits on a monthly basis - NHQ review of treatment plans. (OAG)	2018-March	Level 5 - Full implementation	HSET – Biannual  2021-06-30	DGHPP	<b>Decision:</b> Close & Monitor <b>Mechanism:</b> PIP & Indicator development; monitoring indicator page summary; HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
System of regular peer reviews, medical chart audits and evaluations of medical staff - Regular chart audits (OCI)		NFA	HSET – Biannual  2021-06-30	DGHPP, DGCHS	<b>Decision:</b> Close & Monitor <b>Mechanism:</b> Professional practice; integrated tool?; HSET Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Implementation of EMR integration of physical and mental health (OCI)	EMR implemented in 2016. Monitoring, Troubleshooting, stabilization, and enhancing 2016-2020	Ongoing	2021-06-30	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project; also ongoing expansion of the EMR review; <b>Priority:</b> High <b>Next BF:</b> 2021-06-30 Update
Reviewing information-sharing practices, including obtaining inmate consent in the sharing of health information. (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Consider the application of Clinical Seclusion within Correctional Service Canada and review the need for amendments to policy to provide direction to staff with respect to documentation and the provision of meaningful interactions outside the cell. (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Physical Space (12 flags) - confidentiality and privacy, input from clients, meets laws, regulations and coded, IPAC consulted and input from IPAC/OSH (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Accreditation Preparations - risk analyses, surveys and site visits	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Quality Improvement (54 flags) - (Accreditation Flags - 2018, 2022-Jan) - QI culture, committee for medications management, indicator data (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Strategic Goals and Objectives (8 flags) - operational plans, performance shared staff, clients and partners, contracted services/providers evaluated (Accreditation Flags)	2023-01-30	Ongoing	2022-01-30	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Required Organizational Practices (15 flags) - HH compliance, infections tracked and shared, high alert medications, preventative maintenance program, PSI system (Accreditation Flags)	2023-01-30	Ongoing	2022-01-31	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
Cleaning (4 flags) - frequency, roles (Accreditation Flags)	2023-01-30	Ongoing	2022-01-31	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Regional preparations <b>Priority:</b> Medium <b>Next BF:</b> 2022-01-30 Update
<b>Patient Advocacy &amp; Redress</b>					
Improve patient advocacy. (Departmental Plan)	2021-03-31  LT 2023-03-31	Ongoing	2021-03-31	DGCHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Patient Advocacy - Implementation plan by end of fiscal year 2022-23,	2023-03-31 Implementation Plan	Ongoing	2021-11-30	DGCHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
implementation of the revised model by end of fiscal year 2023-24. (OCI)	2024-03-31 Full Implementat ion				<b>Next BF:</b> 2021-11-30Update
HS will convene an Ethics Roundtable re MAID before March 2021. (OCI)	2021-03-31	Ongoing	2021-02-28	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-02-28 Update
Medical ethics expert review of health care's role in use of force and update of policy. (Audit of Emergency Response Team)	2021-04-03	Ongoing	2021-01-29	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-01-29 Update
Review policies where Health Services is named in use of force procedures... (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Formalize a process where there will be discussions with ADCs on trends - use of force (Audit of Situation Management Process)	2018-02-28	Level 5 - Full implement ation	NFA	DGHPP	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Update to Security Bulletin – Lockdowns (BOI)		Ongoing		COP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Policy Frameworks when inmates locked in cells (BOI)		Ongoing		COP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Review of polices - compliant with Nelson Mandela Rules - Analysis and next steps (OCI)		Complete	None	DGHPP, RDHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Review of Deaths in Custody in Canada (OCI)		Complete	<b>2020-11-30</b>	DGHPP	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
<b>Harm Reduction and Mitigating Health Impacts in a Correctional Environment</b>					
Prioritize infectious disease prevention, harm reduction and treatment. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Update the policy document GL800-4, Response to Medical Emergencies (BOI)		Ongoing		Policy	<b>Decision:</b> Completed <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Harm reduction initiatives - safe tattooing, needle exchange, substance misuse (OCI)		Complete	HSET – Biannual  2021-06-31	DGHPP, RDHS	<b>Decision:</b> Close & Monitor/Follow-up <b>Mechanism:</b> HSET Standing Agenda Item, Biannually <b>Priority:</b> Low <b>Next BF:</b> TBD
<b>Harm Reduction and Mitigating Health Impacts in a Correctional Environment: Substance Use</b>					
Focus on strengthening treatment options for offenders with substance use disorders. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Align the national drug strategy with the four pillars identified in Canada's National Drug and Substances Strategy: Prevention, Treatment, Harm Reduction, and Enforcement. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Continue to provide take-home naloxone kits for inmates on discharge. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
					<b>Next BF:</b> Year-End Report, 2021-03-31
Increase access to naloxone within institutions. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Prevent fatal overdose through overdose prevention services. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Increase the number of inmates on opioid agonist treatment (OAT). (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Decrease the spread of infectious diseases through access to prison needle exchanges. (Departmental Plan)	2021-03-31	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> <b>Priority:</b> High <b>Next BF:</b> Year-End Report, 2021-03-31
Revisit PNEP Program - Report from academic expert (OCI)	2020-Fall	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31 Update
<b>Harm Reduction and Mitigating Health Impacts in a Correctional Environment: SCV</b>					
HS is to issue the draft GL 800-11 which focuses on HS' response to SCV. (OCI)	Spring 2021	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31 Update
HS is to issue the draft GL 800-11 which focuses on HS' response to SCV (OCI)	Not specified	Ongoing	2021-03-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31 Update
Developing Guidelines related to the response to alleged sexual assault. (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
<b>Harm Reduction and Mitigating Health Impacts in a Correctional Environment: Suicide/Self Injury</b>					
Release of Borderline Personality Disorder Guidelines. (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Revisions of CD 843 – improvements, enhance communication (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Suicide prevention and intervention framework - assessment, review, training, performance indicators, opportunities for research (OCI)	2019-06-01/2019-12-01	Ongoing	2021-06-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-06-31
Update the definition of self-injury in Commissioner's Directive 843... (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Review Nursing Clinical Protocols for Emergency Situations Section B. 14.0 Strangulation/Hanging Trauma (June 2018)... (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b>
Oversight and monitoring of suicide and self injury - Revised CD 843, strengthened enhanced observation, and mental health assessments under Enhanced Observation (OAG)	Completed	Level 5 - Full implementation	None	DGHPP	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
<b>Health Care Recruitment, Retention, Training, &amp; Wellness</b>					

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
Recruitment and Retention for New Resource Model - Active recruitment of additional positions (HR Plan)	2021-03-31	Ongoing	2021-03-31	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> High <b>Next BF:</b> 2021-03-31 Update
Recruitment and Retention for New Resource Model/ Orientation and Onboarding/ Manager Development for Clinical Leadership Positions (HR Plan)	2021-03-31	Ongoing	2021-03-31	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31
Recruitment and Retention for New Resource Model – Population Management & Staff Mix Reviews (HR Plan)	2021-03-31	Ongoing	2021-03-31	RDHS & ACHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> High <b>Next BF:</b> 2021-03-31 Update
Workplace Wellness and Work Life Balance - Flexible hrs, part-time, LWIA, EDOs, work from home, EAP, Mental Readiness, Open Communications, Wellness activities (HR Plan)	2021-03-31	Ongoing	2021-03-31	HSET & Managers	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31
Recognition - Formal and informal (HR Plan)	2021-03-31	Ongoing	2021-03-31	ACHS, RDHS, DG & Directors	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31
National Training Standards/ Change Management and Engagement (HR Plan)	2021-03-31	Ongoing	2021-03-31	ACHS, RDHS, DG & Directors	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31
OrgPublisher needs updating with New Resource Model (HR Plan)	2021-03-31	Ongoing	2021-03-31	ACHS, RDHS, DG & Directors	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b> 2021-03-31
Regular ongoing monitoring of the timeliness staffing processes (HR Plan)	2021-03-31	Ongoing	2021-03-31	ACHS, RDHS, DG & Directors	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> High <b>Next BF:</b> 2021-03-31 Update
Plan to have nurses work to their full scope of practice (BOI)		Ongoing		RDHS	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project/File <b>Priority:</b> Medium <b>Next BF:</b>
Judgement-based and ethical training (OCI)		NFA	None	DGHPP, DGCHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
<b>Patient-Centered Care for Diverse Populations</b>					
Independent review of all older individuals in federal custody be conducted to determine whether the community, a long-term care facility or a hospice would be more appropriate. (OCI)	2021-03-31	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
NEW Separate procedural guidelines in policy, which are evidence-based and address the management, supervision and rehabilitation of older offenders, as well as any age-specific vulnerabilities. (OCI)	2021-03-31	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
Staff with training in age-related needs - physical, social and psychological - manage behaviour related to dementia. (OCI)	2020-Jan/2020-03-01	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
Designate facilities for older individuals, facilities are designed or retrofitted to ensure physical accessibility - study to inform multi-year planning (OCI)		Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
Standardized peer assistance and peer support programs across all institutions - caregiver program (OCI)		Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
Fund and implement an integrated and comprehensive National Older Offender Strategy - Study, Infrastructure (OCI)	2021-03-31	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
Reconsider the findings and recommendations Aging and Dying in Prison - national policy framework for aging offender (OCI)	2020-Spring	Ongoing	2021-01-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> 2021-01-31, Update
Gaps identified in the Ewert v. Canada, ensure culturally-responsive indicators (i.e., Indigenous social history factors) of risk/need in assessments of risk and need. (OCI)		NFA	N/A	DGHPP	<b>Decision:</b> Close & NFA <b>Mechanism:</b> Project <b>Priority:</b> Medium <b>Next BF:</b> NFA
Gender dysphoria - Guidelines 800-5 revision - revoked (OCI)		Complete	None	DGHPP	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Collaborate with Indigenous health care professionals to explore options for incorporating traditional mental and physical healing for Indigenous patients (BOI)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b>
Collaborate with Indigenous health care professionals to incorporate traditional mental and physical healing (CR)		Ongoing		DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b>
Reviewing recommendations of Fowler Report and reaching out to community elders and healers. Plan to hire an Indigenous person within CSC Health Services to develop guidelines for Indigenous health and wellness. (MMIWG)	2021-12-31 None	Update	2021-06-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-06-31, Update
<b>NEW</b> Build capacity for culturally safe health services by integrating Western and traditional approaches to care, based on recommendations stemming from the Medicines Working Together report (Dr. Melinda Fowler, 2019) (EXCOM Sub-Committee)	2020-06-30	Ongoing	2021-06-31	DGHPP	<b>Decision:</b> Ongoing <b>Mechanism:</b> Project <b>Priority:</b> High <b>Next BF:</b> 2021-06-31, Update
<b>Corporate Reporting</b>					
Tracking of mental health treatment, staff recruitment, agreements with women's care centres, access to mental health care, waitlists. (OAG)	2021-12-31 Monitoring 2019-05-31	Ongoing	HSET – Biannual 2021-06-30	DGHPP	<b>Decision:</b> Close & Monitoring <b>Mechanism:</b> PIP & Indicator development; monitoring indicator page summary; be clear only pieces being monitored – the treatment piece; wait times – some for referrals; will work if in the PIPs; HSET - Biannual <b>Priority:</b> Medium <b>Next BF:</b> TBD
Improve the Completeness of reportable data regarding mental health needs and access to care. (OAG)	2021-12-31 Monitoring 2018-January	Level 5 - Full implement ation	HSET – Biannual 2021-06-30	DGHPP	<b>Decision:</b> Close & Monitoring <b>Mechanism:</b> PIP & Indicator development; monitoring indicator page summary; HSET - Biannual <b>Priority:</b> Low <b>Next BF:</b> TBD
Accountabilities grid (Review of Mental Health Commitments)		Level 5 - Full implement ation	None	DGCHS	<b>Decision:</b> Close & NFA <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None
Indicators in Performance Measurement Framework - significant mental health need return to federal custody during community supervision, 3 yrs, 5 yrs	a) 2015-09-30 b) 2018-09-30 and ongoing	Level 5 - Full implement ation	None	DGHPP	<b>Decision:</b> Close & NFA; Indicators no longer relevant <b>Mechanism:</b> N/A <b>Priority:</b> N/A <b>Next BF:</b> None

Shortened Summary of Action, Reference	Due	Status	Next BF	OPI	Decision & Priority
(Review of Mental Health Commitments)					

DRAFT DRAFT

## Program NEW: Health Services

Responsible Official: <u>ACHS</u>	Core Responsibility:	NEW Health Services
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### Description

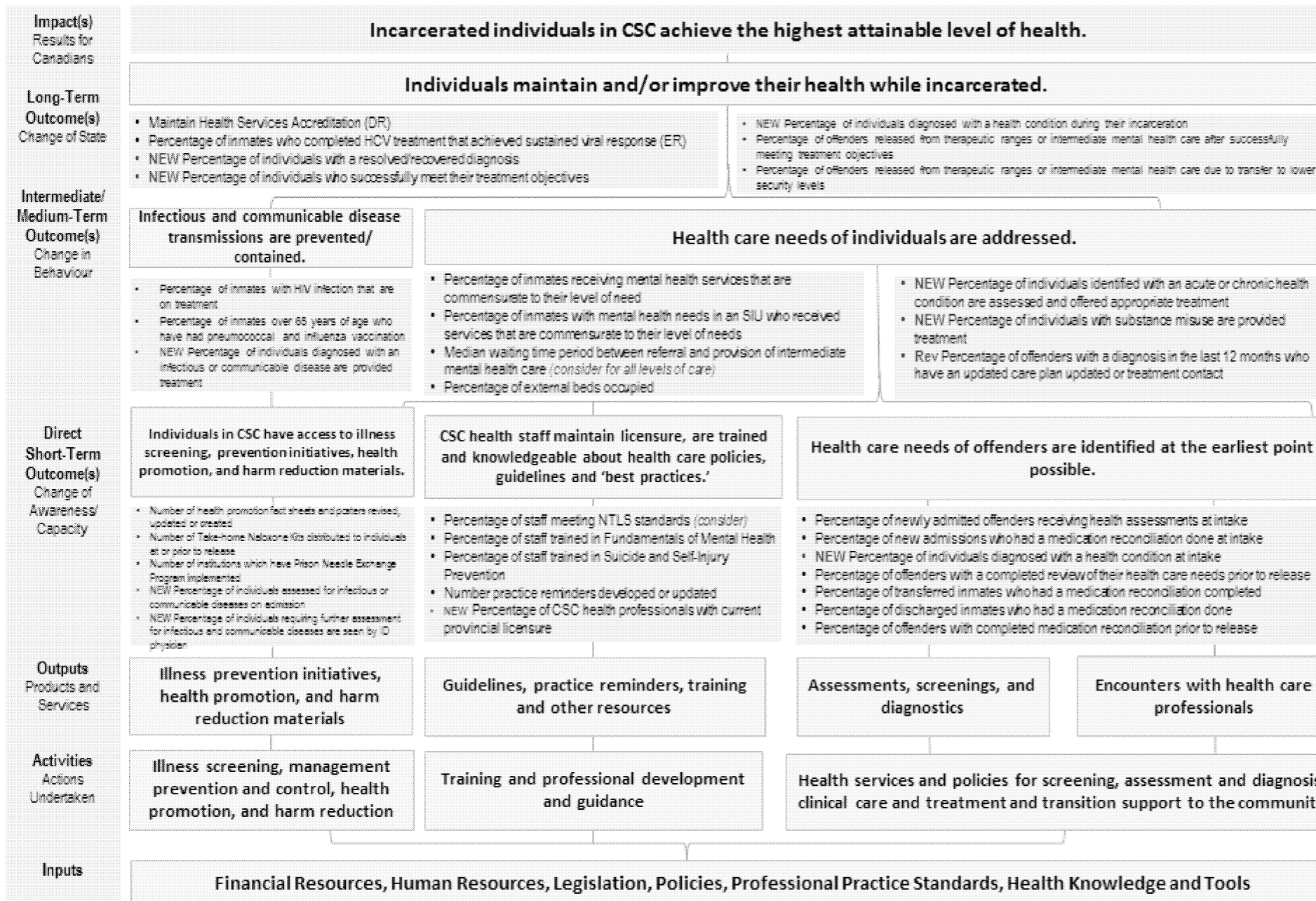
Health Services provides a broad-range of evidence-based health services in line with the diverse needs of our population. Health Services are delivered along three primary streams that form the continuum of care: Primary Care; Intermediate or Secondary Care; and Treatment Centre or Tertiary Care.

Key activities across the continuum of care include 1) illness screening, management, prevention and control, health promotion and harm reduction, 2) training and professional development and guidance 3) screening, assessment and diagnosis; 4) clinical care and treatment and 5) transition support to the community.

### How the Program Works:

The Program establishes National policy that governs the delivery of health services to inmates with the goal of improving individual and population inmate health.

# DRAFT For discussion purposes only 2021-02-28 Logic Model. NEW P: Health Services



\*Also reported separately for women offenders; \*\* Health care needs of offenders are addressed in the interest of public safety where there are gaps in provincial health service delivery

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
Incarcerated individuals maintain and/or improve their health while incarcerated.	Maintain Health Services Accreditation (DR)	Qualitative (Non-numeric)	AC Portal	4 Years	Maintain Accreditation	2023-09-30	Accreditation	ACHS	Every four years, Peer reviewers (clinicians, health care administrators etc), called surveyors, visit CSC institutions across the country to evaluate the extent to which CSC is meeting the standards, share their expertise, and make recommendations (GC Infobase)
	Percentage of inmates who completed HCV treatment that achieved sustained viral response (ER)	Quantitative (numeric)	OHIS-EMR / InfoPoint	Quarterly	90-95%	2021-03-31	90-95%	DGHPP	Calculated by dividing the number of inmates who achieved a sustained viral response (no evidence of viral activity at 12 weeks post end of treatment) divided by the number of inmates who completed treatment.
	NEW Percentage of individuals with a resolved/recovered diagnosis	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated by dividing the number of individuals with a resolved/recovered diagnosis divided by the number of individuals with a diagnosis.
	NEW Percentage of individuals who successfully meet their treatment objectives	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated by dividing the number of individuals who successfully met their treatment objectives (divided by the number of individuals with treatment plan.
	NEW Percentage of individuals who are diagnosed with a health condition during their incarceration	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated by dividing the number of individuals who were diagnosed with a health condition (time period?) during their incarceration divided by the number of incarcerated individuals.
	Percentage of offenders released from therapeutic ranges or intermediate mental health care after successfully meeting treatment objectives (TB)	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated as the percentage of individuals released from intermediate care who met their treatment objectives by all of the releases from intermediate care. Meeting treatment objectives includes a statement that objectives were met by the clinician filling out the final report, or a reduction in Mental Health Need Rating from the start of treatment to the end of treatment.

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
	Percentage of offenders released from therapeutic ranges or intermediate mental health care due to transfer to lower security levels	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated as the percentage of individuals released from intermediate care following transfer to a lower security level by all of the releases from intermediate care.
Infectious and communicable disease transmissions are prevented/ contained.	Percentage of inmates with HIV infection that are on treatment (ER)	Quantitative (numeric)	OHIS-EMR / InfoPoint	Quarterly	90-95%	2021-03-31	90-95%	DGHPP	Calculated by dividing the number of inmates on HAART by the number of inmates known to be living with HIV.
	Percentage of inmates over 65 years of age who have had pneumococcal and influenza vaccination	Quantitative (numeric)	OHIS-EMR	Annual	70-75%	2021-03-31	70-75%	DGHPP	Calculated by dividing the number of offenders who are 65 years of age who have pneumococcal and influenza vaccination over the course of the fiscal year.
	NEW Percentage of individuals diagnosed with an infectious or communicable disease are provided treatment	Quantitative (numeric)	OHIS-EMR	Biannually	TBD	2023-03-31	TBD	DGHPP	Calculated by dividing the number of individuals diagnosed with an infectious or communicable disease provided treatment (time period?) divided by the number of incarcerated individuals diagnosed with an infectious or communicable disease.
Health care needs of individuals are addressed..	Percentage of inmates receiving mental health services that are commensurate to their level of need (TB)	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	≥ 95% after excluding inmates who refuse treatment	2024-03-31	N/A	DGHPP	Work on this indicator will commence in FY 2020-21.
	Percentage of inmates with mental health needs in an SIU who received services that are commensurate to their level of needs (TB)	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	≥ 95% after excluding inmates who refuse treatment	2024-03-31	N/A	DGHPP	Work on this indicator will commence in FY 2020-21. It will flow from the indicator above, but be restricted to the SIU population.
	Median waiting time period in days between referral and provision of intermediate mental health care (TB)	Quantitative (numeric)	OHIS-EMR	Bi-annually	TBD based on 1 <sup>st</sup> year of data collection	2019-2020	N/A	DGHPP	Calculated by taking the difference in days between the referral date and the treatment start date for all individuals who are provided with intermediate mental health care.

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
	Percentage of external hospital beds occupied (mental health beds) (TB)	Quantitative (numeric)	Manual	Bi-annually	90%	2019-2020	90%	DGHPP	External bed occupancy data is tracked manually by a liaison nurse and collected bi-annually for reporting purposes
	NEW Percentage of individuals identified with an acute or chronic health condition are assessed and offered treatment	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	DGHPP	Calculated by dividing the number of individuals identified with an acute or chronic health condition assessed and offered treatment divided by the number of incarcerated individuals identified with an acute or chronic health condition.
	NEW Percentage of individuals with substance misuse are provided treatment	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	DGHPP	Calculated by dividing the number of individuals identified with substance misuse provided treatment divided by the number of incarcerated individuals identified with substance misuse.
	Rev Percentage of offenders with a diagnosis in the last 12 months who have an updated care plan updated or treatment contact	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	DGHPP	Calculated by dividing the number of individuals with a diagnosis in the last 12 months who have an updated care plan or treatment contact divided by the number of incarcerated individuals with a diagnosis in the last 12 months.
Individuals in CSC have access to illness screening, disease prevention initiatives, health promotion, and harm reduction materials.	Number of health promotion fact sheets and posters created	Quantitative (numeric)	Health Services	Annual	NA	2021-03-31	N/A	DGHPP	Calculated by counting the number of fact sheets and posters that had been revised, updated or created in a fiscal year
	Number of Take-home Naloxone Kits distributed to offenders at release	Quantitative (numeric)	OHIS-EMR	Annual	450-500	2021-03-31	N/A	DGHPP	Calculated by counting the number of Take Home Naloxone Kits distributed at release to the community
	Number of institutions which have Prison Needle Exchange Program implemented	Quantitative (numeric)	Health Services	Annual	20-25	2021-03-31	N/A	DGHPP	Calculated by counting the implementation roll-out for PNEP [NOTE: this indicator is time-limited to monitor the PNEP roll-out and will sunset 31-03-23]
	NEW Percentage of individuals assessed for infectious or communicable diseases on admission	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	DGHPP	Calculated by dividing the number of individuals assessed for infectious or communicable diseases on admission divided by the total number of admissions

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
	NEW Percentage of individuals requiring further assessment for infectious and communicable diseases are seen by ID physician	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	DGHPP	Calculated by dividing the number of individuals requiring further assessment for infectious and communicable diseases seen by ID physician divided by the total number individuals requiring further assessment for infectious and communicable diseases
CSC health care professionals are trained and are knowledgeable about health care policies, guidelines and 'best practices.'	Percentage of staff meeting NTLs standards ( health specific)	Quantitative (numeric)	NTS Updates	Annual	TBD	2021-03-31	N/A	DGHPP	Percentage of Health Service staff completing national training standards
	Percentage of target staff trained in Fundamentals of Mental Health (TB)	Quantitative (numeric)	HRMS	Bi-annually	90%	2020-03-31	90%	DGHPP	The target cannot be set at 100% because staff returning from long-term leave from their position (e.g. due to illness or taking another position on assignment/secondment) or new hires are non-compliant against the standard. While current results are significantly above this rate, they do fluctuate over time, and 90% would be the minimum performance that would be acceptable before taking corrective actions.
	Percentage of target staff trained in Suicide and Self-Injury Prevention	Quantitative (numeric)	HRMS	Bi-annually	90%	2020-03-31	90%	DGHPP	Calculated by dividing the number of target staff training in SSIP divided by the number staff requiring the training.
	Number of practice reminders developed or updated	Quantitative (numeric)	Health Services	Annual	TBD	2020-03-31	N/A	DGHPP	Count of the number of practice reminders developed or updated in the last fiscal year
	NEW Percentage of CSC health professionals with current provincial licensure	Quantitative (numeric)	OHIS-EMR/OMS	Bi-annually	TBD	2024-03-31	TBD	ACHS	Calculated by dividing the number of practicing health care professional with a current provincial licensure divided by the total number of practicing health care professionals.
Health care needs of offenders are identified at the earliest point possible	Percentage of newly admitted offenders receiving health assessments at intake (DR)	Quantitative (numeric)	OHIS-EMR/OMS	Biannually	95-100%	2021-03-31	95-100%	DGHPP	The indicator is calculated by dividing the number of inmates with a 24-hour assessment by the number of new warrants of committal in the fiscal year. (GC Infobase)

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
Essential health services screening, assessment and treatment are offered to individuals to prevent or treat their health conditions.	Percentage of new admissions who had a medication reconciliation done at intake	Quantitative (numeric)	NIAA	Quarterly	100%	31-03-19	100%	DGHPP	Calculated by taking a 25% sample of new admissions, and dividing the number of inmates who had a medication reconciliation completed at intake by the sample number of new admissions.
	NEW Percentage of individuals diagnosed with a health condition at intake								Calculated by dividing the number of individuals diagnosed with a health condition at intake divided by the total number of intake admissions.
	The percentage of offenders with a completed review of their health care needs prior to release (DR & ER)	Quantitative (numeric)	EMR-OHIS/OMS	Quarterly	95-100%	2021-03-31	95-100%	CSPH	This indicator is calculated by taking the total number of offenders who have a completed Health Status at Discharge: GIST Report form prior to release (numerator), divided by the total number of offenders who were released to the community.
	Percentage of transferred inmates who had a medication reconciliation completed	Quantitative (numeric)	NIAA	Quarterly	100%	2019-03-31	100%	DGHPP	Calculated by taking a 25% sample of transfers, and dividing the number of inmates who had a medication reconciliation done at the receiving institution by the sample number of transfers.
	Percentage of discharged inmates who had a medication reconciliation done	Quantitative (numeric)	NIAA	Quarterly	100%	2019-03-31	100%	DGHPP	Calculated by taking a 25% sample of released inmates, and dividing the number of inmates who had a medication reconciliation done before being released to the community by the sample number of released inmates.

Immediate & Intermediate Outcomes	Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
<b>Departmental Results (DR):</b> Inmates are managed in a humane manner									
<b>Expected Results (ER):</b> Efficient, effective clinical and public health services to offenders that encourage individual responsibility, promote healthy reintegration and contribute to safe communities									
	The percentage of offenders with a completed medication reconciliation prior to release (ER)	Quantitative (numeric)	NIAA	Quarterly	100%	31-03-19	100%	CSPH	Calculated by taking a 25% sample of released inmates, and dividing the number of inmates who had a medication reconciliation done before being released to the community by the sample number of released inmates.

The following indicators are not linked to outcomes in the logic model, but are maintained as efficiency measures for future evaluation purposes.

Efficiency								
Indicators	Data Type	Data Source	Data Collection Frequency	Target	Date to Achieve Target	Thresholds	Data Owner	Methodology
Average cost of physical health services per day - males	Numeric (dollars)	CRS	Annual	\$25/day	31-03-19		RMB	Average daily cost of providing all health services to male offenders (COMO)
Average cost of physical health services per day - women	Numeric (dollars)	CRS	Annual	\$43/day	31-03-19		RMB	Average daily cost of providing all health services to women offenders (COMO)

<b>Government of Canada Activity Tags</b>	<ul style="list-style-type: none"> <li>Safety and Security</li> </ul>
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### PLANNING HIGHLIGHTS FOR 2019-20

Lead OPI	Planning Highlights
ACHS	Strengthen health professionals' clinical independence and patient advocacy in accordance with <i>Bill C-83 – An Act to amend the Corrections and Conditional Release Act and another Act</i> , that came into force June 21, 2019.
ACHS	Prioritize infectious disease prevention, harm reduction, and treatment.
ACHS	Strengthen health professionals' clinical independence and patient advocacy in accordance with <i>Bill C-83 – An Act to amend the Corrections and Conditional Release Act and another Act</i> , that came into force June 21, 2019.

ACHS	Increase services available for primary and tertiary care (treatment centre) through increased staffing levels and an emphasis on early assessment, diagnosis and direction to appropriate pathways of care in accordance with <i>Bill C-83 – An Act to amend the Corrections and Conditional Release Act and another Act</i> , that came into force June 21, 2019.
ACHS	Provide targeted assessment and intervention for the mental health needs of offenders who may be at risk of engaging in self-injury and/or suicidal behaviour.
ACHS	Adopt measures to support a continuum of health care for offenders during their transition from CSC Health Services to provincial/territorial health coverage.

## RISK MITIGATION

Corporate Risk	CRP Mitigation Strategy	Performance Indicators
1. There is a risk that CSC will not be able to maintain required levels of operational safety and security in institutions and in the community	Continue interventions to reduce inmate self-injury and deaths in custody (Lead OPI: ACS supported by RDCs)	<ul style="list-style-type: none"> <li>Percentage of target staff trained in “The Fundamentals of Mental Health” and “The Suicide and Self-Injury Prevention Refresher”</li> <li>Of the inmates identified as having a significant mental health need, the number and percentage who received mental health treatment</li> </ul>
2. There is a risk that CSC will not be able to respond to the complex and diverse profile of the offender population	Make appropriate updates to the model of care to meet the health needs of offenders (OPI: ACHS)	<ul style="list-style-type: none"> <li>Percentage of newly admitted offenders receiving health screening and assessments at intake</li> <li>Of the inmates identified by the mental health intake screening system as requiring follow-up mental health services, the percentage who received a service</li> <li>Of the offenders with an identified mental health need, the percentage who received mental health treatment</li> <li>Proportion of discharged inmates who had a medication reconciliation done</li> <li>The percentage of offenders with a completed review of their health care needs prior to release.</li> </ul>

## FINANCIAL INFORMATION

### 2021-22 Departmental Plan - Budgetary financial resources (dollars)

2021-22 Main Estimates	2022-2023 Planned spending	2023-2024 Planned spending	2023-2024 Planned spending

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**2021-22 Departmental Plan – Human resources (full-time equivalents)**

2021–22 Planned full-time equivalents	2022–23 Planned full-time equivalents	2023–24 Planned full-time equivalents

**2020-21 Departmental Plan - Budgetary financial resources (dollars)**

2020–21 Main Estimates	2021–22 Planned spending	2022–23 Planned spending	2023–24 Planned spending
177,042.678	177,042.678	178,730,418	180,630,254

**2020-21 Departmental Plan – Human resources (full-time equivalents)**

2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents	2022–23 Planned full-time equivalents
778	778	778

**2019-20 Departmental Plan - Budgetary financial resources (dollars)**

2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
153,754,002	153,754,002	153,382,187	153,273,414

**2019-20 Departmental Plan – Human resources (full-time equivalents)**

2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
759	759	759

## SUMMARY OF PROPOSED EVALUATION NEEDS

<b>The drivers and rationale for evaluation</b>	<ul style="list-style-type: none"> <li>There was a comprehensive Health Services evaluation completed in 2016/17 that covered health services from intake to discharge.</li> <li>No other health services evaluation needs are identified at this time.</li> </ul>
<b>Resources for Evaluation</b>	<ul style="list-style-type: none"> <li>N/A</li> </ul>

## ADDITIONAL INFORMATION

### List of Approved Evaluations Related to the Program

Completed Evaluations - Title of the evaluation(s)	Date evaluation(s) was/were completed
Compliance and Operational Risk Report Fall 2015 – Bleach Distribution (CD 800-06)	Fall 2015
Evaluation of CSC's Health Services	March 2017
Compliance and Operational Risk Report Spring 2016 – Hunger Strikes CD 800, GL 800-1)	Spring 2016
Compliance and Operational Risk Report Spring 2016 – Response to Medical Emergencies (CD 800, GL 800-4)	Fall 2016
Compliance and Operational Risk Report Spring 2018 – Cleaning Blood and Other Bodily Fluids (CD 800-7)	Fall 2018
Compliance and Operational Risk Report Spring 2020 – Discharge Planning and Transfer (Discharge Planning and Transfer Guidelines, September 2020)	Spring 2020

### List of Relevant External Studies Related to the Program

External Studies Related to the Program: Title of the Study	Citation Information
Human Immunodeficiency Virus (HIV) and the Lived Experience of Male Inmates in Canadian Federal Penitentiaries: A Snapshot of the Ontario Region	Queens University MPH candidate
Psychotropic Medications Study	Completed on behalf of CSC by external consultant (Nipissing University)
Antimicrobial Stewardship and Resistance	Completed on behalf of CSC by external consultant (Ottawa Hospital)

External Studies Related to the Program: Title of the Study	Citation Information
Pain Management – Review and Recommendations	Completed on behalf of CSC by external pain specialist consultant
EMR (Electronic Medical Records) review and recommendations	In process (completion date Dec 2020 - on behalf of CSC by external consultant (Health Records Director, Ottawa Hospital)
Profile of Aging Offenders	University of Waterloo / Mount Sinai Hospital Research to describe inmates 65+ according to the Interai-CA instrument
Learning Circle to establish partnerships and build connections between researchers and Aboriginal women in prisons with or at risk of HIV/HCV	CAF – PHAC*
Health Behind Bars: Building Community Capacity and Setting supports for Living successfully with HIV	CAF – PHAC*
HIV/HCV Prevention, Education, Training and Support in Ontario Federal Prison	CAF – PHAC*
Supports for Living Successfully with HIV	CAF – PHAC*
Peer Education for Prevention and Support	CAF – PHAC*
HIV/HCV Prevention, Education, Training and Support in Ontario Federal Prisons	CAF – PHAC*
Centre associative polyvalent d'aide hépatite C	CAF – PHAC*
The following Research is funded through the External Research Partnership Initiative	[Include the date of publication, source, date accessed, and other relevant bibliographic details, link.] The multi-year study will continue in FY 2016-2017 and into FY 2017-2018 until a sufficient sample size has been recruited.
Study #1 <b>Prevalence of Major Mental Disorders among Women Federal Offenders</b> <u>through the MOU with the Institute of Applied Social Research at Nipissing University</u>	
Study #2 <b>Prescription Practices for Psychotropic Medication</b>	R-387 - Approved and “Off-label” use of Prescribed Psychotropic Medications Among Federal Canadian Inmates (not yet published)

\* - PHAC Community Action Fund Proposal (for approval)

#### List of Relevant Major Crown Projects Related to the Program (as appropriate)

Project name	Description
Offender Health Information System (OHIS)	Implementation of Offender Health Information System (OHIS) Electronic Medical Record (OHIS-EMR) and Pharmacy (OHIS-PHARM) systems (ongoing)

#### List of Relevant Transfer Payment Programs Related to the Program (as appropriate)

Name of transfer payment	End Date	Type of transfer payment
University of Saskatchewan	Ongoing	Grant

#### List of Services Related to the Program (as appropriate)

Service name	Description
None	

**List of Horizontal Initiatives Related to the Program (as appropriate)**

Name of horizontal initiative	Lead department(s)	Federal partner organization(s)	Start date of the horizontal initiative	End date of the horizontal initiative
Reducing the health impact of sexually transmitted and blood-borne infections in Canada by 2030: A pan-Canadian STBBI framework for action	PHAC	CSC, CIHR, PHAC, ISDC	July 9 <sup>th</sup> 2018	2030

**GOVERNMENT WIDE POLICY CONSIDERATIONS**

Considerations
Bill C-14 (Medical Assistance in Dying) Bill C-16 (Transgender Rights) Bill C-83 (An Act to amend the CCRA and another Act)