Medicaid Expansion and Inmates
Three Jails Solve the Puzzle

In Memoriam: B. Jaye Anno, PhD, CCHP-A

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For additional Important Safety Information, please see Brief Summary of Prescribing Information on adjacent pages.


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Important Safety Information

Contraindications

VIVITROL is contraindicated in patients:
- Receiving opioid analgesics
- With current physiologic opioid dependence
- In acute opioid withdrawal
- Who have failed the naloxone challenge test or have a positive urine screen for opioids
- Who have exhibited hypersensitivity to naltrexone, polyactide-co-glycolide (PLG), carboxymethylcellulose, or any other components of the diluent

Prior to the initiation of VIVITROL, patients should be opioid-free for a minimum of 7-10 days to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization.
exhibiting signs of abscess, cellulitis, necrosis, or extensive swelling should not be adequate in every patient because of body habitus. Body habitus should
VIVITROL may increase the likelihood of severe injection site reactions. The needles have been reported. Some cases required surgical intervention, including
patient developed an area of induration that continued to enlarge after 4 weeks, with
VIVITROL® (naltrexone for extended-release injectable suspension) is especially dangerous and may lead to life-threatening opioid intoxication or fatal
opioids. Any attempt by a patient to overcome the antagonism by taking opioids following their acute administration may be sufficient to overcome the competitive
surmountable. The plasma concentration of exogenous opioids attained immediately with a prolonged pharmacological effect, the blockade produced by VIVITROL is
This could result in potentially life threatening opioid intoxication (respiratory effects of potent opioids, specifically the establishment and maintenance of opioid withdrawal (which are associated with the discontinuation of opioid in a dependent individual) are uncomfortable, but they are not generally believed to be severe or necessitate hospitalization. However, when withdrawal is precipitated abruptly by the administration of an opioid antagonist to an opioid-dependent patient, the resulting withdrawal syndrome can be severe enough to require hospitalization. Review of postmarketing cases of precipitated opioid withdrawal in association with naltrexone treatment has identified cases with symptoms of withdrawal severe enough to require hospital admission, and in some cases, management in the intensive care unit. To prevent occurrence of precipitated withdrawal in patients dependent on opioids, or exacerbation of a pre-existing subclinical withdrawal syndrome, opioid-dependent patients, including those being treated for alcohol dependence, should be opioid-free (including tramadol) before starting VIVITROL treatment. An opioid-free interval of a minimum of 7–10 days is recommended for patients previously dependent on short-acting opioids. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks. If a more rapid transition from agonist to antagonist therapy is deemed necessary and appropriate by the healthcare provider, monitor the patient closely in an appropriate medical setting where precipitated withdrawal can be managed. In every case, healthcare providers should always be prepared to manage withdrawal symptomatically with non-opioid medications because there is no completely reliable method for determining whether a patient has had an adequate opioid-free period. A naltrexone challenge test may be helpful; however, a few case reports have indicated that patients may experience precipitated withdrawal despite having a negative urinalysis screen or tolerating a naltrexone challenge test. Before the setting of treatment with naltrexone from buprenorphine, patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically recognized as a manifestation of opioid withdrawal, opioid withdrawal that is precipitated abruptly may lead to systemic sequelae including acute liver injury. Patients should be warned of the risk of hepatic injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of VIVITROL should be discontinued in the event of symptoms and/or signs of acute hepatitis. Depression and Suicidality: Alcohol- and opioid-dependent patients, including those taking VIVITROL, should be monitored for the development of depression or suicidal thinking. Families and caregivers of patients being treated with VIVITROL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s healthcare provider. Alcohol Dependence: In controlled clinical trials of VIVITROL administered to adults with alcohol dependence, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo (1% vs 0%). In some cases, the suicidal thoughts or behavior occurred after study discontinuation, but were in the context of an episode of depression that began while the patient was on study drug. Two completed suicides occurred, both involving patients treated with VIVITROL. Depression-related events associated with premature discontinuation of study drug were also more common in patients treated with VIVITROL (1%–1%) than in placebo-treated patients (0%). In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, adverse events involving depressed mood were reported by 10% of patients treated with VIVITROL 380 mg, as compared to 5% of patients treated with placebo injections. Opioid Dependence: In an open-label, long-term safety study conducted in the US, adverse events of a suicidal nature (depressed mood, suicidal ideation, suicide attempt) were reported by 5% of opioid-dependent patients treated
with VIVITROL 380 mg (n=101) and 10% of opioid-dependent patients treated with oral naltrexone (n=20). In the 24-week, placebo-controlled pivotal trial that was conducted in Russia in 250 opioid-dependent patients, adverse events involving depressed mood or suicidal thinking were not reported by any patient in either treatment group (VIVITROL 380 mg or placebo).

When Reversal of VIVITROL Blockade Is Required for Pain Management: In an emergency situation in patients receiving VIVITROL, suggestions for pain management include regional analgesia or use of non-opioid analgesics. If opioid therapy is required as part of anesthesia or analgesia, patients should be continuously monitored in an anesthetic care setting by a qualified anesthesiologist, or in a postanesthesia care or surgical care setting by a qualified anesthesiologist or surgeon. The opioid therapy must be provided by individuals specifically trained in the use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. Irrespective of the drug chosen to reverse VIVITROL blockade, the patient should be monitored closely by appropriately trained personnel in a setting equipped and staffed for cardiopulmonary resuscitation.

Eosinophilic Pneumonia: In clinical trials with VIVITROL, there was one diagnosed case and one suspected case of eosinophilic pneumonia. Both cases required hospitalization, and resolved after treatment with antibiotics and corticosteroids. Similar cases have been reported in postmarketing use. Should a person receiving VIVITROL develop progressive dyspnea and hypoxemia, the diagnosis of eosinophilic pneumonia should be considered. Patients should be warned of the risk of eosinophilic pneumonia, and advised to seek medical attention should they develop symptoms of pneumonia. Clinicians should consider the possibility of eosinophilic pneumonia in patients who developed respiratory symptoms attributable to antibiotics. Hypersensitivity Reactions Including Anaphylaxis: Cases of urticaria, angioedema, and anaphylaxis have been observed with use of VIVITROL in the clinical trial setting and in postmarketing use. Patients should be warned of the risk of hypersensitivity reactions, including anaphylaxis. In the event of a hypersensitivity reaction, patients should be advised to seek immediate medical attention in a healthcare setting prepared to treat anaphylaxis. The patient should not receive any further treatment with VIVITROL.

Intramuscular Injections: As with any intramuscular injection, VIVITROL should be administered with caution to patients with thrombocytopenia or any coagulation disorders, (e.g., hemophilia and severe hepatic failure). Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunoassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunoassay instructions is recommended.

ADVERSE REACTIONS: Serious adverse reactions that may be associated with VIVITROL therapy in clinical use include: severe injection site reactions, eosinophilic pneumonia, serious allergic reactions, unintended precipitation of opioid withdrawal, accidental opioid overdose and depression and suicidality. The adverse events seen most frequently in association with VIVITROL therapy for alcohol dependence (ie, those occurring in ≥5% and at least twice as frequently with VIVITROL than placebo) include nausea, vomiting, injection site reactions (including induration, pruritus, nodules and swelling), muscle cramps, dizziness or syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders. The adverse events seen most frequently in association with VIVITROL therapy in opioid dependent patients (ie, those occurring in ≥2% and at least twice as frequently with VIVITROL than placebo) were hepatic enzyme abnormalities, injection site pain, nasopharyngitis, insomnia, and toothache. Clinical Studies Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In clinical trials and in postmarketing use, the most clinically significant liver dysfunction were observed in association with VIVITROL, including coagulation disorders and severe hepatic failure. In clinical trials of another drug and may not reflect the rates observed in practice. In all controlled and uncontrolled trials during the premarketing development of VIVITROL, more than 1100 patients with alcohol and/or opioid dependence have been treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. Adverse Events Leading to Discontinuation of Treatment: Alcohol Dependence: In controlled trials of 6 months or more in alcohol-dependent patients, 9% of alcohol-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 7% of the alcohol-dependent patients treated with placebo. Adverse events in the VIVITROL 380-mg group that led to more dropouts than in the placebo-treated group were injection site reactions (3%), nausea (2%), pregnancy (1%), headache (1%), and suicide-related events (0.3%). In the placebo group, 1% of patients withdrew due to injection site reactions, and 0% of patients withdrew due to the other adverse events. Opioid Dependence: In a controlled trial of 6 months, 2% of opioid-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 2% of the opioid-dependent patients treated with placebo.

DRUG INTERACTIONS: Patients taking VIVITROL may not benefit from opioid-containing medicines. Naltrexone antagonizes the effects of opioid-containing medicines, such as cough and cold remedies, antiarrhythmic preparations and opioid analgesics.

USE IN SPECIFIC POPULATIONS: Pregnancy: There are no adequate and well-controlled studies of either naltrexone or VIVITROL in pregnant women. VIVITROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Category C: Reproduction and developmental studies have not been conducted for VIVITROL. Studies with naltrexone administered via the oral route have been conducted in pregnant rats and rabbits. Teratogenic Effects: Naltrexone has been shown to increase the incidence of early fetal loss when given to rats at doses ≥30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). Labor and Delivery: The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. Nursing Mothers: Transfer of naltrexone and 6-naltrexol into human milk has been reported with oral naltrexone. Because of the potential for tumorigenicity shown for naltrexone in animal studies, and because of the potential for serious adverse reactions in nursing infants from VIVITROL, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Pediatric Use: The safety and efficacy of VIVITROL have not been established in the pediatric population. The pharmacokinetics of VIVITROL have not been evaluated in a pediatric population. Geriatric Use: In trials of alcohol-dependent subjects, 2.6% (n=26) of subjects were >65 years of age, and one patient was >75 years of age. Clinical studies of VIVITROL did not include sufficient numbers of subjects age 65 and over to determine whether they respond differently from younger subjects. No subjects over age 65 were included in studies of opioid-dependent subjects. The pharmacokinetics of VIVITROL have not been evaluated in the geriatric population. Renal Impairment: Pharmacokinetics of VIVITROL are not altered in subjects with mild renal insufficiency (creatinine clearance of 50-80 mL/min). Dose adjustment is not required in patients with mild renal impairment. VIVITROL pharmacokinetics have not been evaluated in subjects with moderate and severe renal insufficiency. Because naltrexone and its primary metabolite are excreted primarily in the urine, caution is recommended in administering VIVITROL to patients with moderate to severe renal impairment. Hepatic Impairment: The pharmacokinetics of VIVITROL are not altered in subjects with mild to moderate hepatic impairment (Groups A and B of the Child-Pugh classification). Dose adjustment is not required in subjects with mild or moderate hepatic impairment. VIVITROL pharmacokinetics were not evaluated in subjects with severe hepatic impairment.

OVERDOSAGE: There is limited experience with overdose of VIVITROL. Single doses up to 784 mg were administered to 5 healthy subjects. There were no serious or severe adverse events. The most common effects were injection site reactions, nausea, abdominal pain, somnolence, and dizziness. There were no significant increases in hepatic enzymes. In the event of an overdose, appropriate supportive treatment should be initiated.

This brief summary is based on VIVITROL Full Prescribing Information.
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CorrectCare® is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, law and corrections.

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Our Independence Matters
The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.
NCCHC Jail and Prison Standards Now Available Online

The National Commission and PowerDMS are proud to announce the launch of a one-year pilot program that, for the first time, gives correctional health professionals electronic access to NCCHC’s Standards for Health Services for prisons and jails. PowerDMS is a cloud-based document management software company.

Correctional health professionals now have fee-based access to view and search electronic versions of the standards manuals, making it easier than ever to understand and disseminate vital information to help ensure that systems, policies and procedures are in keeping with nationally recognized best practices.

“NCCHC is excited for the opportunity to partner with PowerDMS,” said NCCHC president and CEO Thomas Joseph, MPS, CAE, CCHP. “Correctional facilities, whether or not they are accredited, will find this new format a convenient and cost-effective way to help them improve health care quality.”

The annual subscription fee to access the jail or prison standards electronically is $39.95 for accredited facilities and $59.95 for nonaccredited facilities.

To preview the electronic standards, visit PowerDMS.com/NCCHC and sign up for a free 14-day trial. To subscribe, send an email to sales@powerdms.com, subject line “Requesting access to the NCCHC Jail [or Prison] Standards.” Or call (800) 749-5104, option 1.

NCCHC and Partners Call on Feds to Address Restraint Use in Pregnancy

The National Commission has joined the American Psychological Association and four other national organizations in calling for strict restrictions on the use of restraints on incarcerated women and adolescents during pregnancy, labor and delivery and the postpartum period.

A joint statement issued by the organizations, which represent the fields of physical and mental health, corrections, human rights and criminal justice, calls on Congress and the Department of Justice to work with state and local governments to restrict the use of restraints. The statement amplifies NCCHC’s position statement on the same subject, adopted in 2010 and reaffirmed in 2015, which states that inmates should not be restrained during labor and delivery, and that the application of restraints during all other pre- and postpartum periods should be restricted as much as possible.

The statement also echoes the recommendations in the Department of Justice’s Bureau of Justice Assistance report, Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody, which was developed in 2012 by a federal task force that included NCCHC.

Other statement cosigners include the American Jail Association, the American Congress of Obstetricians and Gynecologists, the Human Rights Project for Girls and the National Council of Juvenile and Family Court Judges.


NCCHC Now Offers Continuing Education Credit for Dentists

The American Dental Association’s Commission for Continuing Education Provider Recognition has approved the National Commission for a two-year term of recognition as a provider of continuing dental education. The term began Nov. 1.

“Receiving recognition as an ADA CERP provider is an impressive accomplishment,” said Nicholas Makrides, DMD, MPH, who serves on NCCHC’s board of directors as the ADA liaison. “This will enable NCCHC to expand its educational programming in the area of correctional oral health care and provide great benefit for dentists who work in correctional settings.” Makrides also is a member of NCCHC’s education committee.

ACCME Grants NCCHC Accreditation With Commendation

The Accreditation Council for Continuing Medical Education has granted NCCHC accreditation with commendation, the highest level of accreditation recognized by the ACCME. This designation is awarded to continuing medical education providers that demonstrate compliance in all criteria and accreditation policies through regular reporting and documentation of performance. NCCHC was lauded as “a learning organization and a change agent for physicians and the patients they serve.”

“This award is the result of concerted efforts on the part of NCCHC’s education committee and staff to excel in meeting the ACCME requirements,” said NCCHC board member Nancy White, MA, who chairs the education committee. “As a consequence, the overall quality of our educational programming has improved considerably.”

Calendar of events

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For the complete list of CCHP exams, including regional exam sites, see www.ncchc.org/cchp.
Jayne Russell, MEd, CCHP-A, began her term as chair of NCCHC’s board of directors at its annual meeting in October. She has served on the board since 2006, when the Academy of Correctional Health Professionals became a supporting organization of NCCHC and she became the Academy’s liaison to the board.

But Russell’s involvement with NCCHC goes back much further. She became a surveyor in 1990 and a lead surveyor soon thereafter. She has been a Certified Correctional Health Professional since 1993, and earned the CCHP-Advanced credential as soon as she was eligible.

Finding Her Life’s Work
During her remarks at the opening ceremony of the 2015 National Conference, Russell asked the audience to reflect on their careers: “How did I get here? What was I thinking?”

For Russell, that path originated in her work as a clinical counselor. With a master’s degree in education and counseling, she worked as a counselor for the Medford, MA, school district and, when she moved to Arizona in 1974, she became a counselor at an Arizona Department of Juvenile Corrections facility.

This experience made a profound impact on her: “I saw struggling youth offenders who needed direction. I knew then that effective interventions were critical to impact their life paths.” Several years later, when the Maricopa County (AZ) jail asked Russell to manage its deficient health services operation, she accepted, despite having little knowledge of health care administration. But she persevered, learned on the job, got involved with NCCHC and became an expert in her field.

Russell later spearheaded statewide accreditation for the Arizona prison system. “I was passionate about accreditation,” she says, “and I now felt better skilled and equipped due to the help and support of NCCHC over the years.” In 2006, she was hired by the California prison federal receiver to help rebuild health services at San Quentin, the pilot facility for the rest of the state.

Now, after a long career in health care administration in both jail and prison settings, Russell keeps busy as an independent consultant. She has worked on many special projects for NCCHC, including helping to develop a training curriculum on the Prison Rape Elimination Act.

Vision for Correctional Health Care
Russell sought the board chair position out of her desire to help advance the field. “Despite great progress in our field in the past four decades, there is still much work to do,” she says.

She espouses multifaceted goals for the year ahead, and for the long-term. First is to ensure that correctional health care practices continue to evolve.

“The board has an opportunity as well as an obligation to lend support and direction regarding evolving correctional practices,” she says. “One example is long-term isolation and its mental health impact. We need to promote effective and humane practices that work in partnership with custody operations.”

A second goal is to expand the Commission’s reach and influence: “NCCHC will continue to build and strengthen its relationships with national, state and local agencies through broad-based education, national policy direction and unrivaled jail and prison standards. We are conveners and a catalyst for change.”

Given Russell’s track record of achievement, there can be no doubt that under her well-experienced stewardship, NCCHC will make great strides toward fulfilling these goals. And that couldn’t please her more: “I am excited when I see productive ideas become reality.”

In Other Board News ...
- Eileen Couture, DO, CCHP-P, has been elected chair-elect. She has been the liaison of the American College of Emergency Physicians since 2007 and serves on NCCHC’s accreditation and policy and standards committees. She also served on the CCHP-Physician task force, is a physician surveyor and chaired the Academy board of directors. Dr. Couture works in several emergency departments in the Chicago area and is an adjunct professor in family medicine at Midwestern University, Downers Grove, IL.
- The American College of Healthcare Executives has a new liaison on the board. Samuel Soltis, PhD, has served as assistant deputy director of health services for the South Carolina Department of Corrections since 2013. Previously, he was director of health services for the state’s Department of Juvenile Justice from 2002 to 2013.
A pioneer and preeminent leader in the correctional health care field has died. B. Jaye Anno, PhD, CCHP-A, 69, passed away Nov. 3 in Santa Fe, NM, where she had lived. A founder of the National Commission on Correctional Health Care, Dr. Anno was one of the nation’s most knowledgeable experts on health care delivery systems in jails and prisons and a tireless advocate for improvement in these systems.

Over her 46-year career, most of them in correctional health care, Dr. Anno amassed an extensive body of work and well-deserved accolades. Her career began with a two-year stint as a parole officer in New Jersey. She then turned her sharp intellect to research while she earned a master’s degree in criminal justice. During this same period, in 1972, she began consulting for the American Medical Association as it embarked on the jail health care project that would evolve into the National Commission. Along with Bernard P. Harrison, JD, then a vice president at the AMA, she helped to establish the nation’s first standards for health care delivery in jails and a related accreditation program. In 1979, Dr. Anno officially joined the AMA as director of the department of correctional activities. In 1981, she earned a doctorate in criminology.

The jail program moved outside of the AMA in 1982 and a year later became the independent National Commission on Correctional Health Care, with representatives from the AMA and 21 other major supporting organizations serving as the first board of directors. Also on the board were Mr. Harrison and Dr. Anno, who served as vice president. After an 18-month departure to serve as assistant director for health services for the Texas Department of Criminal Justice, she returned to NCCHC in 1986 and was its senior vice president until 1991, when she retired to establish an independent consultancy that was active until her death.

In 2003, the Institute of Medicine of the National Academies recognized Dr. Anno and Mr. Harrison by awarding them the Gustav O. Lienhard Award for the Advancement of Personal Health Services for their leadership in promoting correctional health services through their work at the National Commission. In 1996, she received NCCHC’s highest honor, the Bernard P. Harrison Award of Merit.

**A True Pioneer**

“Jaye was a true pioneer in the field of correctional health care,” says NCCHC president and CEO Thomas Joseph, MPS, CAE, CCHP. “During my tenure, Jaye provided me with a deep insight and understanding into the health care delivery systems for our nation’s jails and prisons. Jaye will be greatly missed by everyone who met her—she made an impact on all of us.”

Throughout her career, Dr. Anno was a prolific writer and educator who authored, coauthored or edited dozens of reports, articles, chapters and books, including the seminal *Prison Health Care: Guidelines for the Management of an Adequate Delivery System.* She was the editor of NCCHC’s *Journal of Correctional Health Care* for six years, and in 1999 received NCCHC’s Award of Excellence in Communication, which was later renamed in her honor. She was an instructor at the National Academy of Corrections in the 1990s and gave countless presentations on correctional health care topics at NCCHC and other conferences. Dr. Anno was among the first to earn the Certified Correctional Health Professional credential upon the program’s launch in 1990, and when the CCHP-Advanced credential was introduced in 1993, she achieved that, as well. She also served on numerous boards, committees and task forces.

But just as important as what she achieved was what she gave to the field. A towering figure in the correctional health care landscape, Dr. Anno was admired by her many colleagues and protégés as a consummate professional who was nurturing and generous with her time and wisdom. “Jaye had an astute ability to examine situations with clarity, confidence and integrity,” says NCCHC board chair Jayne Russell, MEd, CCHP-A. “Her life was about educating and reaching out to others, which earned her the respect and admiration of all who knew her. She doggedly championed correctional health care, inspiring many and recruiting new members to the profession. We may never know the full impact of her work and service to us as professionals or to the lives of those incarcerated.”

Dr. Anno was preceded in death by her husband, Bernard Harrison. Services were held Nov. 8 in Santa Fe.

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**Share Your Memories**

Jaye Anno made an indelible impression on all who knew her. At the 2016 National Conference on Correctional Health Care—which celebrates its 40th anniversary this year—we will honor Dr. Anno with a special memorial during the conference. We invite you to share your anecdotes about Dr. Anno. At this year’s Spring and Summer conferences, we will set aside time for attendees to take part in videotaped storytelling.

This year also marks the 40th anniversary of *Estelle v. Gamble,* the Supreme Court case that is the basis for prisoners’ constitutional right to health care, setting the stage for the nationwide effort to improve correctional health care. 2016 also marks the 25th anniversary of NCCHC’s Certified Correctional Health Professional program. We also will collect personal and professional memories of these landmark events.

**Mark Your Calendar**

To participate, check our website (www.ncchc.org) for registration information for these meetings:

- Spring Conference on Correctional Health Care
  - April 9-12, Nashville
- Correctional Health Care Leadership Institutes
  - July 15-16, Boston
- Correctional Mental Health Care Conference
  - July 17-18, Boston

Donations in Jaye Anno’s honor may be sent to the Food Depot, 1222 Silver Road, Santa Fe, NM 87507. Send messages of condolence to edharrison@edharrison.com, or sign the obituary guest book at www.legacy.com.
Join an all-star lineup of correctional health care speakers, leaders and colleagues for top-notch educational programming, CE opportunities and networking. Quality correctional care gets top billing at the Spring Conference with more than 50 presentations like these:

- Adolescents: Health Risks and Solutions
- Beyond Wet to Dry: Advanced Wound Care Techniques
- Correctional Nurses: Roles, Responsibilities and Learning Needs
- Developing a Sound Policy for Canteen and Care Packaging
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- Reentry: Whose Job Is It?
- Seizure Disorder Primer for the Correctional Nurse
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- Social workers
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Meeting Location and Housing

All conference events take place at the Gaylord Opryland Resort & Convention Center. To receive the special conference rate of $189 a night (single or double), make your reservation by March 14. Call 877-491-7397 or 888-777-6779, or visit the conference website for a link to online reservations.

Register by **March 4** to save $50 on the full conference registration fee. April 1 is the last day to preregister; after that date, please register on-site. For more details about the conference—including full-day and half-day preconference seminars—or to register, visit [www.ncchc.org](http://www.ncchc.org).
Betty Hron, 1938-2015
NCCHC regrets the passing of our colleague, Betty Hron, RN-A. Hron, 77, died Dec. 27. She dedicated her career to correctional health care, serving as health services administrator at Jefferson Parish Correctional Center, Gretna, LA, for nearly 25 years. A longtime participant in the CCHP-A program as well as a past CCHP board member, she was a mentor and friend to many in the correctional health care community, sharing her knowledge as an accreditation lead surveyor and as a frequent presenter for the NCCHC standards seminars. Hron’s considerable accomplishments were recognized in 2005, when she was named recipient of NCCHC’s Bernard P. Harrison Award of Merit.

Disability Among Jail and Prison Inmates
In a report detailing the prevalence of six types of disability—hearing, vision, cognitive, ambulatory, self-care and independent living—19% of prisoners and 31% of jail inmates reported having a cognitive disability, the most common reported disability in each population. An ambulatory disability was the second most common disability, reported by 10% of each population. More than half of prisoners (54%) and jail inmates (53%) with a disability reported a co-occurring chronic condition. Overall, about 32% of prisoners and 40% of jail inmates reported having at least one disability. Prisoners were nearly three times more likely and jail inmates were more than four times more likely than the general population to report having at least one disability. The Bureau of Justice Statistics report, issued Dec. 14, is titled Disabilities Among Prison and Jail Inmates, 2011–12.

• www.bjs.gov/index.cfm?ty=pbdetail&iid=5500

Antibiotic-Resistant Gonorrhea Threat Emerges
Echoing warnings issued recently in Great Britain, the Centers for Disease Control and Prevention has said that the emergence of multidrug- and cephalosporin-resistant gonorrhea in the United States would make gonorrhea much more difficult to treat. The warnings are based on findings of antibiotic-resistance cases in Britain and other countries. Says CDC epidemiologist Robert Kirkcaldy, MD, “The threat of untreatable gonorrhea underscores the importance of identifying new treatment options, ensuring adherence to screening and treatment guidelines—including treatment of (infected) partners—and increasing awareness among individuals on how they can best protect themselves from infection.” Providers are urged to quickly report all treatment failures to public health authorities.

• medicalxpress.com/news/2016-01-antibiotic-resistant-gonorrhea-threat.html

Diabetes Rate Declines
From 1991 to 2009, the number of new cases of diabetes among adults in the United States increased sharply, from 573,000 to more than 1.7 million. However, from 2009 to 2014, the number of new cases decreased significantly to approximately 1.4 million, according to data published by the CDC. Overall, some 29 million persons have diabetes and 86 million adults have prediabetes, putting them at risk for developing type 2 diabetes, heart disease, and stroke.

• www.cdc.gov/diabetes/statistics/incidence/fig1.htm
• www.cdc.gov/mmwr/preview/mmwrhtml/mm6445a1.htm?s_cid=mm6445a1_w

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Leveraging NCCHC’s expertise in correctional health care, NCCHC Resources, Inc., provides customized education and training, preparation for accreditation and professional certification, performance improvement initiatives and technical assistance to correctional facilities interested in health care quality improvement. NRI will put together a team of experts — clinicians, educators, administrators or other thought leaders — to address any sized project or challenge. A nonprofit organization, NRI works to strengthen NCCHC’s mission: to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities.

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We have a unique opportunity to provide care to a vulnerable population.”
Spotlight on the standards

Juvenile Standards 2015: What’s New?

by Tracey Titus, RN, CCHP-RN

The 2015 edition of NCCHC’s Standards for Health Services in Juvenile Detention and Confinement Facilities is the product of a task force of experts representing all disciplines within correctional health care.

The Standards lay the foundation for constitutionally acceptable health services systems and are the basis for NCCHC accreditation, which is a voluntary, ongoing process for continuing improvement. They address nine general areas: governance and administration, safety, personnel and training, health care services and support, patient care and treatment, health promotion, special needs and services, health records and medical-legal issues.

Each entry consists of the standard’s number and name, the standard itself, the compliance indicators, definitions (if any) and the discussion. The standard’s intent remains the first sentence of the discussion. The “optional recommendations” and “performance measures” from 2011 have either been eliminated or incorporated into the discussion.

Each standard is designated as either essential (facilities must meet 100% of those applicable) or important (facilities must meet 85% of those applicable). Four standards that were classified as important in the 2011 manual have either been eliminated or incorporated into the discussion.

Thirteen standards were renamed or renumbered, and one section was renamed:

• A-08 Communication on Patients With Special Needs is now Communication on Patients’ Health Needs
• B-01 Infection Control Program is now Infection Prevention and Control Program
• B-05 Federal Sexual Abuse Reporting Regulations is now Federal Sexual Abuse Regulations
• B-06 Procedure in the Event of Sexual Assault is now Response to Sexual Abuse
• C-01 Credentialing is now Credentials and Privileges
• C-12 Continuity of Care During Incarceration is now Continuity and Coordination of Care During Incarceration
• G-06 Intoxication and Withdrawal is now G-07
• G-07 Care of the Pregnant Juvenile is now G-09 Counseling and Care of the Pregnant and Postpartum Juvenile
• G-08 Juveniles With Alcohol and Other Drug Problems is now G-06 Patients With Alcohol and Other Drug Problems
• G-09 Family Planning Services is now G-08 Contraception and Family Planning Services
• G-10 Aids to Impairment is now Aids to Reduce Effects of Impairment
• H-03 Access to Custody Records is now H-04
• H-04 Management of Health Records is now H-03
• Section E Juvenile Care and Treatment is now Patient Care and Treatment

Some changes to the standards were substantial, others were more subtle. These standards were extensively revised:

• A-03 Medical Autonomy
• A-06 Continuous Quality Improvement Program
• B-03 Patient Safety
• B-06 Response to Sexual Abuse
• C-02 Clinical Performance Enhancement
• C-08 Health Care Liaison
• D-02 Medication Services
• D-05 Hospital and Specialty Care
• E-02 Receiving Screening
• E-04 Health Assessment
• E-07 Nonemergency Health Care Requests and Services
• E-12 Continuity and Coordination of Care During Incarceration
• F-05 Use of Tobacco
• G-01 Chronic Disease Services
• G-07 Intoxication and Withdrawal
• G-08 Contraception and Family Planning Services
• G-09 Counseling and Care of the Pregnant and Postpartum Juvenile
• G-11 Care for the Terminally Ill
• I-02 Emergency Psychotropic Medication
• I-03 Forensic Information

Snapshot of Notable Changes

A few of the notable changes in the 2015 standards are outlined below.

In the Governance and Administration section, A-03 Medical Autonomy introduces a new concept to the standards: Health staff members do not write disciplinary reports. While it is permissible for health staff to write an informational report about an incident, they should not be involved with the determination of disciplinary action as a result of the incident. If juveniles believe that health staff are able to influence discipline, it may discourage their use of the health care system, potentially creating a barrier to access to care.

A-06 Continuous Quality Improvement Program has changed significantly. This standard no longer requires a basic or comprehensive CQI program in which facilities had to conduct one to two process studies and one to two outcome studies per year, depending on their average daily population. Now, all facilities must establish a quality improvement committee. They must continue to study site-specific problems, but the type of study conducted is determined by the health care problem in question.

In the Personnel and Training section, C-02 Clinical
Performance Enhancement was broadened to encompass all direct patient care clinicians, including RNs and LPNs. C-08 Health Care Liaison was changed to clarify when a health care liaison is required. A liaison is required when qualified health care professionals are not available for 24 hours, instead of when they are not on-site. A plan must still be in place that tells child care staff what to do when a health situation arises when health staff are not present.

In the Health Care Services and Support section, D-02 Medication Services has a new compliance indicator that focuses on issues of timeliness with medication delivery. The standard requires specific time frames from ordering to delivery, and backup plans if the time frames cannot be met. In D-05 Hospital and Specialty Care, a written agreement with the community hospital or off-site specialty services is no longer required, but it is recommended.

In the Patient Care and Treatment section, several standards have notable changes. E-02 Receiving Screening now requires that all females be offered a test for pregnancy; those who report opiate use are offered the test immediately and others are referred to health staff within 48 hours for testing. Tests for sexually transmitted diseases must be offered upon arrival or within 24 to 48 hours. Additional inquiries are now required on the receiving screening form.

E-04 Health Assessment now requires that all positive findings are reviewed by a treating clinician no matter who conducts the health assessment, and for this standard, a treating clinician is defined as a nurse practitioner, physician assistant or physician. A test for tuberculosis is required unless there is documentation from the health department that the prevalence rate does not warrant it.

E-09 Segregated Juveniles discourages prolonged segregation of more than two to five hours except under documented exceptional circumstances.

E-12 Continuity and Coordination of Care During Incarceration was almost entirely rewritten to be more patient-centered. Compliance indicators require timely care and sharing of treatment plans and testing results with patients.

In the Special Needs and Services section, G-01 Chronic Disease Services now requires clinical protocols for hypertension and sickle cell disease. The requirements for documentation in the health record were changed to include monitoring disease control (poor, fair or good) and patient status (stable, improving or deteriorating), as well as taking appropriate action to improve outcome. G-05 Suicide Prevention Program redefined several terms, for example, “actively suicidal” was changed to “acutely suicidal” and “potentially suicidal” was changed to “nonacutely suicidal.” G-08 Contraception and Family Planning Services has significant changes and also introduces language regarding the availability of contraception.

Finally, in the Medical-Legal Issues section, I-01 Restraint and Seclusion now specifies that health staff should order clinical restraints and seclusion only for patients exhibiting behavior dangerous to self or others as a result of medical or mental illness. I-02 Emergency Psychotropic Medication has additional follow-up care requirements following the use of such intervention.

Complying With the New Standards
Accredited facilities may choose to follow either the 2011 or the 2015 edition of the Standards until May 1, when all programs must be in compliance with the 2015 edition. Facilities that are undergoing surveys before May 2016 and choose to be accredited under the 2011 edition must submit a transition plan to NCCHC by May 1 outlining the changes that will be made to comply with 2015 Standards.

Tracey Titus, RN, CCHP-RN, is NCCHC’s manager of accreditation services. If you have a question about the NCCHC standards, write to accreditation@ncchc.org. Find the complete Spotlight series at www.ncchc.org/standards-explained.
Exotic Medical Condition and Some Care: Deliberate Indifference Not Present for Clinicians

by Fred Cohen, LLM

Correctional health care law is loaded with anomalies and complexities. There is the verbal maze of deliberate indifferences appended to the question of a serious medical condition and within that maze there are a number of corridors that lead nowhere and a few that lead to an exit. Whether it is a desirable exit likely will depend on whether you are a plaintiff or a defendant.

_Tandel v. County of Sacramento_, 2015 WL 1291377 (E.D. Cal. 2015) illustrates every corner of the above introduction—and more. The factual narrative of the plight of a hapless detainee and his two trips through the Sacramento jail raises a number of legal issues just below the basic constitutional framework of “seriousness” and “deliberate indifference.”

For example, once there is a medical diagnosis and some responsive treatment, is it the duty of the detainee-patient to keep staff informed of progress or its lack thereof, or is it the duty of health care staff to do regular follow-ups assessing progress? Is the legal requirement on progress placed on the caregiver and the patient?

The complex facts in _Tandel_ led me to distinguish between staff simply not responding to a medical complaint with an examination and a diagnosis and responding but getting the diagnosis wrong. In the same vein, there is the issue of a custodian providing no treatment versus treatment that simply does not work. Where does deliberate indifference fit?

With this as an introduction, let’s take an abbreviated look at the facts in _Tandel_, noting first that the posture of the case is a decision on defendant’s motion for summary judgment.

**Facts**

Plaintiff, who seeks damages based on a claim of deliberate indifference to his serious medical needs, apparently has a difficult to diagnose, rare disease. A U.C. Davis diagnosis was acute disseminated encephalomyelitis (ADEM). A few years later, a Stanford clinic changed the diagnosis to neuromyelitis optica (NMO), an extremely rare condition.

_Tandel’s_ jail medical journey began in 2007 while a detainee in the Sacramento jail. He suffered a head injury as a result of an altercation with two other inmates. His wound was cleaned and sutured but soon afterward he began to experience headaches, inability to sleep followed by difficulty seeing and a debilitating weakness in his legs. Indeed, he simply collapsed one day in the shower and his cries for help were not responded to.

Initial complaints about his vision and legs did not result in any medical follow-up. Plaintiff claims he tried using his cell’s call bell to get help but was told to stop using the button and then punished for again doing so.

When finally examined, no neurological problems were found. Only after his sixth day of hospitalization was the diagnosis of ADEM applied. He required catheterization to void his bladder. Damage to his optic nerve left him with decreased vision.

To this point, the plaintiff is claiming that the delay in diagnosis and appropriate care exacerbated his symptoms and pain. He was released from jail in 2007 and his family provided constant nursing care at home.

In 2009, he filed suit over his 2007 confinement. In 2010, he obtained the Stanford NMO diagnosis. Later in 2010, plaintiff was again arrested, this time for possession of bullets in violation of his probation. Plaintiff said he acquired the bullets to commit suicide. As an aside, why the local probation folks violated a person with his medical condition, and then over a minor event, baffles me.

Plaintiff was put on suicide watch and received some psychiatric services and supposedly the same level of health care provided to others on the health care unit. He was then unexpectedly transferred to general population, which diminished his access to needed health care.

Plaintiff experienced pain and a number of technical problems with the catheterization he was receiving. He was repeatedly medically evaluated during this interim period of seven days in 2010.

Finally, he was also diagnosed with neuritis in his right optic nerve. Plaintiff claims this occurred due to staff indifference to his treatment needs.

**Legal Analysis**

Plaintiff must establish deliberate indifference to his serious medical needs. The district court easily finds that there were sufficient facts alleged to show his medical need was serious during his 2007 and 2010 incarcerations.

It’s deliberate indifference that is the most difficult call. Defendants must know of, and disregard, a serious medically related risk. That can be shown by not providing care or the unresponsiveness of the care to the condition.

Interestingly, Sheriff McGinness is found potentially liable. He was aware of the long-standing deficits in his jail’s medical staff and care. Indeed, a local grand jury made such findings.

Plaintiff claims his use of the call button to summon custodial staff and request medical care was repeatedly ignored; indeed, the housing logs themselves contain no mention of many of the complaints made by plaintiff despite the fact that custodial staff should have documented all such requests. Additionally, when plaintiff collapsed in the show-
er on May 17, 2007, his requests for help went unheeded for more than 30 minutes, and the responding deputy failed to even file an incident report in contravention of jail policy, a frightening that led to his formal discipline. Two days later, custodial staff went so far as to lock down plaintiff’s entire pod for what is alleged to have been plaintiff’s excess use of the call button for aid.

Given McGinness’s prior knowledge of understaffing at the jail and the effect that it had on needed medical care, as revealed by the grand jury’s 2005-06 report and also a subsequent report, as well as the fact that plaintiff’s subsequent incarceration contains allegations of ongoing impediments to seeking medical assistance, the court concludes that factual issues exist that preclude summary adjudication as to Sheriff McGinness. These factual issues extend both to the extent of McGinness’ knowledge about understaffing and lack of access to medical care at the jail, and to whether those shortcomings exacerbated plaintiff’s condition.

As for the claims relating to the 2010 incarceration, the defendants are medical professionals, custodial staff or supervisors. The court finds that the facts alleged do not support a claim of deliberate indifference. As an opening example, let me use Dr. Bauer for that purpose.

Dr. Bauer’s primary involvement in plaintiff’s care occurred over five visits between April 27 and May 4, 2010, for management of plaintiff’s chronic pain. During this period, Dr. Bauer did not refuse to provide plaintiff with medication; to the contrary, he adjusted dosages in an attempt to better manage plaintiff’s pain, and discontinued morphine use because of concerns that it was causing plaintiff’s headaches. While plaintiff speculates that Dr. Bauer adjusted his pain medication to help him get through his deposition on May 14, 2014, that hardly amounts to deliberate indifference. The court finds that plaintiff has not met the high standard for asserting deliberate indifference against Dr. Bauer.

Plaintiff fares no better in his claims against Drs. Sahba and Sotok, the remaining two physician defendants. Plaintiff’s chart indicates Dr. Sahba initially saw him on March 25, 2010, after he had threatened suicide. Although plaintiff takes issue with the suicide precautions taken by Dr. Sahba, her chart note reflects a concern about plaintiff’s ability to transfer from his mattress to his wheelchair and indicates she followed up with two other physicians about that concern. The fact that she felt it was “too risky” under the circumstances to permit clothing and a different kind of bed does not equate to deliberate indifference. Nor does Dr. Sahba’s examination on April 9, when she prescribed ointment for plaintiff’s pressure sores, and ordered urinalysis and other testing to see whether plaintiff’s complaints of penile pain were related to a sexually transmitted disease, suggest anything approaching deliberate indifference.

Finally, when plaintiff saw Dr. Sahba a third and final time on April 22, she referred him to an ophthalmologist and a neurologist given his reports of continuing leg and back pain, as well as vision issues. She also ordered follow-up urinalysis. Again, the fact that Dr. Sahba examined plaintiff and recommended treatment for what she observed does not show deliberate indifference. The fact that Dr. Sahba, and other jail medical personnel, did not immediately recognize symptomatology suggesting either ADEM or NMO cannot be deliberate indifference given the rarity of those conditions and the fact that neurological specialists at the U.C. Davis Medical Center had difficulty in properly diagnosing plaintiff’s condition.

Comment

Once an exotic medical condition was established with conflicting expert diagnosis, along with some regular medical attention, the case for deliberate indifference fades and then disappears. Could the medical care have been better? Yes. Does that equate with deliberate indifference? No.

It is the sheriff who ends up holding the potential liability bag. He knew how bad things were with staff and access to care and apparently for a period of time did nothing when he had a duty to do something.

Fred Cohen, LLM, is executive editor of the Correctional Health Care Report. This article was published in the November/December 2015 issue, ©2015 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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Health care reform has been the law of the land since Jan. 1, 2014. Thanks to the provisions of the Affordable Care Act, many jail inmates are now eligible for Medicaid based on their income, while others may be able to afford federally subsidized insurance through state health insurance exchanges. Accordingly, jails around the country are now proactively supporting inmate access to health services covered by Medicaid and enrollment in their state’s health insurance exchange.

The National Institute of Corrections reports that jails can see significant financial benefits by taking advantage of these opportunities. According to a September 2013 report of the Large Jail Network, careful local planning and coordination of services can ultimately reduce costs to the jail. Furthermore, access to community-based health care and substance abuse treatment is likely to decrease recidivism.

The legal status of a person involved in the justice system has a major impact on their eligibility for coverage under the ACA. The chart on page 17 illustrates these differences. For specific guidance and information on the ACA and jails, see the resources cited on page 19.

One fruitful area for savings is inpatient hospitalization in the community: When a Medicaid-eligible inmate is admitted for 24 hours or longer, Medicaid-covered services provided will be covered pending subsequent enrollment. The same is true for admission to non-correctional nursing, juvenile psychiatric and intermediate care facilities. This rule existed prior to the ACA, but the expanded eligibility criteria means that jails (and prisons) can pass along the expense when these inmates require inpatient care.

The potential impact of ACA on correctional facilities depends largely on each state’s decision about whether to expand Medicaid. In the 31 expansion states, eligibility is extended to all citizens with incomes at or below 133% of the federal poverty level—a criterion that applies to most people who enter our jails. In these states, many inmates are eligible for Medicaid upon release.

One fruitful area for savings is inpatient hospitalization in the community: When a Medicaid-eligible inmate is admitted for 24 hours or longer, Medicaid-covered services provided will be covered pending subsequent enrollment. The same is true for admission to non-corrective nursing, juvenile psychiatric and intermediate care facilities. This rule existed prior to the ACA, but the expanded eligibility criteria means that jails (and prisons) can pass along the expense when these inmates require inpatient care.

This article summarizes the experiences of three jail facilities in Colorado, New York and Oregon, all of which participated in the ACA’s Medicaid expansion. To collect this information, a survey was sent to a key contact at each facility and then follow-up questions were posed to gather more details. All three jails house individuals who are non-arraigned, arraigned and pending disposition, and sentenced.
Colorado: El Paso County Criminal Justice Center, Colorado Springs

Survey Responder: Wendy Habert, MBA, CCHP, fiscal and compliance services manager

Facility Size: The average daily population is 1,428 and the average daily intake is approximately 64.

Summary: Screening for insurance coverage is done at admission by CJC contracted medical staff. The facility does not bill insurance for medical care provided inside the facility. For Medicaid-eligible inmates admitted to a local hospital for 24 hours or longer, the hospital will bill Medicaid; the same is true for inmates with private insurance. (An exception is that state law allows for charging the inmate for care provided for self-inflicted injuries and preexisting conditions.)

CJC is the first county jail in Colorado to be classified as an official Medicaid enrollment site. In August, the sheriff’s office entered into a partnership with the El Paso County Department of Human Services in which DHS employees work inside the jail Monday through Friday, at no cost to taxpayers, to meet with inmates as they release from custody. DHS staff screen individuals for Medicaid eligibility and enroll those who qualify; they also provide information on local resources and programs. These staff also aid in Medicaid screening and enrollment for inmates being admitted to local hospitals. Each housing unit has literature explaining the various DHS resources available to inmates upon release, along with other informational materials such as the inmate handbook.

As an official Medicaid enrollment site, CJC is one of only a handful of jails across the county providing this kind of direct access to Medicaid screening for eligibility and direct enrollment, not only for inmates but also for the general public, who can visit the jail and ask for assistance from a DHS staff member. And, through the partnership with DHS, inmates also have ready access to other resources to help them succeed in the community, such as food assistance, temporary assistance to needy families, aid to the needy disabled and job placement assistance.

Results: During the first three months of the DHS partnership, 440 people—about 27% of all releasees during DHS-staffed hours—were enrolled in Medicaid at release. Another impressive outcome is financial: In 2015, approximately $567,000 in hospital inpatient medical expenses incurred by inmates was billed to and paid by Medicaid.

In recognition of these successes, the state agency that administers the Medicaid program has invited Habert to join a work group designed to help Colorado counties understand how best to use Medicaid to assist the jail-involved population. Habert also is arranging a partnership with the El Paso County Public Health Department that will complement the one with DHS. It will enable releasing inmates to be assessed and referred for assistance in the community, including medical and mental health care as well as prescription assistance coverage.

According to Wendy Habert, these activities to educate, screen and enroll individuals may lead to other positive outcomes:

- A healthier inmate population
- Reduction in expense related to the contracted medical services provider
- Reduction in the community/taxpayer burden of paying for medical and mental health care provided in jail
- Better quality of life and health for individuals with access to medical, mental health and substance abuse treatment
- Encouragement for former inmates to become more productive and successful members of the community
- Reduction in recidivism rates to the jail
- Strengthened relationships among agencies vested in public health, medical and mental health care, healthy living and reduced recidivism

To contact Habert about the El Paso County Criminal Justice Center’s inmate assistance programs, write to wendyhabert@elpasoco.com.

Which justice-involved individuals are eligible for coverage under the ACA?

<table>
<thead>
<tr>
<th>Status</th>
<th>Health Insurance Exchange</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretrial but not detained</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pretrial, detained</td>
<td>Yes, depending on specific plan requirements</td>
<td>No (unless he or she receives inpatient treatment outside the jail)</td>
</tr>
<tr>
<td>Sentenced but not detained</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sentenced and incarcerated</td>
<td>No</td>
<td>No (unless he or she receives inpatient treatment outside the jail)</td>
</tr>
</tbody>
</table>

Source: Questions & Answers: The Affordable Care Act and County Jails (2014), National Association of Counties

continued on page 18
**Oregon: Multnomah County Detention Center, Multnomah County Inverness Jail, Portland**

**Survey Responder:** Nancy Griffith, LMFT, director of corrections health

**Facility Size:** The detention center, which comprises two adult facilities, has an average daily population of 1,280 and approximately 100 intakes per day.

**Summary:** Screening for insurance coverage is done at admission by health services staff.

Medicaid (known as the Oregon Health Plan) is suspended for inmates who were on Medicaid in the community prior to their incarceration. State regulations stipulate that if an inmate is incarcerated for more than a year, Medicaid is terminated. In either case—in suspension or termination—jail health staff help to reinstate or reenroll inmates before release.

Once they have been housed, all inmates are screened for Medicaid eligibility and eligible inmates are enrolled during the release process.

The jail’s health services department hired two individuals to fill a 1.5 FTE position as eligibility specialist. The ES identifies and enrolls eligible inmates in Medicaid and for those who don’t qualify, helps them to enroll in a private health plan through the federal health insurance marketplace. (Oregon’s state marketplace, Cover Oregon, ceased operation in mid-2015.)

The eligibility specialist targets inmates for enrollment in several ways. During intake screening, inmates may tell the nurse that they want to be enrolled, and the nurse will then send a note to the ES. The inmate housing areas also have sign-up sheets to meet with the ES. To ensure that nobody slips through the cracks, each day the ES cross-references the jail admission list with a database of all current participants in the Oregon Health Plan and identifiies inmates who need to be enrolled. Finally, the ES reviews the chronic disease list to ensure that all eligible individuals have insurance before release.

Off-site hospital services are available for inmates. If the patient stays longer than 24 hours and is Medicaid eligible, then the hospital bills Medicaid for the stay. Eligibility is communicated to the hospital by the eligibility specialist.

The jail does not bill for health care provided to inmates with private insurance, mainly because the cost to modify the electronic record system to do that would exceed the monies reimbursed, according Griffith.

**Results:** To date, some 4,000 individuals have been enrolled in insurance via the jail. In 2014, the county saved more than $1 million in medical costs by having the hospital bill Medicaid instead of the county.

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**New York: Monroe County Jail, Rochester**

**Survey Responder:** Ronald Harling, MPA, superintendent

**Facility Size:** The jail has an average daily population of 1,400, and books 52 inmates per day.

**Summary:** Screening for insurance coverage is done at admission by medical staff from the jail’s contracted health services provider. In New York, Medicaid is suspended for inmates who were on Medicaid prior to their incarceration. Working remotely, staff from the Monroe County Department of Human Services use an electronic jail census report to cross-reference with the Medicaid rolls. DHS staff also reinstate these inmates to Medicaid upon release.

In addition, at intake critical-need and high-risk individuals are screened for Medicaid eligibility by the medical personnel and DHS “navigators.” The navigators are funded by the state-based health insurance exchange (NY State of Health) through the federal navigator program. Both the navigators and the jail medical personnel enter the inmate’s background information into the exchange enrollment program, which determines their eligibility. The navigators enroll those eligible prior to their release to the community.

When inmates who have private insurance are hospitalized, the jail provides the hospital with the insurance information. A county law that took effect in December 2012 enables the hospital to bill for medical expenses for inmates who have private insurance. For Medicaid-eligible inmates, the inmate will be enrolled at the hospital, and the hospital will then bill Medicaid. However, Harling says, inmates are sometimes held in the hospital observation rooms for extended period without being admitted. In these cases, Medicaid is not billed and the county continues to cover the cost.

**Results:** Implementing the screening and enrollment processes did not require the addition of new staff. While Harling does not yet have hard data on the financial impact, he says that the savings gained by having Medicaid and private insurance cover hospitalization costs are substantial. In addition, the savings were reflected in the latest contract with the jail’s health services provider.
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• Helps obtain community support and provides justification for budget requests
• Protects the health of the public, staff and inmates

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Significant Successes

With just a few changes to process as well as partnerships with other county agencies, the three jails profiled here have made significant strides in securing Medicaid for individuals who previously had no health insurance coverage.

At all three jails, health staff screen inmates for insurance upon admission. All three jails also strive to identify Medicaid-eligible inmates, either at intake or during incarceration, and assist the inmates in enrolling prior to release. In Monroe County, this is done by “navigators” from the Department of Human Services as well as health staff, with a focus on critical-need and high-risk individuals. In Multnomah County, this assistance is given by eligibility specialists on staff, who use several methods to identify all eligible inmates. Multnomah was the only county of the three to hire new staff for these purposes. In El Paso County, this work is done by staff from the county Department of Human Services. The DHS also provides significant assistance with other reentry needs.

For inmates with private insurance, the jails do not bill insurance for health care provided inside the jail.

The jails work with the local hospitals to ensure that Medicaid-eligible inmates admitted for at least 24 hours have their expenses billed to Medicaid. The jails report significant savings on these expenses. For Multnomah County, it amounted to more than $1 million in 2014.

Judith Cox, MA, CCHP, is principal of JFC Consulting, which specializes in forensic consulting to the correctional health care field. Contact her at cox@nycap.rr.com. Jaime Shimkus is the editor of CorrectCare®.

For Further Reading

• The Affordable Care Act and Criminal Justice: Intersections and Implications (July 2012)
  Bureau of Justice Assistance

• Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System (December 2013)
  Council of State Governments Justice Center

• Questions & Answers: The Affordable Care Act and County Jails (October 2014)
  National Association of Counties

• County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage (March 2012)
  National Association of Counties

• Health Care Coverage Options for Incarcerated People
  HealthCare.Gov
  www.healthcare.gov/incarcerated-people

• Resources on the Impact of the Affordable Care Act on the Criminal Justice System
  National Criminal Justice Association
  www.ncja.org/issues-and-legislation/aca
Five-Step Challenge to Implement CQI

by Lisa DeBilio, PhD, LPC, and Lorraine Steefel, DNP, CTN-A

If you and members of your organization continually ask, “How can we do it better, more efficiently?” then continuous quality improvement is the answer. CQI is a systematic method for continuously finding better ways to provide patient care and services.

At Rutgers University Correctional Health Care, CQI is a core competency that facilitates success in implementing UCHC’s strategic plan to provide mental and physical health services to approximately 21,486 patients within 12 prisons, three secure care facilities and nine juvenile residential community homes across New Jersey. Here, CQI teams work together to identify problems and implement solutions.

Charged with a fundamental CQI spirit, UCHC encourages all staff to take up the following five-step challenge, UCHC’s “how-tos” that organizations can follow to implement CQI.

1. Involve New Staff From the Beginning

At UCHC, the new staff orientation period lays the foundation for CQI. Through dialogue, staff learn what CQI is and how it relates to UCHC’s strategic plan, discuss any previous experiences they may have had with CQI and dissect the inner workings of a CQI project that substantially affected the quality of care in the correctional setting.

New staff who may ask, “Why do I need to know about this?” or state “I was not hired to do CQI” learn that CQI is a requirement for maintaining NCCHC accreditation, making it an essential practice for all—physicians, psychiatrists, dentists, mental health clinicians, nurses, medical technicians, leaders and support staff. At a half-day class held shortly after orientation, they learn the nuts and bolts of CQI.

2. Support a CQI Culture Through Inclusivity and Team Spirit

To kick off a group-oriented project, UCHC staff of all levels and disciplines form teams of five to eight, including staff involved in the day-to-day operations and at least one who has decision-making responsibility to help facilitate the implementation of proposed interventions. The team brainstorms ideas for possible projects (until ideas are exhausted), without critique from the group, as a scribe writes the ideas on a flip chart. Members vote for their choice of project, which should be related to the mission and values of the organization, involve high-risk or high-volume processes such as medication errors, be based on client needs or staff views of the needs and provide an opportunity for improved clinical outcomes and/or cost savings.

With the project chosen, teams categorize the probable causes of the problem, listing them on a cause-and-effect fishbone diagram (so named for its shape); vote on the main causes; and use Pareto charts, vertical bar graphs that clearly show the relative importance of the problem’s causes from highest to lowest. With their newfound team spirit, they then brainstorm interventions and work to develop the final interventions and the pre- and post-measures they will apply, working with those who are closest to the problem. For example, if there is a problem with keep-on-person medication distribution, in addition to those who distribute KOP medication, the team may involve the site administrator, the pharmacist, the nurse manager and custody officers.

3. Use a Framework

There are a variety of ways to conduct CQI studies. NCCHC recommends using a general outline for correctional CQI programs, and encourages facilities to use a structured process to identify areas in need and to develop and implement strategies for improvement. At UCHC, CQI teams follow the four phases of the CQI process: plan and design, measure, assess, and improve, using the resource “Bridging the Gap Between ‘What Is’ and ‘What Should Be’: A Step-by-Step Workbook and Reference Guide,” written by QI directors at UCHC and University Behavioral Health Care (see author information for web address).

At the CQI plan-and-design stage, teams flesh out the purpose of the project, how it relates to the organization’s mission and values, who should be involved and the resources needed to implement interventions that address the problem. At the measurement phase, they implement interventions and collect and analyze data to measure their effectiveness.

During the assessment phase, the team reviews the data analysis and the effects of the intervention, comparing the data to other sources of information in the literature, from accrediting organizations such as NCCHC, and the facility’s prior performance as well as that of other facilities within the organization. During this phase, the project is either declared a success with the intent to test the intervention or it is abandoned. If they declare a project successful, they create new or revised processes, educate staff, share the improvements and continually monitor the improvements to ensure continued success. Because the CQI model is circular, it may be necessary to take a step back and work through the previous steps before proceeding. For example, if an intervention is not successful, the team can revisit, revise and then reimplement it.

4. Share the Results and Network

In collaboration with the New Jersey Department of Corrections, medical and mental health services are provided by Rutgers, the State University of New Jersey, Trenton, through its subsidiaries University Correctional Health Care and UCHC’s parent organization, University Behavioral Health Care.
Corrections, UCHC hosts an annual performance improvement fair for all employees as a forum for staff to share information about their CQI initiatives and achievements. Teams present posters and project summaries while attendees have the opportunity to view each poster and network with the teams, which drives staff to consider projects for their facilities.

An expert panel of judges representing the NJDOC, the Juvenile Justice Commission and UBHC evaluates the projects for their clarity of purpose and strong performance improvement focus; potentially strong impact on quality of care; evidence of consistent, comprehensive planning; and the application of the CQI process.

The top three projects from the mental health and medical divisions receive plaques, and all participants receive certificates of appreciation. Winning projects are considered for submission to the annual statewide QI fair cohosted by the New Jersey Department of Human Services, the New Jersey Department of Children and Families and UBHC. Since the PI fair’s inception in 2006, the number of projects has increased from 30 to more than 40, and more than 300 staff members participated in 2014.

5. Sustain CQI

Rather than an endpoint, CQI is a journey that includes accountability and the continuous review of processes. Built into their performance reviews, UCHC leaders are held accountable to guide the development of at least one CQI project per unit that will be submitted to the PI fair and accomplished during the year.

Every Friday, clinical leaders track NJDOC specific objective performance indicators, which are based on NCCHC standards and other sources, in day-to-day operations such as intake assessments, chronic care visits, dental visits and mental health encounters. Positive OPIs show that the CQI process is working.

One example of a major improvement achieved through the CQI process is the increase in overall patient satisfaction with mental health services, as shown by patient satisfaction surveys that have trended upward from 3.7 in 2005 to 4.0 in 2015.

Overcoming the Challenge

Providing quality of care is especially challenging in a complex organizational structure. In the New Jersey DOC, following the five-step challenge to implement CQI has made a difference in looking at “what is” and changing it to “what should be.”

Lisa DeBilio, PhD, LPC, is director of quality improvement and Lorraine Steefel, DNP, CTN-A, is nurse educator and clinical coordinator with Rutgers University Correctional Health Care, Trenton, NJ. To contact the authors, email Lisa.DeBilio@Rutgers.edu or Lorraine.Steefel@Rutgers.edu.


To read about the first UCHC PI fair, see Staff Health Fair Celebrates Quality Improvement in the Summer 2007 issue of CorrectCare®, available from the online archive at www.ncchc.org/correctcare-archive.
Tips for Effective—and Safe—Phlebotomy in Prisons and Jails

by Mark Morin, PBT (ASCP)

Corrections phlebotomy entails all of the same standards as phlebotomy at a general hospital or clinic. But in correctional settings, it also has other considerations: the safety and security of the patient, the safety of other correctional employees and the phlebotomist’s personal safety.

Although each environment has its own idiosyncrasies, performing phlebotomies on inmate-patients—especially in maximum security settings—presents a unique set of challenges compared to working in a hospital or at a community-based lab. This article offers suggestions for addressing those challenges.

Organization Is Essential

Be organized. Focus on the task. Yes, this is true for every phlebotomist, but it is especially true for a correctional phlebotomist. Most experienced phlebotomists have supplies within an arm’s reach and have extra supplies available, and know what tubes are needed. All necessary supplies need to be within reach of the phlebotomist, but not within reach of the patient. Most phlebotomists will have extra supplies such as needles within easy reach. They keep needles and all sharps locked inside a cabinet, and only the needle needed for that phlebotomy is out. Make sure that inmates do not have access to sharps or anything else.

Know your supplies. Correctional phlebotomists know what supplies they have, especially sharps. The hard polypropylene material that most vacuum tubes are made of can be sharpened and can become a dangerous weapon. Glass tubes are easily weaponized. Iodine and alcohol, of course, are poison. Inmates should not have access to lab supplies. All of this demands scrutiny and vigilance.

Patients in Restraints

Be prepared to draw blood from patients who are wearing restraints and handcuffs. Sometimes an inmate is confined to his or her cell and placed into in-cell restraints. This may include full stationary restraint, leg irons, belly chains or handcuffs. Often when an inmate’s behavior has decompensated to where this level of confinement becomes necessary, the health care provider will want stat or ASAP blood work. Unfortunately, the patient who is most decompensated is often the patient whom the provider is most anxious to have drawn. In the facility in which I work, modification of any inmate’s restraints is usually within the purview of the custody supervisor and/or psychiatry. The restraints may not and should not be removed by request from a phlebotomist.

Blood can be obtained from an inmate in handcuffs, and in our restrictive housing units, this is done rou- tinely. Instruct the patient to straighten his arm to be drawn with the palm up. Also, instruct him to hold his hands together so the weight of the arm not being drawn from is supported by his hands and not held up by the cuffs. Consult with your supervisor if you cannot safely perform a phlebotomy.

Stay organized when entering an inmate cell. Special housing can present challenges. For example, an inmate suspected of having tuberculosis is placed in a negative pressure cell inside a correctional infirmary. A phlebotomist arranges all necessary supplies before donning gown, mask and gloves, and enters a the negative pressure room with all supplies needed. A cell will not have a wall-mounted sharps container, so the phlebotomist needs to bring a sharps container into the cell.

Managing Supplies and Specimens

Use equipment and carts to aid organization. Use a cart, if one is available, to carry your supplies into a cell. You can organize and arrange your supplies easily on a cart. This helps with inventorying all of your supplies before entering and before leaving the cell. Except for the dressing applied after the phlebotomy, leave nothing inside an inmate cell.

The phlebotomist is responsible for making sure that all specimens are labeled before leaving the patient area. Most phlebotomists will label specimens at the patient’s bedside. A correctional phlebotomist will label all the tubes before entering a patient’s cell. This lessens the movement and shortens the time spent in the patient’s cell.

Summing Up

If correctional phlebotomy were not fraught with many challenges, it would probably be less rewarding. But lives depend on the safety and security of our institutions. Pay attention to your surroundings. Be vigilant. Know what, sharps, tubes and other supplies are in your cabinets. Know what sharps, tubes and supplies are in use. Be organized. Focus on the task.

Mark G. Morin, PBT (ASCP) is a lab assistant 3 with Correctional Managed Health Care, UConn Health, Cheshire Correctional Institution, Cheshire, CT.
Correctional mental health professionals face unique challenges. They must provide effective, efficient care to a high-acuity population while facing strict security regulations, crowded facilities and myriad legal and public health concerns. Specialty certification for qualified mental health professionals recognizes dedication to quality service delivery.

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For more information, visit www.ncchc.org/CCHP.
A Correctional Health Care Risk Reduction Program

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the fifth in a series on patient safety.

P
atient safety is foundational to a successful risk reduction program and provides support for every program component. Risk reduction in correctional health care includes both traditional processes and elements that are unique to the practice setting. Here are five components of a correctional health care risk reduction program: adverse event analysis, inmate grievance management, credentialing and competency, regulatory and accreditation compliance and claims management.

Adverse Event Analysis

Adverse event analysis is a primary function of risk management. A structure that supports patient safety principles in reporting and analyzing adverse events will also support the reduction of patient harm and liability in the correctional setting.

An adverse event is any injury caused by medical care. Adverse event analysis proactively identifies and corrects potential system failures. Adverse event analysis differentiates clinical error from other types of injury and seeks to prevent similar errors from arising in the future. The components of adverse event analysis are identification, cumulative tracking and evaluation.

Identification

For adverse event identification to effectively enhance organizational learning and reduce future error, institutions must be attuned to the structure and process of initial event reporting. First, the reporting of errors must be non-punitive, protected and voluntary. This is especially true for errors that might have been caused by a significant breach in protocol; however, any error reporting can be mishandled in a dysfunctional or punitive environment. Staff members must feel that the information they share will be handled fairly and treated confidentially.

Cumulative Tracking

Although each adverse event must be evaluated individually, cumulative tracking of types of events provides important systems information. Here is where efforts to quantify types of events can be important. Cumulative tracking helps identify persistent systems issues and failure-prone processes that must be addressed. Quantification can also determine priorities for system changes. A consistent method for accumulating and reporting adverse events is an important component of both risk management and quality improvement efforts.

Evaluation

The power of an adverse event reporting program is in the evaluation process. Adverse event evaluation then considers engineering human factors concepts and potential for normalization of deviation in determining a course of action to reduce likelihood of another such event. A primary method of adverse event evaluation is root cause analysis, which reconstructs the events and trajectory of an incident to determine causative factors and safety failure modes. The strength of root cause analysis is the ability to thoroughly evaluate all possible contributing causes for the event, rather than simply relying on the first or most obvious cause discovered on investigation.

Inmate Grievance Management

Management of inmate grievances is another key component of risk management in correctional health care. An inmate grievance is equivalent to a patient complaint in a traditional health care setting. Grievances can involve a variety of situations and conditions, with a number of them related to health care. Like adverse events, grievances must be evaluated both individually and in aggregate. They provide clues to unsafe systems and providers, even acting as an early warning system regarding safety issues.

Promptly dealing with individual inmate grievances can often avert future legal action. Even if unfounded, inmate legal claims can tie up considerable time and financial resources to establish and account for the actual care provided. Reviewing aggregate reports of inmate grievances over time can identify latent system issues for proactive attention. For example, accumulating grievances about lack of attention to dental issues may reveal a delay in the sick-call request triaging system or a need for more dental staff hours to accommodate the number of requests.

Some correctional settings have a culture that trivializes inmate complaints and ascribes manipulative motivations to all inmates filing grievances. On an individual case basis, this is demeaning, but on an organizational level, disregarding patient complaints in the form of grievances can result in a lost opportunity to reduce error and increase patient safety. Using inmate grievances as an opportunity for system and process improvement supports a patient-centered approach to health care provision and harm reduction.

Credentialing and Competency

Competent and appropriately credentialed care providers are the backbone of a safe health care delivery system. An essential element of risk management programs is the confirmation of credentials at the start of employment, followed by an initial evaluation of competence and an ongoing program to develop competencies of all staff in the organization. It is not uncommon for incompetent providers to seek employment in the correctional system on the mistaken belief that standards are lower when dealing with inmate-patients than the general public. Safeguards must be in place to prevent these individuals from entering the correctional health care field.
Regulatory and Accreditation Compliance

Compliance with regulatory and accreditation standards is another major component of risk management programs. These requirements reflect the standard of practice in the field and provide the structure for delivery of safe patient care.

Regulatory Compliance

Government regulatory agencies seek to protect the public from harm through legal requirements and oversight. Correctional health care providers are no different; they must comply with federal, and possibly state, regulations—and the list can be daunting. The following are a few prime examples of agencies and legal acts that must be considered:

- Occupational Safety and Health Administration – use of sharp safety devices, employee injury, environmental chemicals (material safety data sheets)
- Clinical Laboratory Improvement Amendments – on-site laboratory testing
- Patient Self-Determination Act – consent and advanced directives
- Child Protective Services – reporting of abuse or neglect

Accreditation Compliance

Although not all correctional health care settings are accredited, accreditation principles are often used as the reference for agency policy and procedure. Accreditation standards are considered standards of practice from a legal perspective. Prudent management of risk ensures that health care delivery in correctional facilities matches accreditation standards as closely as possible.

Claims Management

Claims management is a significant part of the risk management program. Once a patient makes a claim of injury, the health care entity initiates steps to reduce liability and provide appropriate defense of actions. There are significant financial, professional and personal implications to the resolution of these claims. Correctional health care claims can take two forms: professional liability claims and civil rights claims.

Professional Liability Claims

Professional liability claims are the most common claim in traditional health care settings and involve an allegation of professional negligence in an action or omission by a care provider. To prevail in the case, the claimant (plaintiff) must prove four basic elements:

1. The defendant had a duty to the claimant in his or her professional capacity.
2. There was a breach of duty in the incident under consideration.
3. This breach of duty caused the injury in question.
4. The plaintiff suffered damages due to the breach of duty. Damages could include pain, suffering, medical expenses or other losses.

Duty to a patient is often encapsulated as standard of care. In correctional health care, standard of care is determined by community or constitutional standard. Accreditation standards are often considered the standard of care in correctional health care litigation. Expert testimony is then used to determine the standard of care for a particular professional in a clinical situation.

Civil Rights Claims

Civil rights claims are more common in the correctional health care setting as these claim abrogation of the plaintiff’s constitutional rights under the Eighth or 14th Amendment to the U.S. Constitution. Civil rights claims are adjudicated through Section 1983 of the Civil Rights Act of 1871, which provides for civil liability on any person who deprives another citizen of his or her constitutional rights. The Eighth Amendment protects citizens from cruel and unusual criminal punishment. In the landmark ruling regarding Estelle v. Gamble in 1976, the Supreme Court determined that withholding necessary medical care constituted cruel and unusual punishment as defined by this amendment. Case law following Estelle established three basic rights to sentenced inmates:

1. The right to access care
2. The right to receive the care that was ordered
3. The right to a professional health care judgment

In addition, Estelle prompted the court to establish the term “deliberate indifference to serious medical need.” Deliberate indifference requires the defendant to both know about and disregard a serious health need. A serious medical need is defined as one that is diagnosed as needing treatment and/or a condition so obvious as to be recognized by even a layperson as needing medical care.

Robust Framework

The patient safety movement, developed in traditional practice settings over the last two decades, provides a robust and fruitful organizational framework for managing risk in correctional health care. By focusing on the patient, efforts to reduce harm lead to decreased clinical error and therefore reduced litigation risk. Likewise, a patient safety focus will naturally lead to the improved clinical processes and outcomes desired by continuous quality improvement programs. Therefore, a patient safety management model benefits all stakeholders in correctional health care.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation to jails and prisons on projects to improve professional practice and patient safety. Her latest book, the Correctional Health Care Patient Safety Handbook, is available in print and Kindle versions from amazon.com. Contact her at lorry@correctionalnurse.net.
Meet the 2015 Recipients of the Most Prestigious Awards in Our Field

NCCHC’s annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud this year’s recipients of the most prestigious awards in this field. The awards were given Oct. 19 at the opening ceremony of the National Conference on Correctional Health Care in Dallas, TX.

Bernard P. Harrison Award of Merit
NCCHC’s highest honor, this award is presented to an individual or group that has demonstrated excellence and service that has advanced the correctional health care field, either through an individual project or a history of service. The award is named after NCCHC’s cofounder and first president.

RADM Newton E. Kendig, MD
For visionary leadership in the field of correctional health care

Over the course of his illustrious career, Rear Adm. Newton Kendig, MD, has proved to be one of the country’s foremost experts on correctional health care. The Bernard P. Harrison Award of Merit joins the many other awards he has received, including the U.S. Public Health Service’s highest honor, the Distinguished Service Medal.

As medical director for the Federal Bureau of Prisons and assistant director for its health services division, Dr. Kendig (now retired) was responsible for the medical care, food services and occupational health and safety of inmates in the nation’s largest correctional system, the BOP’s 121 institutions. He also provided oversight for more than 850 commissioned officers, 3,800 health care providers and a staff of nearly 40,000 people working in those facilities.

He ensured the delivery of medically necessary health care and nutritionally sound meals to an inmate population of 210,000, as well as securing safe living and working conditions for inmates and staff. In meeting those responsibilities, he was both a meticulous manager and a visionary leader. The lengthy list of his contributions to the field illustrates his commitment to quality health care and innovation.

Dr. Kendig took an active role in improving clinical care for inmates: he expanded pharmacists’ role in patient care, implemented a primary care provider team model that assigns patients to a specific provider and ensures continuity of care, and designed a clinical director peer review program that strengthened the BOP’s physician workforce. Under his watch, the BOP published comprehensive clinical practice guidelines and a national drug formulary that broadly define the scope of health care services for federal inmates and are widely adopted by state correctional systems. He established BOP centers of excellence, resulting in improved clinical care for the sickest inmates; developed a systemwide infection control program; changed federal policy allowing inmates access to organ transplantation; and implemented a comprehensive preventive health care program for inmates.

His contributions range from structural enhancements (establishment of the National Health Care Governing Board and the Mental Health Clinical Care Committee) to technological advances (the launch of a Web-based medical and pharmacy record system in 2009, before electronic health records were widespread, and expanded telehealth programming to include telepsychiatry) and nutritional improvements (adoption of a BOP national menu, which improved nutrition for inmates and staff).

Before joining the BOP in 1996 as chief of infectious diseases, Dr. Kendig was medical director of the Maryland Department of Corrections and Public Safety. In 1999, he was tapped to be the BOP medical director, and in 2006 he was named assistant director of the health services division.

He has shared his visionary perspective and expertise with NCCHC conference attendees on topics including “The State of Correctional Health Care at the End of the Millennium” and “What Correctional Health Will Need From Its Leaders in 2019 and Beyond,” as well as the keynote address at the 2015 National Conference on Correctional Health Care.

B. Jaye Anno Award of Excellence in Communication
This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. The award is named after NCCHC’s cofounder and first vice president.

John R. Miles, MPA
For advancing the field of correctional health care through his stewardship of NCCHC’s professional journal

In a career spanning almost four decades, John Miles, MPA, has communicated his deep understanding of public health, correctional health and the ways the two intersect with readers, students, health care practitioners, government agencies and private-sector clients. As a writer, editor, educator, administrator and consultant, he has generously shared his expertise and knowledge. Experienced in multiple dimensions of public health program planning, implementation, administration, management and evaluation at the local, state and federal levels, he is an invaluable asset to the Journal of Correctional Health Care.

For almost 15 years, Mr. Miles has served at the helm of the Journal, now widely recognized as the premier academic publication in the field. As editor, he has provided invaluable insight and experience. He oversaw the transition of the Journal from a self-published, twice-yearly publication...
into a quarterly journal on par with the most respected peer-reviewed journals, bringing added legitimacy and scholarship to the field.

Mr. Miles was a key player in NCCHC’s Health Status of Soon-to-Be-Released Inmates report, a seminal national research project that provided Congress with policy recommendations on correctional health, public health and inmate reentry. He also served as managing editor of the Surgeon General’s Call to Action on Correctional Health and the Community.

After several years working on HIV/AIDS and other STDs for the New York City Department of Health, Mr. Miles joined the Centers for Disease Control and Prevention, where he served as a public health advisor for the National Center for HIV, STD and TB Prevention. He retired from the CDC after 34 years of service.

Currently, Mr. Miles provides extensive consultation in the area of correctional health through his role as executive vice president of Carter Consulting, Inc., headquartered in Atlanta, which provides management and technical support services to federal, state and local government and private sector health agencies. He is the author of numerous government reports that have shaped public health policy, and textbook chapters that have inspired the field of correctional health care.

R. Scott Chavez Facility of the Year Award

This prestigious award is presented to one facility selected from among the nearly 500 prisons, jails and juvenile facilities accredited by NCCHC. The award is named after NCCHC’s longtime vice president.

Maricopa County Jail System, Phoenix, Arizona

The Maricopa County Jail System is made up of six NCCHC-accredited jails; it has an average daily population of more than 8,000 and a health staff of more than 300. Despite those large numbers, Maricopa County Correctional Health Services is a study in efficiency, coordination, information-sharing and quality care, provided by a team of professionals who understand that every person housed in the jail system is their patient.

This coordinated care begins at intake, where everyone entering the system—that’s about 300 people a day—receives comprehensive health screening. While health providers assess new arrivals, a corrections officer keeps them informed of the intake process and answers questions. Each individual must receive medical approval for booking to begin, allowing the staff to provide continuity of care as well as make necessary referrals to mental health, substance abuse or acute care services.

Each jail is equipped with an outpatient clinic for sick call, acute medical needs, chronic care visits and wound care, as well as mental health services. A 60-bed infirmary is staffed by board-certified physicians who, according to one surveyor, exemplify the system’s remarkable degree of coordination: “With no notes in front of him, [the doctor] knew each patient’s case and was able to answer my questions without hesitation. These were not all his patients, but because of utilization review, grand rounds, shift reports and general information sharing, he was knowledgeable of all the patients.”

With between 700 and 800 seriously mentally ill inmates at any given time, the need for mental health services is considerable. Mental health and psychiatric care is available at each jail and in a 220-bed inpatient mental health unit staffed around-the-clock by psychiatrists and mental health professionals.

A state-of-the-art electronic health record helps tie the system together and facilitates coordination. Continuous quality improvement programs are well-developed; copies of the NCCHC Standards are in evidence throughout the jails and are frequently cited by staff. Surveyors were especially impressed by the quality of care and concern for the patients, leading one to say that Maricopa County’s health staff “would be the envy of the best hospitals in any city.”

NCCHC Program of the Year Award

This award recognizes programs of excellence among the thousands provided by accredited prisons, jails and juvenile facilities.

South Texas Detention Complex, Pearsall, Texas Continuous Quality Improvement Program

The South Texas Detention Complex is, in the words of an NCCHC surveyor, dedicated “to doing the right thing, and doing it well.” The complex is a privately owned detention facility under contract with U.S. Immigration and Customs Enforcement to house people who have entered the country illegally, with a capacity of more than 1,900 detainees. For some of them, this represents their first experience with professional medical care.

The facility’s dedication to providing quality health services is evident in its continuous quality improvement program, which uses specific measurable indicators to ensure timely treatment, continuity of care and compliance with NCCHC standards. The CQI program encompasses the entire care delivery system, addressing both the quality and safety of clinical care and the nonclinical aspects of services identified by NCCHC. The multidisciplinary CQI committee’s objectives include evaluating health services for the purpose of improvement and developing and implementing corrective action plans where problems or opportunities for improvement are identified.

Recent studies examined medication safety, chronic care management of diabetes and hypertension, medical housing unit care plans and urgent sick call care. All resulted in improvements.

The South Texas Detention Complex received NCCHC accreditation as a result of its initial survey—a testament to the continuous quality improvement practiced at the facility.
Chlamydia Prevalence Supports Universal Screening at Intake for Female Youth

Chlamydia is most common among young women, is usually asymptomatic and is highly prevalent among incarcerated populations. Therefore, the Centers for Disease Control and Prevention recommends universal chlamydia screening for all females younger than 35 years of age upon intake to correctional facilities.

But in juvenile detention facilities, is this comprehensive approach really necessary? If the right screening criteria were used, could a targeted approach identify almost all infections while also reducing costs? To find out, a team of researchers from the CDC and the San Diego County (CA) Health and Human Services Agency conducted a study to identify factors associated with chlamydia among females aged 12 to 18 entering a county juvenile detention facility over an 18-month period. The results are summarized by Elizabeth Torrone and colleagues in the January issue of the Journal of Correctional Health Care.

Identifying Screening Criteria
In San Diego, policy has been to screen all females entering juvenile detention within six hours, with more than 92% screened per year, on average. Overall, a high positivity rate of 12% was found from 2003 to 2012. Although this suggests a need to continue universal screening, the program was assessed as part of a quality improvement study.

The facility in this study completes a sexual risk assessment, including chlamydia risk factors, for every juvenile booked. The researchers examined demographic, arrest and health data from the records of all intakes in which the female tested positive, and a random sample of negative intakes.

Statistical analysis was used to link these potential risk factors to infection, and different screening criteria were created based on combinations of five variables associated with infection: age, arrest for sex work, sexually active, STD risk factor and prior positive chlamydia test in record. Screening criteria performance was assessed in terms of the proportion of infections detected (sensitivity) and the proportion of females that would be screened (efficiency).

Results
During the period under study, 93.7% of female intakes at the facility received a chlamydia test. Of the 1,771 tests, 10.3% were chlamydia positive. Of the positive tests, intake records were available for review for 89.1%. In addition, records for 10.5% of all negative intakes were selected at random. Overall, 331 intakes were reviewed—163 positive and 168 negative—representing 294 females (some had multiple intakes).

Many combinations of the five variables had high efficiency but low sensitivity. To find 85% of all infections using combinations of factors associated with chlamydia, more than 70% of intakes would need to be screened. Even among females reporting no sexual activity, chlamydia prevalence was 4.2%, higher than the usual cut-point of 3% prevalence for screening cost-effectiveness.

The authors found that this study could not identify an acceptable targeted screening approach—one that reduced the number of females screened while capturing most chlamydia cases. “It is possible that there is a combination of factors that could be used to effectively target screening — but that those factors are not routinely collected,” they say. However, they conclude, “Our findings support the current recommendation of screening all young females at intake to correctional facilities.”
Jaye Anno, CCHP Extraordinaire

Certified Correctional Health Professionals around the country mourn the passing of one of the most influential individuals in the field, B. Jaye Anno, PhD, CCHP-A, cofounder of the National Commission on Correctional Health Care.

“Jaye's knowledge and vision were indispensable to the successful creation of the CCHP program,” says current chair and longtime trustee Edwin Megargee, PhD, CCHP.

Dr. Anno was a member of the first ad-hoc CCHP committee, which met in 1989 to develop the program, and was reappointed to the committee in 1991. In 1994 she was appointed to a three-year term on the CCHP board of trustees and served one year as its chair.

Among the first correctional health care professionals to earn the CCHP credential when it was introduced in 1990, Dr. Anno also was one of the first to achieve CCHP-Advanced status.

Dr. Anno was a mentor, inspiration and friend to many. For more about her life and work, please see page 8.

CCHP Program Strong and Growing

All five components of the Certified Correctional Health Professional program experienced great activity in the last three months of 2015. The exams yielded 109 professionals who became newly certified as CCHP. In addition, 10 CCHPs earned specialty certification as a CCHP-RN and nine as CCHP-MH. For an update on the new CCHP-Physician credential and a special callout for advanced certification, see the news items below.

These certifications took effect Jan. 1. Lists of these individuals can be found online at www.ncchc.org/cchp-program-Q4-2015.

New CCHP-Ps

The inaugural group of CCHP-Ps includes 20 physicians who passed the Certified Correctional Health Professional – Physician exam offered at NCCHC’s National Conference in October. Congratulations to these groundbreakers for their leadership, as well as for their demonstrated commitment to the field and mastery of correctional medicine’s specialized knowledge. For a list of names, see the What’s New section at www.ncchc.org.

The CCHP-P exam will be offered again on April 10 in conjunction with the Spring Conference on Correctional Health Care. The deadline to apply is March 3. For program details, including eligibility requirements, visit www.ncchc.org/cchp-p.

New CCHP-As

Heartfelt congratulations to three professionals who recently earned advanced CCHP certification: Patricia Blair, JD, PhD, CCHP-A, Clarence Cryer, Jr., MSPH, CCHP-A, and Esmaiel Porsa, MD, MPH, CCHP-P, CCHP-A.

Is this your year to earn advanced certification? Find the details at http://www.ncchc.org/cchp-a.

Welcome to New Board Members

The CCHP board of trustees welcomes two new board members:

- Johnnie Lambert, RN, CCHP, is a correctional health care consultant with Centurion Managed Care, LLC, based in Fort Royal, SC.
- Patricia Reams, MD, CCHP-P, is pediatrician at Cumberland Hospital, Richmond, VA. She also serves on the NCCHC board of directors as the liaison of the American Academy of Pediatrics.

Ralf Salke, BSN, CCHP-A, vice president of operations for Corizon, will serve a second term as an elected member of the board.

Worth a Thousand Words

Attendees at the National Conference on Correctional Health Care in Dallas really shared the love through the #iheartcchp social media campaign. Participants were asked to get creative with photos featuring the CCHP button that was distributed at the conference, and then to post their pics to Facebook, with the promise of a great prize for the more creative entry.

Contest winner Valerie Lindenberger, RN, CCHP, Saint David, AZ, received full registration to NCCHC’s 2016 National Conference in Las Vegas plus two free nights hotel at the Paris Hotel for her depiction of an inmate-patient “jumping for joy” at the quality health care he receives from Certified Correctional Health Professionals.

To see all of the contest entries, log on to your Facebook account and search for the hashtag #iheartcchp.

CCHP Exam Dates

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<tr>
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We are seeking sites for regional exams as well as CCHPs to proctor the exams. To participate, contact the certification assistant at 773-880-1460 or cchp@ncchc.org. See the complete calendar at www.ncchc.org/cchp/calendar.
Who Attended in 2015?
Nurse/nurse practitioner 39%
Physician/physician assistant 28%
Administrator 10%
Psychiatrist/psychologist 8%
Social worker, therapist, counselor 7%

Decision Makers With Authority
State/facility medical director, director of nursing, other directors 17%
Health services administrator 8%
Department manager/supervisor 15%
Health services, dental or mental health staff 20%

Who Do Attendees Represent?
Jail facility 50%
Prison facility 17%
State DOC/agency 9%
Private corporation 9%
Juvenile detention or confinement facility 4%
Federal agency 3%

Categories Attendees Recommend or Buy
• Dental care and supplies
• Disaster planning
• Electronic health records
• Health care staffing
• Information technology
• Medical devices and equipment
• Optometry services
• Pharmacy services
• Substance abuse services

Draw Qualified Customers to Your Booth
NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and outreach to local facilities and agencies.
• Three days of exhibit hall activities
• Two free full conference registrations per 10’ x 10’ booth
• Discounted full registration for up to three additional exhibit personnel (per company)
• Access to 1,000 attendees for premium face time
• 50-word listing in the Final Program (deadline applies)
• Electronic attendee lists for pre- and postshow marketing
• Discounts on advertising in the conference programs
• Opportunity to participate in raffle drawings
• Priority booth selection for upcoming conferences
• Continuing education credits for all sessions attended
• Exclusive opportunity to become a sponsor or advertiser

Sponsorship Puts You at Center Stage
Enhance your exposure to conference attendees and provide a memorable conference experience. Sponsors receive extra recognition in conference materials and pre- and postconference promotion. Ask the NCCHC sales representative to help you maximize your marketing exposure.
• Conference app
• Keynote speaker
• Premier educational programming
• Internet kiosks
• First-timers’ reception
• Conference bags
• Show bag insert
• Exhibit hall aisle drop

Become an Exhibitor Today!
Make an impact on a cost-effective budget! This premier event is where you can meet with key contacts and raise your profile, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For more information and a reservation form, contact Carmela Barhany: sales@ncchc.org or 773-880-1460, ext. 298. Be sure to ask about sponsorships and advertising.
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Northern California) is seeking BC/BE Family Medicine or Internal Medicine Physician for a small group practice in Custody Health. We offer competitive compensation, comprehensive benefits and paid malpractice. Please submit a letter of intent and CV to roya.rousta@hhs.sccgov.org. SCVMC is an Equal Opportunity employer.

2015 STANDARDS for Mental Health Services in Correctional Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing mental health services delivery in adult correctional facilities. This second edition represents the culmination of hundreds of hours of careful review by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain the most authoritative resource for correctional mental health care services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women’s health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

About CorrectCare®

CorrectCare is the quarterly magazine of the National Commission on Correctional Health Care. Its mission is to publish news, articles and commentary of relevance to professionals in the field of correctional health care.

Subscriptions: CorrectCare is mailed free of charge to members of the Academy of Correctional Health Professionals, key personnel at accredited facilities and other recipients at our discretion. To see if you qualify for a subscription, create an account online at www.ncchc.org or email us at info@ncchc.org. The magazine is also posted at www.ncchc.org.

Change of Address: Send notification four weeks in advance, including both old and new addresses and, if possible, the mailing label from the most recent issue. See page 1 for contact information.

Editorial Submissions: Submitted articles may be published at our discretion. Manuscripts must be original and unpublished elsewhere. For guidelines, email editor@ncchc.org or call 773-880-1460. We also invite letters or correction of facts, which will be printed as space allows.

Advertising: Contact Carmela Barhany, sales manager, at sales@ncchc.org or 773-880-1460, ext. 298.

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Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Nurse Staffing Nights and Weekends

We are evaluating our staffing model. My question is whether a medical department can be staffed by all LPNs at night and on weekends, or do the standards require an RN on-site at those times?

In standard C-07 Staffing, the discussion states that number and types of qualified health care professionals required depend on the size of the facility, the types (e.g., medical, nursing, dental, mental health) and scope (e.g., outpatient, inpatient, specialty care) of health services delivered, the needs of the inmate population and the organizational structure (e.g., hours of service, use of assistants, scheduling). The staffing plan should take into account labor-intensive activities such as medication distribution, sick call and cell checks in segregated housing. Because the sufficiency of the staffing plan can be assessed by a number of factors, NCCHC does not have a prescribed nursing (RN or LPN) ratio. The adequacy and effectiveness of a staffing plan should be assessed by the facility’s ability to meet the health needs of the inmate population. The standards also require that qualified health care professionals do not perform tasks beyond those permitted by their credentials.

Time Frame for Chronic Care Assessment

How soon should patients with chronic care issues be assessed by a medical provider? Is it supposed to be within 30 days?

The NCCHC standards do not specify a time frame for initiating chronic care; rather, patients should be referred for assessment by a clinician based on their individual clinical needs. Standard G-01 Chronic Disease Services requires that patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function. The chronic disease program should incorporate a treatment plan and regular clinic visits. The clinician should monitor the patient’s progress during clinic visits and when necessary, change the treatment. The program should also include patient education for symptom management.

Lice and Pregnancy

Do the NCCHC Standards have a specific standard that addresses policies on lice treatment for pregnant women?

Standard B-01 Infection Prevention and Control Program requires that effective ectoparasite control procedures are used to treat infected inmates and to disinfect bedding and clothing. It also requires that prescribed treatment given to infected inmates considers all conditions such as pregnancy, open sores or rashes, and that treatment is ordered only by clinicians.

To order or to see a list of all NCCHC publications, visit www.ncchc.org.

Tracey Titus, RN, CCHP-RN, is NCCHC’s manager of accreditation services. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460.
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