



Fall 2021 | Volume 35 | Issue 2

# CorrectCare®

The magazine of the National Commission on Correctional Health Care

## The Importance of Custody – Health Care Collaboration

*Two Perspectives*



**Communication Strategies  
for Vaccine Hesitancy**

**Juvenile Down! Simulating  
Emergency Response**

**Novel Health Care Claims  
from a Novel Virus**

National Commission on Correctional Health Care  
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Send correspondence to Barbara Granner, CCHP, Editor  
NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614  
Phone 773-880-1460; Fax 773-880-2424  
info@ncchc.org; ncchc.org  
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## Hillsborough County Earns First Pinnacle Recognition for Three NCCHC Accreditations

The Hillsborough County Sheriff's Office in Tampa, Fla., has become the first agency in the country to receive NCCHC's prestigious Pinnacle recognition for having earned NCCHC accreditations in three separate service areas.

HCSO's Falkenburg Road Jail and Orient Road Jail are now both accredited for their health services, mental health services, and opioid treatment programs, the first facilities in the nation to achieve this trifecta of accreditations by demonstrating compliance with NCCHC's *Standards for Health Services in Jails*, *Standards for Mental Health Services in Correctional Facilities*,

and *Standards for Opioid Treatment Programs in Correctional Facilities*.

"This prestigious award is the highest honor in correctional health care, signaling the Hillsborough County Sheriff's Office's commitment to excellence," Jim Martin, MPSA, CCHP, vice president, program development, said at a presentation ceremony in Tampa.

"From now on, you will be a model for other sheriffs to follow," he said. "Let this be a challenge to our nation's sheriffs to not only meet the basics of constitutional correctional health care, but to go well beyond them." ●



### New Partners Join Annual Giving Society; Scholarship Recipients Attend Conference

The NCCHC Foundation welcomes the newest members of the Partners in Correctional Health Annual Giving Society: Indivior (Platinum level), CFG Health Systems (Silver level), and Swisslog Healthcare (Bronze level). They join Corizon Health and Centurion Health in sharing their commitment to correctional health through corporate support for the NCCHC Foundation's mission: to champion the correctional health care field and serve the public by supporting research, professional education, scholarships, and patient reentry into the community.



Thanks in part to the generosity of Corizon Health and Centurion Health, 18 promising students and young professionals received scholarships to the virtual Correctional Mental Health Care Conference in July. Said scholarship winner Samia Coaxum, a master's degree candidate at Clark Atlanta University, "The conference contributed to my purpose and passion, and positively impacted my thoughts of pursuing my social work career in the corrections arena." She also reported learning that "correctional health is public health," a message the Foundation seeks to spread through its outreach and programming.

## Upcoming Events

<b>OCTOBER 4</b>	CCHP EXAMS, ELKHART LAKE, WI
<b>OCTOBER 12</b>	CCHP EXAMS, ALEXANDRIA, MN
<b>OCTOBER 27</b>	CCHP EXAMS, HUMBLE, TX
<b>OCT 30-NOV 3</b>	NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE, CHICAGO
<b>OCTOBER 31</b>	CCHP EXAMS, CHICAGO
<b>NOVEMBER 1</b>	CCHP-P EXAM, CHICAGO
<b>APRIL 9-12</b>	SPRING CONFERENCE ON CORRECTIONAL HEALTH CARE, ATLANTA

### NCCHC Continues to Grow

Cheryl Giddens, MBA, CPA, has joined NCCHC as chief financial officer. She brings to the role extensive expertise in accounting, finance, operations management, compliance, due diligence, litigation support, IT, and audit services. Most recently, as president of CAR Consulting, Inc., she provided CFO, COO, and accounting services to a variety of clients.



BACK  
TOGETHER.  
  
BETTER  
THAN EVER.

# Keep Breathing: The COVID Marathon Goes On

by Joseph V. Penn, MD, CCHP-MH

I have a small, polished quartz rock in my office with the word BREATHE carved on it. It catches my eye at various times throughout the day, especially when the day is stressful. I periodically move the rock to strategic locations in my office, always within view, to help me refocus as needed (PRN) during particularly trying meetings or patient encounters.

Due to the complex challenges of our correctional work, we all require resiliency. These challenges, our daily work and family responsibilities, and the need to be resilient have been greatly tested during COVID-19. Now is a good time to breathe.

## Hopeful Signs

As I approach the end of my year as chair of the NCCHC Board of Representatives, I am extremely hopeful that with the availability of safe and effective vaccines, we are closer than ever to the end of this marathon. I've never run a marathon, but I hear those last few miles are the hardest.

In the early months of the pandemic, I recall seeing footage of hospital staff in major metropolitan areas being cheered and applauded at change of shift.

I doubt anyone stood outside your unit and cheered for you. But I applaud you, as does the entire board, the NCCHC staff, and especially your patients.

You have worked wonders over the past year and a half and continue to do so. You check temperatures, perform nasal swabs, screen new intakes, work with custody staff to identify and house at-risk individuals in medical isolation or quarantine, carefully document and report to state health departments, and take on countless other duties.

Thanks to your hard work and commitment, the delivery of health care behind bars has continued throughout the pandemic, and the incarcerated are now being vaccinated against the virus in large numbers.

Your compassion and dedication mean that your patients have continued to have critical access and continuity of health care during one of the most stressful times imaginable. You and your teammates in both custody and health care have overwhelmingly succeeded in confining

and limiting the spread of COVID to the best of your abilities in a closed environment.

You have seen firsthand the effects of COVID, and may have experienced the loss of family, friends, colleagues, and patients. Simultaneously you faced the continuous risk and fear of becoming infected and bringing the virus home to friends and loved ones, all while the media painted a picture of jails and prisons as festering petri dishes for COVID spread.

## A Million Thanks

When someone graduates, there is a ceremony and celebration. Similarly, when a patient with cancer finishes a course of chemotherapy or radiation treatment, the patient rings a bell and staff cheer for this tremendous milestone.

I wish we could arrange for a celebration at your work site with a color guard, a spread of tasty Texas barbeque, Tex-Mex food, and fried catfish with all the fixings, plenty of home-baked goodies and desserts, a flyover by the U.S. Thunderbirds or Navy Blue Angels, and a live concert by your favorite musicians. You deserve all that and more.

Kudos, also, to the tremendous NCCHC staff under the leadership of Chief Executive Officer Deborah

Ross, as well as the dedicated surveyors, board members, committee members, and all the volunteers who work to uphold the NCCHC mission.

I hope to see all of you in Chicago at the National Conference, where I will turn over the reins to Sam Soltis, the next chair. We can celebrate in person and enjoy our friendships once again, even if we need to wear masks as we do so.

In the meantime, take of yourself, appreciate the little things in life, focus on the important stuff, "move the rock" (as needed), and don't forget to breathe. ●



Photo © kenary820/Shutterstock

*Joseph V. Penn, MD, CCHP-MH, is the 2021 chair of NCCHC's Board of Representatives and board liaison of the American Academy of Psychiatry and the Law.*

## Before *Estelle*: A Firsthand View

By John Miles, MPA



It is hard to imagine now, but in the late 1960s and early 1970s there were only about 400,000 individuals housed in prisons and jails in the United States. In 1973 the rate of incarceration began a sustained period of growth.

Prison and jail health care at the time was not seen as a right, and suffering was often believed to be part of an individual's punishment. The Supreme Court's ruling in *Estelle v. Gamble* in 1976 stated that substandard medical care violated the Constitution and that "deliberate indifference" by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment.

I first became involved with correctional health care more than 50 years ago – before *Estelle v. Gamble*, before correctional health care was a profession, and long before it became the multibillion-dollar industry it is today.

I began my public health career with the Centers for Disease Control and Prevention in 1967 with the venereal disease program as a public health advisor assigned to the Chicago Department of Health. My work home for the next year and a half was on the South Side of Chicago in a 19th-century three-story red brick schoolhouse. At the time, it was the largest VD clinic in the United States, serving over 200 patients daily. A feature of the clinic was its proximity to the South Side elevated train line with the adjacent trains shaking the building as they passed.

### Shoe-Leather Epidemiology

Field epidemiology brought me into contact with all elements of society, good and bad, and taught me valuable lessons about human behavior. Countless hours were spent conducting shoe-leather epidemiology (knocking on doors, following leads, and talking with individuals who knew the neighborhood).

My first interaction with corrections came as I followed up on individuals who had tested positive for syphilis on intake at the Cook County Jail. This required a visit to the jail to find and interview them for their contacts. Little did I know then that throughout my public health career, I would have increasing interactions with correctional systems at all levels – federal, state, and local.

The Cook County Jail in the late 1960s was an enormous and foreboding stone facility with its own set of rules that limited access and added layers of complexity on when and how medical care would be delivered. Clinical areas were cramped and chaotic, providing only basic services. Seriously ill individuals had to be transported to nearby Cook County Hospital. Record systems were cumbersome and files were frequently misplaced or lost.

Finding the right incarcerated individual and ensuring that they received treatment was no small feat; you could work all day to find the individual and get them brought to the clinic only to find that the doctor had left for the day or had been called away. It was difficult for me to see at the time how we were making a difference in the health and safety of individuals in the jail, much less the larger community.

My assignment to the jail was an educational experience that helped form my understanding of the interrelationship of community health, public health, and correctional health and their impact on society and the larger community. I saw firsthand that jails were ill-equipped to deal with societal issues such as drug abuse and mental health, which were becoming an increasing problem for corrections. At the same time, the health of individuals in jails/prisons was not a concern for the community. It was the old "out of sight, out of mind – not my problem" syndrome.

### 50 Years Later

Much has changed since my first visit to the Cook County Jail in 1967. Litigation since *Estelle* has brought about significant change in how care is provided and the attitude of policy makers and the public alike. The work of NCCHC and its continued promulgation of standards and accreditation along with development of state and local corrections/public health/community partnerships have moved correctional care forward to meet today's challenges. The utilization of standards of care that incorporate public health interventions in corrections coupled with quality care are having a lasting impact on community health in the United States by reducing the burden of disease and the costs associated with care.

Change has not been without problems, but the conditions experienced by incarcerated individuals in the past are not tolerated today. The standard of decency continues to evolve. We must be vigilant and continue to protect and promote access to good quality and affordable care for everyone, including incarcerated individuals, because improving the health and safety of our nation benefits everyone. ●

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*John Miles, MPA, is editor-in-chief of the Journal of Correctional Health Care. This editorial is an excerpt of a longer letter published in the September 2021 issue of JCHC. Printed with permission of the author and publisher. All rights reserved.*

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CALIFORNIA CORRECTIONAL  
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# Is Infirmary Housing Forced Medical Care?

By Fred Cohen, LLM

New York state inmate McKenzie has a history of dangerously high blood pressure. He also has a history of refusing blood pressure control medication while supposedly following his own views of diet and exercise, nominal as they may be.

In his latest confrontation with a nurse practitioner, McKenzie strenuously objected to being placed in the infirmary as a precaution following a dangerously high blood pressure reading.

The defendant nurse practitioner feared the patient was at risk of a stroke or dangerous heart attack.

In *McKenzie v. Oberitean* (W.D. N.Y. 2021), plaintiff McKenzie argued that his enforced infirmary stay violated his constitutional and specific New York-based right to avoid enforced infirmary care. Federal Judge Wolford replied that she did not find a single case where requiring enforced infirmary care and housing while a prisoner was experiencing a medical crisis, as here, constitutes enforced medical care.

Even assuming that requiring the plaintiff to remain in the infirmary constituted “medical treatment,” it was not clearly established whether the plaintiff’s right to refuse this treatment was outweighed by prison officials’ legitimate penological interests in not having people experience life-threatening medical crises in the general population area.

## Undisputed Disruption

The Second Circuit has affirmatively stated that an “obvious example” of a case in which prison officials may override a refusal of medical treatment is to prevent “disruption by illness-induced behaviors.”

Here, it is undisputed that the plaintiff was experiencing a hypertensive crisis that put him at immediate risk of stroke, heart attack, and/or death. It would have been extremely disruptive to the prison environment had he been sent back to the general population only to experience a catastrophic medical event, potentially in a communal area.

In other words, it is not at all clear that a prisoner’s right to refuse potentially life-saving medical treatment carries with it a right to demand that he be allowed to return to his normal activities, as opposed to being housed in the infirmary until the immediate crisis has passed.

In an earlier case, *McCormick v. Stalder* (D. Or. 1977), a prisoner who had tested positive for tuberculosis was entitled to refuse treatment and could not be forcibly medicated, but could nonetheless be “confined for medical observation for signs of the active disease.”

In the case of *McKenzie v. Oberitean*, the only coercion in the record is the infirmary admission, and it is far from clear that the admission per se is treated as treatment. For the purposes of qualified immunity, there is then the lack of a clearly established right made out.

Plaintiff, then, fails to prevail.

## Comment

The point in this case is that a place designated for care and treatment could be viewed as unconsented-to treatment. ●

*Fred Cohen, LLM, is editor of the Correctional Law Reporter. This article is reprinted (with minor modifications) from Correctional Law Reporter with permission of the publisher. All rights reserved.*

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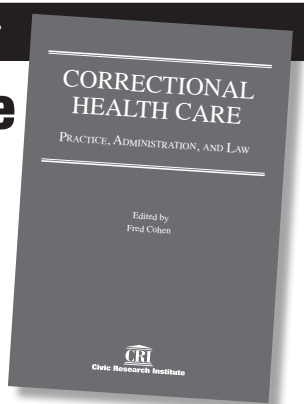
“Insight into the most significant issues in correctional health.”

## Correctional Health Care Practice, Administration & Law

Edited by Fred Cohen, LL.M., LL.B.

We live in an era of unprecedented promise and uncertainty in health care—nowhere more so than in America’s prisons and jails. New drugs and devices for treating infectious and chronic conditions are revolutionizing care, but often at very high costs. Courts are mandating better levels of service, while the resources available to correctional agencies are increasingly subject to severe budget constraints. The work can be incredibly rewarding—yet burnout is a constant threat to the well-being of caregivers and patients alike.

Written to help professionals meet these challenges, this contributed volume brings together the insights and experiences of thirty of the nation’s top experts to provide a comprehensive working guide designed to benefit every correctional health care provider, from specialist physicians to GPs, PAs, nurses, and the correctional administrators who are responsible for the overall well-being and care of their residents.



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# The Importance of Custody – Health Care Collaboration

## *Two Perspectives*



By Michael Teasdale, RN, CCHP

If you work in correctional health care, you not only have to interact and care for incarcerated patients; you also need to collaborate with security and correctional administration at your facility. That might seem obvious, but it never ceases to amaze me how often correctional health care professionals don't seem to understand the importance of developing good working relationships with custody staff, or how to do that.

Health staff – and other civilians – are often thrust into a very foreign world with little or no training on how to navigate a correctional environment. As a result, the relationship between custody and health staff can at times seem almost adversarial. All too often, it's “us vs. them.” But health and custody staff are on the same team, and “playing well together” benefits everyone – most importantly, the incarcerated patient population.

The importance of collaboration is directly addressed in NCCHC Standard A-03 Medical Autonomy, which states, “The delivery of health care in a correctional facility is a joint effort of custody and health staffs and is best achieved through trust and cooperation.”

### **Inside the Head of a Correctional Officer**

For effective communication to occur, each party needs to understand the other's background, motivation, and priorities. Health care professionals are trained to provide care and save lives; that is our priority. It can be difficult, especially when new to corrections, to understand that custody's priorities are different, but complementary: that is, to ensure the safety and security of the incarcerated, staff, and facility.

No matter the designation – sheriff’s deputies, correctional officers, or private security – the custody staff in your facility is a law enforcement group. Their ranking structure, training, tactics, and even professional interactions mirror those of other law enforcement groups. There are strict procedures, protocols, and orders that all custody staff must follow. Understanding the orders that dictate procedures in your facility, especially concerning inmate movement, will improve your department’s workflow and also make the job of the custody staff in your area easier. For example, during count is not a good time to request that a patient come to the medical department or clinic for an appointment.

Custody officers respond well to direct communication. Be respectful, polite, and succinct. Always address them by their rank and surname, e.g., “Deputy Chief Meyer.” Be careful not to appear to be commanding or demanding. Showing respect and understanding for the work of the custody staff will go a long way in building trust and building a good working relationship.

## **Navigating the Chain of Command**

In any law enforcement organization, the chain of command is essential. To maintain good relations with custody staff, you need to understand – and follow – the chain of command.

For example, if there is an issue in your department, your first step should be to speak with the officer in charge, followed, in most situations, by contacting the sergeant, lieutenant, captain, and major, in that order. Finally, if you have followed the chain of command and the issue is not resolved, you can bring your complaint to the warden or administrator. Breaking the chain can mean breaking the trust that custody staff have in you and your department. It would be like a staff nurse skipping over the director of nursing and health services administrator and going directly to a regional manager. Better to follow the chain of command.

Health care administrators should find out from the warden or facility administrator who they are to speak to in a variety of situations. Some administrators want all issues brought to them; others would rather have a major or captain be the contact point. Whatever the case, meet with the appropriate people regularly. Be responsive and address their concerns as priorities. Provide updates between meetings.

## **Custody Is the Customer**

It’s important to remember that as civilian contractors, which most of us are, we are guests in the facility. That is one of the most difficult things for correctional health care professionals to wrap their minds around, especially if they are new to the field. But treating custody staff like valued customers will go a long way toward cementing good relationships.

If an officer from one of the housing areas calls with a question or request, for instance, do your best to assist. If the warden or administrator needs information or has an issue, respond quickly and accurately. Promptly addressing requests and concerns improves not only your reputation, but that of the company you work for as well.

It is also vital for health care administration to lead by example. Maintaining a customer service mindset will not lessen your position but rather make you a stronger leader.

If at any time custody asks you to do something that is not in the patient’s best interest, you can – and should – advocate for your patient. You can voice your concerns and suggest an alternative but do so in a respectful manner and follow the chain of command. Approaching custody staff as members of the same team will help ensure that they are open to your suggestions.

## **Listen and Learn**

Listen. That one little word will foster the best working relationships you can have ... and could actually save a life. Custody staff interacts with the incarcerated population every day; they can notice subtle changes that the health staff, busy taking care of patients in the clinic, might not. If a custody staff member expresses a concern, listen, and take that concern seriously. If an officer tells you that an incarcerated individual does not look well or does not seem like themselves, that individual should be seen and evaluated. It is always better to spend five minutes evaluating a patient than risking a poor outcome. In addition to improving patient care, this practice will validate the officer, who in turn will continue to monitor the population for signs of medical or mental distress.

Pro tip: If you want to know what really went on during the previous shift or get a heads-up on a potential problem, talk the custody staff working in your area.

## **Communicate to Collaborate**

While it is fine for health care professionals to have camaraderie with custody staff, always be professional. We are licensed health care professionals and should conduct ourselves as such. Follow these tips:

- Do not communicate (in any form) in an overly familiar manner. Save your emojis for personal emails and texts.
- Do not take part in gallows humor.
- Reputations are built quickly within the correctional setting. Make sure that yours is glowing.
- Managers, lead by example. Make it clear to your staff that you value and respect the custody staff, their role, and their contributions to the care of your patients.
- Be transparent. Always be the one to bring issues to custody; don’t let them hear it from someone else. Stuff happens; bringing problems to light and working

*Continued on next page*



together on solutions will foster trust.

- If corrective action is necessary, present your plan, monitor progress, and follow up.
- Get custody staff involved in medical emergency drills and disaster drills.
- Invite custody staff to your meetings and ask for their opinions and ideas.
- Encourage custody to participate in CQI or performance improvement projects.

Most importantly, don't allow an "us vs. them" feeling to fester between health staff and custody staff. Remember we are working with each other, not next to each other.

No matter the setting – pretrial, prison, or reentry – the strategies presented here will serve you well as a civilian health care professional working in corrections. Most of the difficulties for civilians in the correctional

setting are about adapting to the environment and learning how to function within a law enforcement setting.

Understanding the role of custody, respecting the chain of command, having a customer service mindset, and maintaining professional communication will foster a collaborative and cooperative relationship with custody staff, and that will improve your work environment and facilitate your ultimate goal: to provide the best care possible to your patient population. ●



*Photo © michaeljung/Shutterstock*

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*Michael Teasdale, RN, CCHP, is a regional nurse manager with Rutgers University Correctional Health Care, which provides medical, mental health, dental, and sex offender treatment services to individuals involved in the New Jersey criminal and juvenile justice systems.*

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## The Custody Perspective: We're Safer Together

**By Deputy Chief Fred W. Meyer, MA, CJM, CCHP**

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**W**hile knowledgeable leadership is critical to ensuring that a correctional system runs effectively, no group is more important to the day-to-day success of an organization than the line-level employees who make things happen: the custody staff who supervise the individuals incarcerated in the facility, and the health care staff who ensure that those individuals receive appropriate care.

Those two professional groups are uniquely situated to observe behavior, evaluate changes over time, and ensure chronic, urgent, and emergent issues are handled appropriately. They help make sure that a safe and secure environment is maintained while effective medical, dental, and mental health services are provided. When they work well together, they make each other's jobs easier and everyone safer.

### **Inside the Head of a Health Professional**

These two groups, however, may sometimes feel like they are operating at cross purposes. After all, the primary mission of custody staff is to maintain order and secure the environment. The primary mission of health care staff is to identify, assess, and treat individuals' health needs. The two groups look at the world through different, though complementary and equally important, lenses.

Faced with their own stressors, it can be easy for custody to forget the tough position health care is in. Providing medical, mental health, and dental care in a correctional environment presents many unique challenges. It takes an especially motivated and dedicated professional to seek employment and work effectively in correctional health.

Within incarcerated populations, acute and chronic health issues far exceed those found in the outside community. Recruiting high-quality health care professionals can be a challenge due to stereotypes associated with corrections; staff shortages are common. The strictly structured routines and strong personalities often found in corrections can be quite foreign to those new to the environment, creating additional challenges.

But it is important to understand, respect, and appreciate the value health care professionals bring to a correctional environment, in addition to mitigating health issues. When incarcerated people receive appropriate care and attention, they are less likely to file grievances or engage in disruptive behavior, making the job of a custody professional safer and easier.

Communication between custody and health care is critical to providing quality care. The more open dialogue there is, the fewer adverse events will occur. Health care staff can

act as a force multiplier, addressing inmate concerns before they turn into disruptive behavior. This team-centered perspective makes the environment safer for everyone working within the facility, as well as for the incarcerated.

## It Goes Both Ways

Most custody personnel understand that the input of health care staff is valuable and helpful to them; health care personnel can be confident that their perspectives will be heard and respected.

But health care staff members also need to remain open to information provided by their custody counterparts, who can be a valuable source of intel. Since they are constantly with the incarcerated, they might know relevant information about an individual. They may witness threatening behavior or recognize a threatening demeanor that calls for heightened security.

It is critical that health care and mental health staff work with custody to gain perspective on at-risk individuals. While clinical autonomy is required per NCCHC standards, behavioral information from custody can be very important in making health care decisions, providing effective care, and staying safe.

## Tips for Leadership

I strongly encourage each leader reading this article, from any discipline, to take a critical look at yourself and the overall operation of your organization. If you are making your area “look good” instead of critically analyzing your operation and how it impacts the big picture, you are not as effective as you could be.

- Avoid a “siloeed” leadership style. Without open and receptive relationships among leaders, the operation will not be as successful.
- Model the behavior and communication style you want your people to emulate. When cross-disciplinary leaders are engaged with each other on a regular basis, staff understands that communication is accepted and expected.
- Provide substantial cross-training for custody personnel. While custody staff is primarily trained to focus on safety and security, some health care-related training is essential. Since jails and prisons are now the largest mental health facilities in the country, training should include recognizing mental health issues as well. Crisis Intervention Training is also becoming important. As discussed in NCCHC Standard C-04 Health Training for Correctional Officers, “Because correctional personnel are often the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations and understand their part in the early detection of illness and injury.”
- Adhere to NCCHC standards. Include reference to standards compliance into policies and procedures and make

clear that they pertain to health care and custody alike.

- Engage custody staff in all disaster, emergency, and man-down drills.
- Include custody representation in regular weekly meetings to make sure aspects of incident review and operations are not missed.
- Involve everyone in the CQI process. Accurate and timely statistics are critical to identifying areas that need to be addressed. Failures should be openly discussed among custody and health care leadership, with strategies and tactics identified to address the problem and improve operations.
- In the event of an in-custody death or significant event, conduct a critical review and openly communicate about ways to prevent future incidents of a similar nature. The sooner leaders work together to identify gaps and fill them, the better operations will be.
- Become certified as a CCHP. There is no better way to become fluent in the NCCHC standards than studying for the exam to become a Certified Correctional Health Professional. Not only can certification improve operations, it also is an effective way to hold people accountable to the standards.
- Provide CCHP training and/or pay for health care and custody staff to take the exam.

Working collaboratively creates opportunities to go from good to great. When there is a team atmosphere among custody and health care at all levels of the organization, everyone wins. Adverse events are more regularly prevented and mitigated; leadership teams are more effective; staff is safer and more productive; and patients receive the best, most appropriate care. ●

**RELEVANT NCCHC STANDARDS** Standard A-03 Medical Autonomy: Health care decisions are made by qualified health care professionals for clinical purposes.

Standard C-04 Health Training for Correctional Officers: Correctional Officers are trained to recognize the need to refer an inmate to a qualified health care professional.

*NCCHC Standards for Health Services in Jails, 2015*



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*Fred W. Meyer, MA, CJM, CCHP, is deputy chief of the Las Vegas Metropolitan Police Department. He oversees the largest jail system in the State of Nevada, with over 56,000 bookings a year, and provides leadership to 1,300 commissioned and civilian employees.*

# Juvenile Down!

## Using Simulation to Improve Emergency Response



By Heather Walsh, MSN, RN, PCNS-BC, CPN; Pavan Zaveri, MEd, MD, and Alsan J. Bellard, Jr., MBA, MD, CCHP-P

**A**dolescents in detention generally are in good overall physical health. So while bumps, scrapes, and bruises tend to happen regularly, the opportunities to respond to acute medical emergencies can be few and far between.

While serious medical emergencies are uncommon, staff at youth detention facilities need to be prepared for such events. Waiting for an emergency to occur to test the response is not enough. Both NCCHC and the Department of Justice recommend conducting “juvenile-down” drills – simulated emergencies affecting an individual who needs immediate medical intervention – to help ensure that staff is prepared.

### Not Kidding Around

When the medical director of the Department of Youth Rehabilitation Services in Washington, DC, contacted us (the Simulation Program at nearby Children’s National Hospital) about collaborating on training to improve staff preparedness for medical emergencies, we suggested a simulation-based curriculum, using the program’s lifelike manikins to play the part of the “patient” in emergency situations.

Manikins have come a long way since Resusci-Anne was introduced in the 1970s. Today’s state-of-the-art manikins can simulate a variety of medical scenarios and respond to treatment, giving health professionals a chance to hone their skills in a safe, risk-free environment. They can simulate lifelike emotions through facial expressions, movement, and even speech.

In our early discussions, DYRS reviewed recent and potential medical emergencies and laid out the three main concerns they hoped training could help resolve: inadequate readiness for emergencies, lack of familiarity with emergency processes due to staff turnover, and the need for a collaborative relationship between health staff and direct care staff (whom DYRS calls youth development

representatives; sometimes referred to as custody, security, or child care staff).

With that information, we designed a number of scenarios to address possible and probable emergencies, including anaphylaxis (from food, medication, or a bee sting), asthma exacerbation, seizure, concussion/head injury resulting from a fight or fall, and sudden cardiac arrest. Learning objectives included managing a patient with an acute medical emergency; demonstrating effective communication and handoffs to subsequent providers; and initiating, testing, and refining the facility’s emergency response system.

### A New Kind of Patient

Over the past six years, we have conducted 33 juvenile-down exercises at two DYRS locations, with more than 200 staff members, both health care and direct care, participating. With a school-age child-sized manikin portraying the patient, the staff members play their roles and respond as they would in an actual emergency. The scenarios take place in various locations within the facilities, including the intake area, classroom, housing areas, and gymnasium, adding to the realism.

Before each simulated emergency, we provide an overview of the manikin and explain its capabilities and limitations. For instance, although the manikin can blink, speak, and demonstrate cyanosis and breath sounds, we explain that we will supply additional cues when necessary. We also set expectations for a safe learning environment by encouraging participants to fully engage, suspend disbelief, and ask questions.

Each exercise starts with a direct care staff member accompanying a “client” (the manikin), who begins to experience some sort of distress congruent with one of the previously identified medical scenarios. As the client



deteriorates, participants act and react as if it were an actual emergency. For instance, they must choose to contact either the control center or the medical unit directly for assistance using a walkie-talkie or a phone and also determine whether they should wait in place for medical assistance or transport the patient to the medical unit. A scenario typically ends after about 10 minutes with staff practicing a handoff to arriving EMS personnel.

In a debriefing held after handoff, participants are prompted to discuss how they think the event went and how they felt during it. Staff first responders are asked to explain what initially happened and the actions they took to help the client, since not everyone involved is present to observe the initial interventions. Then each staff member is asked to share a learning point – a takeaway that they and their colleagues can apply to real-life situations in the future. Following the debriefing, each participant completes a written evaluation.

Throughout the entire exercise, we observe, take notes, and then compile the details into an after-action report summarizing the event and the debriefing, including things that went well, challenges, notable learnings, areas for improvement, and recommendations for facility leadership. All of this is shared with the DYRS medical director.

## Learnings and Improvements

The information we provide after each scenario has led to some important improvements at the participating facilities. Certain systems used and tested during the drills were identified as being in need of repair or upgrade; it became clear that other things needed to be (and have been) procured, including a single emergency box that can be wheeled to the patient's location and a portable suction unit. Other improvements include relocating nebulizer masks, making oxygen more available, and stocking the emergency box with all the necessary emergency equipment and supplies.

Participating staff report that the simulations taught or reinforced important concepts, such as appropriate use of a cervical collar in the event of a head injury, when and how to communicate with EMS, how to locate and use emergency medical supplies, and the importance of knowing a patient's medical history. Sometimes participants request that specific hands-on skills, such as using an epinephrine auto-injector or setting up a nebulizer treatment, be reviewed.

Many of the staff members have participated in multiple simulations and, as facilitators, we have noticed improvements over time in their responses. Early on, the initial responders, generally youth development representatives, tended to “freeze” before calling for additional help. Sometimes health care staff would arrive at the scene without emergency equipment, causing a potentially dangerous delay in treatment.

With repeated practice, the youth development representatives have become aware of emergency expectations and are able to act promptly in a variety of medical emergencies. Now the first responders immediately assess the scene and call for help; meanwhile, they begin interventions until others arrive to help. In a recent simulation, the initial responder contacted health staff and stated simply, “The client is seizing.” That succinct information exchange allowed the health staff to respond efficiently and appropriately, arriving quickly with the emergency box and oxygen.

One youth development representative told us how grateful he was to be well-prepared when he had to respond to an actual client experiencing the very emergency that had been simulated during his training.

Data gathered over the past six years confirm what we have heard and observed: participants' comfort in and knowledge of managing medical emergencies increase as a result of participating in the simulation scenarios.

## Interested?

With simulation centers now housed in many universities and hospitals, this training model can be replicated at other detention facilities to enhance staff response, facility processes, client safety, and health outcomes. Another option is to purchase a simple manikin to represent a patient during juvenile-down drills.

With a small financial investment, health staff, direct care staff, and facility leadership can become more comfortable and proactive in managing medical emergencies. ●

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*Heather Walsh, MSN, RN, PCNS-BC, CPN, is simulation program manager and Pavan Zaveri, MEd, MD, is simulation medical director at Children's National Hospital; Alsan J. Bellard, Jr., MBA, MD, CCHP-P, is chief medical officer at Community of Hope DC and a physician consultant with the DC Department of Youth Rehabilitation Services.*



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# Running Up Against Vaccine Hesitancy? These Communication Strategies Could Help

By Christina Kraus and Alysse Wurcel MD, MS

**C**OVID-19 vaccines are safe and extremely effective against severe disease and death from COVID. And yet, the CDC reports that as of August 1, close to 33% of the United States population eligible for vaccination has not received even their first dose.

Individuals have many reasons for vaccine hesitancy, with many different experiences with vaccines and the medical system contributing. Those reasons and experiences are important to take into account when communicating about the importance of the vaccine.

We have created a flowchart with examples of common vaccine-related concerns along with suggested strategies for addressing them.

## Go With the Flowchart

As you work through the flowchart, imagine that an incarcerated individual or staff member has come to you with the comment in quotations. Think about how you might respond to the comment before reading the suggested answer strategy and “communication pearl” bubbles. Then reflect on how you can incorporate those ideas into your response. All the questions and suggested answers can be applicable to anyone, not just to the labeled headings.

These strategies – and the resources listed to the right – can also be used as a toolkit for planning more formal presentations or communication sessions in your facility. ●



## FOR MORE INFORMATION

[CDC.gov/coronavirus](https://www.cdc.gov/coronavirus)  
[HealthLeadsUSA.org](https://www.healthleadsusa.org): Tools & Resources  
[NRCRIM.org](https://www.nrcrim.org) (the National Resource Center for Refugees, Immigrants, and Migrants): Vaccines  
[VaccineMisinformation.Guide](https://www.vaccine-misinformation-guide.org) (The Vaccine Misinformation Management Guide, produced by UNICEF, First Draft, Yale Institute for Global Health, and PGP)

*Christina Kraus is a medical student and Alysse Wurcel, MD, MS, is assistant professor in the department of medicine at Tufts University School of Medicine.*

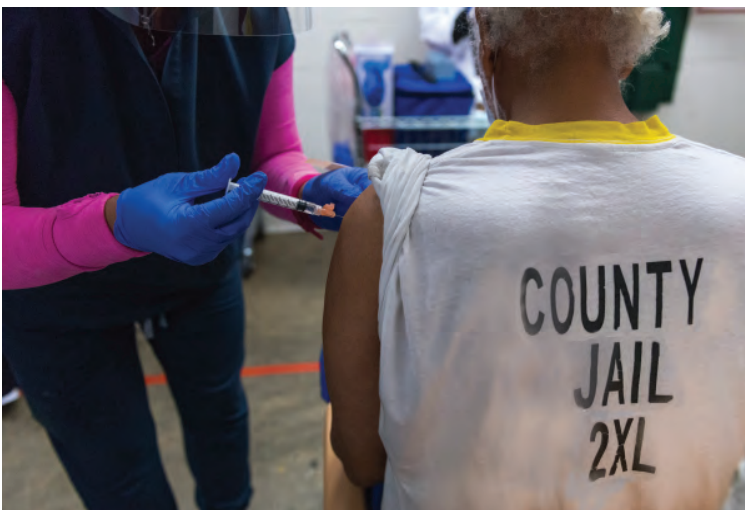
## Feedback, Please!

Provide the researchers with feedback!

Scan this QR code to take a one-minute survey about the usefulness of the vaccine communication flowchart.

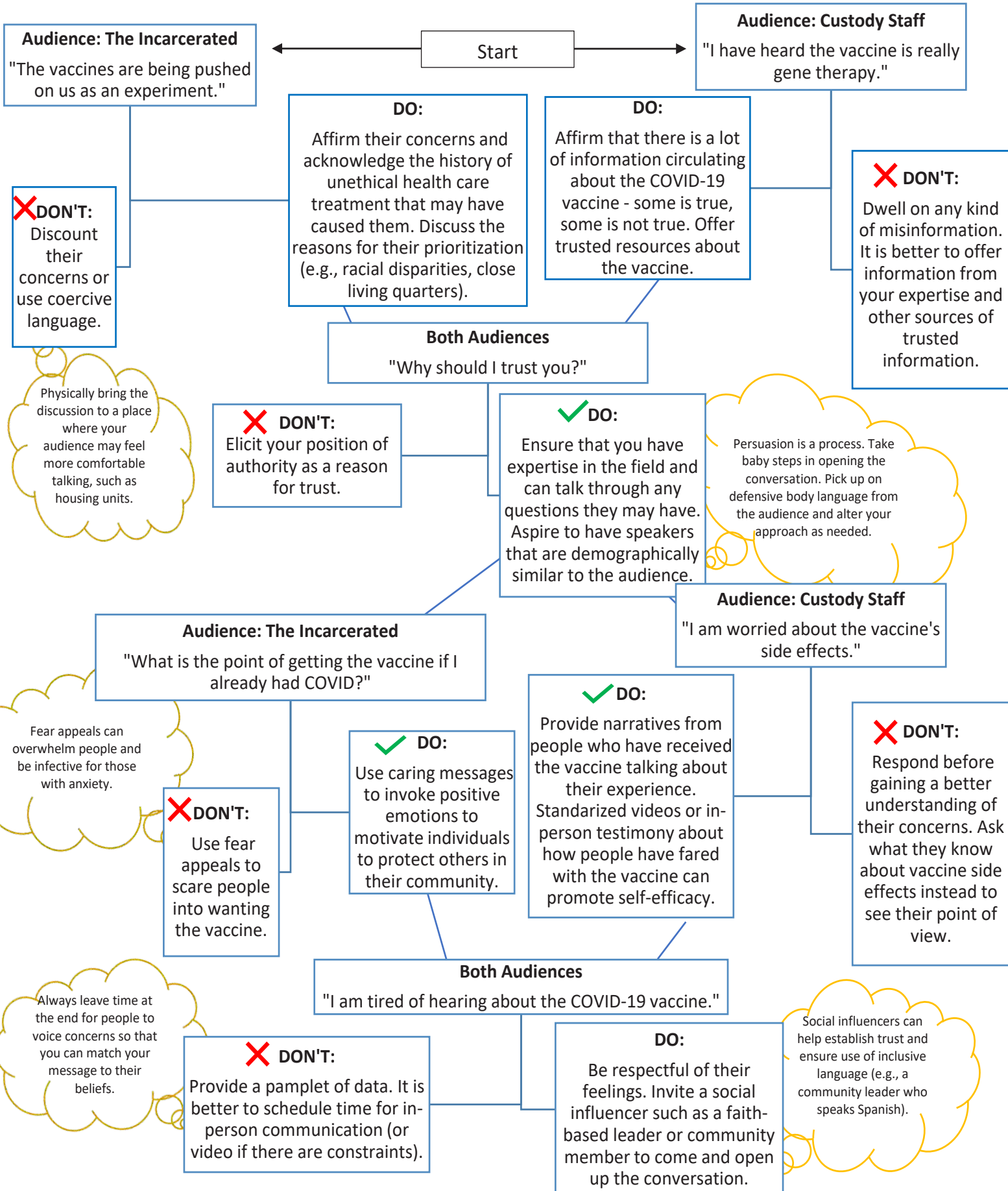


**You can also take the survey by clicking anywhere on this box.**



Photos © Heidi de Marco/KHN

# Vaccine Hesitancy Communications Flowchart





# Medications for Opioid Use Disorder in State Prisons: A Look at Current Delivery Status

by Christy K. Scott, PhD, Lauren Duhaime, MA, and Erika Ostlie, MA

As the United States battles a growing opioid epidemic, corrections professionals face the considerable demands of managing a population increasingly dependent on opioids. Although substantial information about best practices for treating opioid use disorder exists, there is little information about how correctional systems and prisons within them are actually responding to the epidemic. And despite widespread evidence that medications to treat opioid use disorder are effective – and strong recommendations for the use of MOUD in criminal justice settings – the corrections field is not always current regarding what treatments are available for and accessible to incarcerated people with OUD.

In 2019, the research team at Chestnut Health Systems, a nonprofit organization that offers comprehensive behavioral health and human services in Illinois and Missouri, received funding from the National Institute on Drug Abuse to conduct a study of health care practices currently being implemented by correctional facilities and organizations to address the opioid epidemic, particularly in areas hard hit by the crisis. Working with Carnevale Associates, a Washington, DC-based consulting firm specializing in substance use, behavioral health, and criminal justice research, we hoped to learn what types of resources, training, and technical assistance corrections staff need to improve their capacity to mitigate the effects of the opioid crisis within their state systems.

CHS conducted in-depth interviews with representatives from 21 prison systems representing 538 prisons in states with the highest number or rates of opioid-overdose fatalities. Participants were asked about the types of MOUD available in their state system and/or their facility, the criteria for determining which individuals are eligible to receive MOUD over the course of their incarceration, and any barriers to implementation. We also asked about their future plans and needs to address the challenges of the opioid epidemic, including efforts to link individuals to community-based treatment upon release.

What we found paints a complex picture of how, when, and to whom MOUD is provided across prison systems in the states most heavily impacted by opioids. We believe our

findings have implications for policies related to expanding MOUD availability by addressing funding and regulatory barriers, expanding clinical capacity, and reducing stigma associated with treatment for OUD.

## Availability and Delivery of Medications for OUD

All 21 participating state prison systems reported that one or more of their prisons provide at least one of the three types of MOUD currently authorized by the Food and Drug Administration (i.e., methadone, buprenorphine, and/or naltrexone). However, only 62% reported that one or more of their prisons provide all three types of MOUD, and 61% of the 538 individual prisons do not provide any MOUD.

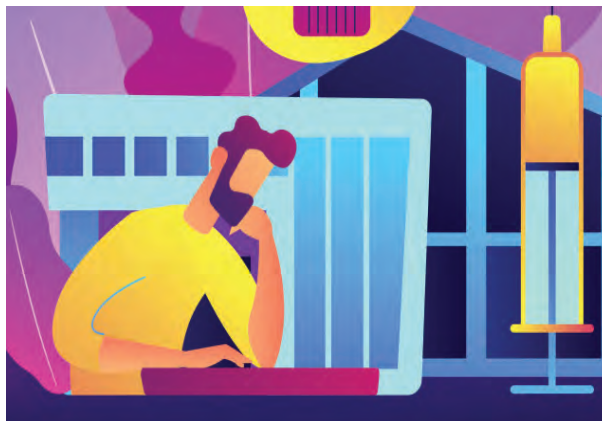


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Almost all (19 of 21) prison systems reported that treatment with buprenorphine is available in at least one prison within their system, provided specific conditions are met. Slightly over half (52%) provide buprenorphine to individuals already being treated with it at the time of admission. Further, buprenorphine is only used in a relatively small proportion of the prisons within these state systems

(15%). Given the need for specialized medical staff to administer buprenorphine, it may be that states opt to use it in a few select facilities within their systems, perhaps due to resource limitations.

Methadone also is available in at least one prison within most state systems surveyed (19 of 21). Its use, however, is largely restricted to specific subgroups, such as pregnant women, those who were being treated with methadone before being admitted to prison, and those close to release. Despite the fact that methadone is widely available, only 9% of the 538 prisons surveyed reported that they are equipped to provide it. Given the need for licensure to dispense methadone, regulatory barriers were most often cited as restricting prison capacity to administer this medication more broadly.

Most state prison systems surveyed (18 of 21) report that injectable or oral naltrexone is available to individuals with OUD in one or more of their prisons. It is more widely available than buprenorphine or methadone in that it is used in over one-third (36%) of the 538 prisons

in these systems. In addition to providing naltrexone to individuals who are already being treated with it at the time of admission, most state systems (86%) dispense it to individuals at release. Because its effects last for approximately one month, the injectable form (Vivitrol®) is often used at release, which helps facilitate the individual's transition to community-based treatment.

Since only a small subset of prisons provide these medications, most individuals being treated with MOUD when they enter prison do not receive continuing care. Moreover, they are unlikely to be linked to community treatment providers upon release, exacerbating the risk of relapse and overdose when they return to the community.

Respondents cited a variety of barriers to linking individuals to community treatment at the time of release, most often a lack of available providers, as well as a lack of transportation to community facilities. That lack of treatment capacity was particularly true in remote, rural areas. In fact, many respondents discussed the ethics of providing MOUD to individuals while incarcerated, knowing they will not be able to maintain treatment once they are released due to such barriers.

## Addressing Barriers to Implementation

When asked about ways to assist the expansion of MOUD within their system, 75% of respondents identified a need for training on how to prevent MOUD diversion, screen for OUD, determine which type of MOUD to prescribe, and coordinate with community providers. There is a need, perhaps national in scope, for prison-specific training materials and technical assistance with implementation.

Nearly all survey respondents (over 90%) agreed with the statement that more resources are necessary to address stigma and negative attitudes about MOUD treatment. Additionally, over one-third of the 21 prison systems identified the state's "preference for abstinence" as a barrier to incorporating MOUD into treatment plans.

To expand state prison systems' capacity to provide treatment, respondents strongly endorsed the need for education for a wide range of audiences regarding OUD, addiction, and MOUD. Those audiences include judges, health care professionals, probation and parole staff, corrections administrators, church leadership, and the general community.

The most frequently cited barrier to expanding prison capacity to all three types of MOUD was lack of funding. This includes funding for medical staff, resources to prevent diversion, and funding to cover the medications' cost. Staffing needs include physicians trained and certified to prescribe the medications, nurses to dispense the

medications, and social workers to assist with reentry planning for linkages to community-based treatments at discharge. Additional funding is needed for resources to expand the availability and accessibility of MOUD across all prisons to a wider range of individuals.

## What's Next?

Our study demonstrates that more forms of medications for opioid use disorder are available across state prison systems than reported in prior studies. Many previously identified challenges still exist, however.

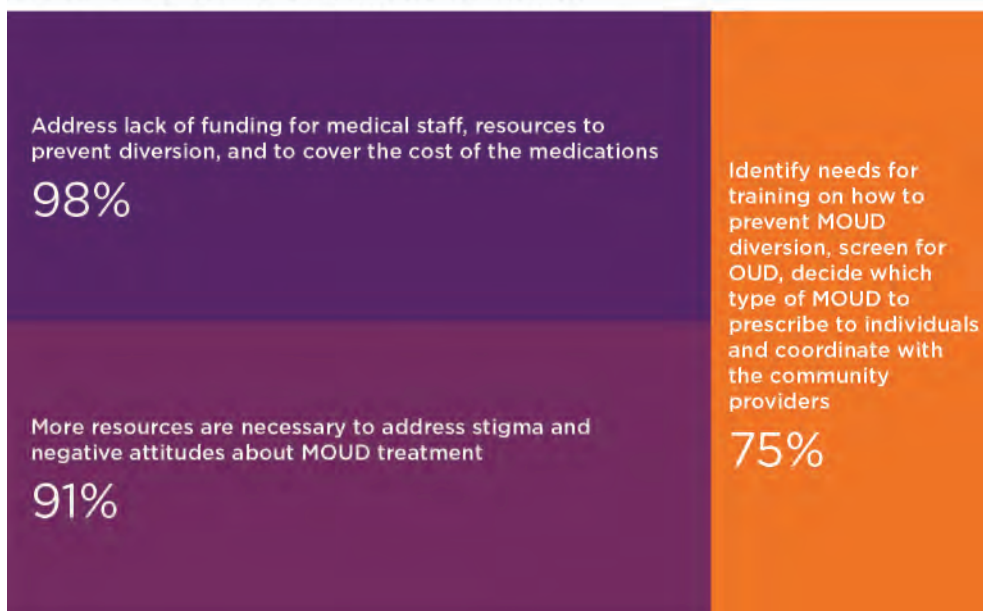
Awareness of commonly cited barriers is key to guiding future policies and initiatives designed to expand MOUD use in state prisons. The survey results provide a basis to help states pinpoint common challenges when expanding their systems for treating individuals with OUD, identify the resources needed to address those challenges, and build a foundation to develop enhanced MOUD policies. ●

### FOR MORE INFORMATION

Scott, C.K., Dennis, M.L., Grella, C.E., Mischel, A.F., & Carnevale, J. (2021). The Impact of the Opioid Crisis on U.S. State Prison Systems. Health and Justice. <https://doi.org/10.1186/s40352-021-00143-9>.

*Christy K. Scott, PhD, is director of research and development at Lighthouse Institute, the applied behavioral research division of Chestnut Health Systems. Lauren Duhaime, MA, is a research associate and Erika Ostlie, MA, is chief operating officer at Carnevale Associates LLC. The opinions expressed here are those of the authors and do not represent official positions of the United States government.*

## Addressing Barriers to Implementation



*Percentages in the visualization reflect the portion of the 21 prison system sample responding with the above answers when asked about ways to assist the expansion of MOUD in their system.*



# Unprecedented: Novel Health Care Claims from a Novel Virus

By Daniel Griffith, JD

Graphic © AHMET.AGLAMAZ/Shutterstock

Over the past year and a half, the COVID-19 pandemic resulted in not only medical outbreaks but also in legal “outbreaks”: new types of legal claims – and rulings – previously unheard-of in correctional health care litigation.

The medical profession and the legal profession both rely on a foundation built over centuries of knowledge and precedent. In health care, precedent takes the form of research and clinical trials that inform diagnoses and treatment plans. In the legal profession, precedent is known as *stare decisis*, meaning “to stand by things decided.” In both cases, decisions are based on knowledge and information developed from prior experience.

Although the word unprecedented was perhaps overused in the early months of COVID-19, in this case it is the perfect word. Attorneys and courts were unable to rely on precedent because there was none.

Before COVID-19, correctional health care litigation had become somewhat routine. Legal standards were well-established and the universe of potential claims (delayed diagnosis, failure to diagnose, delayed treatment, etc.) was limited and finite. The remedy for a patient’s past pain and suffering was a claim for money damages; the remedy for preventing future harm was a request for an injunction – that is, an order requiring or discontinuing a certain treatment. Consequently, although the cases were often high-stakes and (literally) life-or-death situations, the legal issues were recurring and familiar.

The pandemic changed all that.

## An Epidemic of Pandemic-Related Lawsuits

As the coronavirus began sweeping across the country, three types of lawsuits became prevalent: claims by medically vulnerable employees concerned about returning to a possibly unsafe work environment, insurance claims by business owners impacted or shut down by the pandemic, and correctional health care claims.

It’s not surprising to find correctional health care claims on that list. Correctional facilities are high-density congregate settings. From the pandemic’s earliest days, incarcerated people were especially susceptible to virus exposure, and many with preexisting medical and mental health conditions were at high risk for serious disease and death.

According to the National Commission on COVID-19 and Criminal Justice, an incarcerated individual is four times as likely to become infected and twice as likely to die from COVID-19 as someone in the free world. Through June 2021, there were approximately 400,000 positive cases of COVID-19 reported among incarcerated persons and approximately 2,700 deaths, although those numbers are probably an undercount.

The proliferation of pandemic-related correctional health care claims matched the speed with which the virus spread.

Only two weeks after the national emergency was declared in March 2020, a federal court in California had already considered one of the first correctional health care claims arising from the pandemic, and also noted the unique risks the virus posed to incarcerated persons:

The Government cannot deny the fact that the risk of infection in immigration detention facilities – and jails – is particularly high if an asymptomatic guard, or other employee, enters a facility.

*Castillo v. Barr (C.D. Cal. 2020)*

In addition to more traditional lawsuits seeking money damages and requests for injunction, beginning in early 2020 the courts became flooded with three new types of correctional health care suits:

**Class actions**, in which large groups of similarly affected people come together and file a lawsuit against the same defendant

**Claims seeking release** from incarceration as a result of the pandemic



**Lawsuits seeking an injunction** requiring changes to the correctional facility's COVID protocols rather than money damages or release

## Class Actions

Prepandemic, correctional health care class actions generally challenged facilitywide conditions, policies, procedures, or practices imposed equally on the entire incarcerated population. In that a person's medical treatment is individual to that person, correctional health care lawsuits generally do not lend themselves to class actions.

That changed, however, with the arrival of the coronavirus and the fear it invoked, especially in closed environments like jail or prison. Class action suits seeking release from incarceration or improved protocols were filed by groups of inmates, powerful groups such as the ACLU, and others.

The law imposes rigid standards for groups wishing to be declared a "class" for lawsuit purposes. Among other things, the group must prove that there are so many of them that separate lawsuits are not practical (the "numerosity requirement") and that they share common grievances and complaints (the "commonality requirement").

For pandemic-related class actions, the numerosity requirement has been easily met, since all members of the class – that is, all incarcerated persons housed in a particular area – have been exposed more or less to an equal degree. The commonality requirement is more difficult because incarcerated persons have vastly different ages, preexisting conditions, medical needs, and sentences.

The first correctional health care class actions involving the pandemic attempted to define the class as consisting of all "medically vulnerable" patients, but that description was ruled to be too broad and required narrowing. To define "medically vulnerable," the Centers for Disease Control and Prevention guidelines regarding who is particularly susceptible to the virus was added. The Court concluded that was a sufficient definition for a "class" and those cases have been allowed to proceed. (Efforts to expand the description of the class beyond that definition, however, have been unsuccessful.)

The result has been an avalanche of pandemic-related class action filings by incarcerated persons. As of June 2021, the pandemic had generated more class action correctional health care claims than any previous medical issue – more than 70. Many have been successful, particularly those filed by organizations that have investigated the facility's protocols, compared them to the CDC guidelines, and found disparities; many others have not.

## Claims Seeking Release

Correctional health care lawsuits historically have challenged the medical conditions of an individual's confinement, not the fact that the person is incarcerated

or the duration of the confinement. Demands for release from incarceration have been reserved for *habeas corpus* proceedings in the criminal court system, essentially appealing the conviction and arguing the legality of the incarceration. Release from incarceration has been almost unheard-of in the context of correctional health care litigation, up until now.

Recognizing that incarcerated people face unique exposure to the coronavirus and that this exposure is involuntary, out of their control, and possibly fatal, courts have intertwined *habeas corpus* proceedings and correctional health care claims in analyzing whether release is an appropriate remedy. In *Martinez-Brooks v. Easter* (D. Conn. 2020), the Connecticut federal court concluded that pandemic-related cases also challenge the fact of confinement itself. That approach has been relatively consistent and has allowed incarcerated persons access to a remedy, release from incarceration, that was historically unavailable in correctional health care litigation.

Most of these have been class action lawsuits involving a group of medically vulnerable individuals, and they have been surprisingly successful. As of June 2021, more than 100,000 people have been released from incarceration for medical reasons as a consequence of the pandemic, reducing the prison population by a staggering 8%.

## Claims for Injunctive Relief

The most common correctional health care claims since the pandemic began have not been individual challenges to a specific course of treatment but rather challenges to a correctional facility's COVID protocols claiming that the facility's failure to implement appropriate safeguards has jeopardized or damaged the health of the incarcerated. The relief sought typically includes an injunction requiring that the facility improve its COVID protocols.

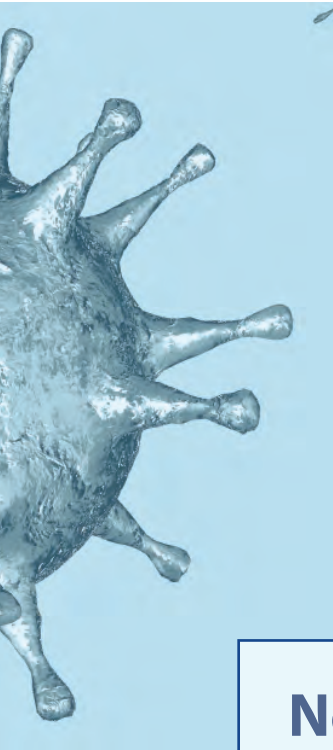
A successful correctional health care claim for an injunction requires, among other things, that the patient prove he or she will suffer irreparable harm (i.e., harm that cannot be compensated by money) if the injunction is not granted. That can be difficult to prove in a correctional setting, and courts have often noted their disfavor for injunctive relief when it comes to correctional health care claims. That position was summed up recently by a Pennsylvania federal court:

In the prison context, a request for injunctive relief must always be viewed with great caution because judicial restraint is especially called for in dealing with the complex and intractable problems of prison administration.

*Easley v. Wetzel* (W.D. Pa. 2021)

In pandemic-related claims for injunction, the federal courts have almost uniformly compared the facility's protocols to the CDC's recommendations for detention facilities as

*Continued on next page*



delineated in “Guidance for Correctional and Detention Facilities.” Those guidelines address such issues as testing and tracing protocols, medical isolation, and personal protective equipment to safeguard against the spread of the virus.

For claims seeking changes to institutional handling of COVID issues, courts routinely compare the facility’s plan and operations to CDC guidance, which has become the standard by which courts evaluate a correctional facility’s liability for virus-related claims. Compliance with the CDC guidelines constitutes almost a complete defense and strongly insulates a facility against liability.

In a relatively short period of time, the pandemic changed the landscape of

correctional health care lawsuits. In addition to routine claims and issues, the past year and a half saw an influx of class action lawsuits, demands for release from incarceration, and claims for injunctive relief challenging correctional facilities’ COVID protocols. In that respect, the novel coronavirus spawned an array of “novel” correctional health care claims. ●

**FOR MORE INFORMATION**

[CDC.gov/coronavirus](https://www.cdc.gov/coronavirus)  
[TheMarshallProject.org](https://www.themarshallproject.org)  
[CovidPrisonProject.com](https://www.covidprisonproject.com)  
[UCLACovidBehindBars.org](https://www.uclacovidbehindbars.org)

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*Daniel Griffith, JD, is a partner with Whiteford, Taylor, Preston LLC and managing attorney of the firm’s Delaware office.*

## New Position Statements Call for COVID Vaccines, Portable Health Records

### COVID-19 Vaccination in Correctional Settings

NCCHC supports vaccination plans that prioritize correctional health professionals, custody and support staff, and incarcerated individuals as candidates for vaccination, as outlined in the position statement COVID-19 Vaccination in Correctional Settings. Other priority criteria (e.g., age, medical comorbidities) should also guide distribution plans in correctional settings.

NCCHC correctional health standards require that incarcerated people be provided with clinical preventive services, including flu shots and other immunizations administered as clinically indicated. This essential standard should be upheld, especially during the disaster related to the COVID-19 pandemic.

### Sharing of Patient Health Records on Release

Continuity of care is critical for people with medical or mental health needs who are being released from incarceration. Although many correctional facilities facilitate care with community providers as part of discharge planning for people with serious health needs, health records are not routinely shared for all patients. NCCHC’s new position statement, Sharing of Patient Health Records Upon Release From Incarceration, seeks to close this gap by recommending the following:

- Update the “Release of Information” policy to include the person’s right to obtain a copy of their health record upon release
- Combine consent for treatment upon incarceration with an authorization to share health information to a community agency or provider upon release
- Respond to requests for information from community entities within 5 business days
- Waive the cost of sharing health records
- Use electronic health records for better legibility and thoroughness
- Partner with health information exchanges for seamless sharing of information
- Ensure that all sharing of patient health information complies with the Health Insurance Portability and Accountability Act

**Restrictive Housing in Juvenile Correctional Settings**, approved by the NCCHC Board of Representatives in February, has been officially endorsed by the American Academy of Pediatrics and the Society for Adolescent Health and Medicine.

To read the statements in their entirety, visit [ncchc.org/position-statements](https://www.ncchc.org/position-statements). ●

# Reducing Cervical Cancer Disparities

**W**omen who are incarcerated or otherwise involved in the justice system are known to have higher rates of cervical cancer than women in the general population. Underlying this disparity are risk factors for human papillomavirus, which is linked to cervical cancer. Among these risk factors are sexually transmitted infections including HIV, unprotected sex with multiple partners, history of sex work, sexual violence, and use of tobacco products.

In light of the World Health Organization's 2018 call for the eradication of cervical cancer, authors Mya Roberson, MSPH, and Jennifer McGee-Avila, MPH, conducted a literature review to examine surveillance, education, and policy issues that affect cervical cancer disparities and inequities among justice-involved women. Their article appears in the September issue of the *Journal of Correctional Health Care*.

## Surveillance

National population health surveillance related to cervical and other cancers does not capture incarceration history, and data collection methods omit incarcerated people and likely miss many people postincarceration. Also, questions on reproductive health preventive care or screening are lacking in federal studies such as the National Survey of Prison Health Care and the Survey of Prison Inmates, which has a section on health. Bottom line: Information on screening and vaccination among justice-involved women is lacking, despite their clear health care needs.

## Health Education

Little is known about justice-involved women's knowledge, attitudes, and beliefs concerning cervical cancer screening, and what scant research exists suggests low health literacy on the topic. Similarly, data on the prevalence of HPV vaccination among these women is lacking, although recent research has found that willingness to receive the vaccine was high. Furthermore, a pilot intervention yielded notable gains in cervical health literacy. Nevertheless, justice-involved women have reported difficulty accessing follow-up care for abnormal Pap smears because of cost, insurance, and life instability related to incarceration.

## Policy Issues

Issues affecting justice-involved women's access to prevention and treatment for cervical cancer are familiar ones in correctional health care: limited or nonexistent health insurance; interruption in Medicaid coverage while incarcerated, and variable access to and quality of care across states and correctional systems, including copay policies.

## Suggestions for Improvement

Roberson and McGee-Avila conclude that cervical cancer disparities could be addressed by eliminating policy barriers – e.g., by continuing Medicaid coverage and eliminating copayments. Educational efforts should aim to correct common misconceptions about reproductive health. And surveillance is essential to create a solid understanding of screening and vaccination behaviors.

Importantly, women must receive continuity of care when they return to the community. The authors point to successful models of prevention, treatment, and care for HIV that could be adapted for cervical cancer, especially since risk factors overlap for both health conditions. ●

## JCHC Vol. 27, No. 3: September 2021

- Implementing a Culture of Health Among Probationers
- Nutrition in Midwestern State Department of Corrections Prisons: A Comparison of Offerings With Commonly Utilized Standards
- Substance Use Disorder and Viral Infections (Hepatitis, HIV): A Multicenter Study in Tuscan Prisons
- Validity of Self-Reported Hepatitis C Virus Status Among Criminal Justice-Involved Persons Living With HIV
- Juvenile Correctional Officer Beliefs About Trauma and Mental Illness: Perceptions of Training and Youth Behaviors
- Prevalence and Correlates of Self-Injurious Behaviors Among Justice-Involved Youth
- A Proposed Transitional Care Tool to Improve Medication Continuity After Release of Older Inmates
- Audit of a Mindfulness-Based Cognitive Therapy Course Within a Prison
- Justice-Involved Women and Cervical Cancer Disparities: Issues of Surveillance, Education, and Policy
- Medicolegal Considerations in the Management of Opioid Use Disorder With Buprenorphine in the Correctional Setting

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### FOR MORE INFORMATION

<https://home.liebertpub.com/publications/journal-of-correctional-health-care/664>



## CCHPs Reflect on Three Decades of Progress As Program Celebrates 30th Anniversary

In the 30 years since the first group passed the CCHP examination to become Certified Correctional Health Professionals, much in the correctional health care field has changed – including attitudes toward incarcerated patients, the people who care for them, and their chosen profession.

And that is no coincidence. For three decades, the CCHP program has been a major force in changing perceptions, bringing legitimacy and professionalism to correctional health care, and recognizing the unique knowledge and specialized skill set required in the field.

“The CCHP program has grown from one that few were aware of to become a nationally recognized and sought-after professional achievement,” says Jim Voisard, CCHP-A, a member of the original “graduating class” of CCHPs. “The CCHP lapel pin has evolved from an unrecognizable shiny object into a symbol of pride that others notice.”

### A Bit of History

NCCHC’s early work in the 1970s uncovered an appalling lack of health care in the nation’s jails and prisons, which led to the establishment of the NCCHC standards. Health care behind bars slowly began to improve. In 1976, the Supreme Court’s ruling in *Estelle v. Gamble* cemented inmates’ right to health care. By the late 1980s, remembers Ned Megargee, PhD, CCHP-MH, “We had the accreditation program for sites, but there was increasing demand for individuals to somehow get involved with NCCHC. What could we do for individuals?” Dr. Megargee was a member of the ad hoc Certification Committee that was formed to explore that question. The answer was the CCHP program.

Late in 1990, 182 individuals took the first CCHP examination,

and early in 1991 became the original CCHPs. Many of them are still working in correctional health care – and still certified!



But the environment in which they worked 30 years ago was very different from today.

### Perception Is Not Reality

Back then, the attitude toward health care professionals who worked in jails and prisons was very negative. “When I started out, there was kind of a stigma about working in corrections,” says George Pramstaller, DO, CCHP. “You were either on your way out, you were an on-the-job retiree, or you couldn’t get a job anywhere else.”

Judy Cox, MA, CCHP, concurs. “It used to be the last place a health care provider would work. The attitude was, ‘You work in a prison? You must not be any good!’”

The public at large was also clueless. “It was an area that no one paid any attention to,” says Robby Morris, MD, CCHP-P. “You’d talk to people and they’d be like, ‘Huh? Prison health care? What kind of health care is in prison?’ It was hard to recruit physicians and nurses.”

“It was easy to get a job in a jail in those days,” agrees Jorene Kern, BSN, CCHP. “They were begging for people.”

### Changes for the Better

Fortunately, and with help from NCCHC, the CCHP program, and dedicated correctional health care workers, that stigma has faded. “It’s no longer, ‘I’m going to go there because I can’t go anywhere else.’ People see it as a career now,” says Kern. “And not just the nurses but the doctors, psychologists, and psychiatrists too. The professionals who work in corrections now are just so talented.”

### Celebrate with CCHP at the National Conference!

**Party like it’s 1991.** Enjoy food, drink, music, and merriment on Monday, Nov. 1, 5:15 - 6:30 pm at the Hyatt Regency. Everyone is welcome! Sponsored by Centurion Health.

**It’s going to be iconic.** Chicago is an iconic city, and CCHP is an iconic symbol of the correctional health profession. Grab a special CCHP 30th anniversary pin and let your creativity flow by taking a photo that displays both the pin and the city. Then post it to social media with the hashtag #IconicCCHP. The most iconic photographer wins a prize!

**Look the part.** Commemorative T-shirts featuring the CCHP 30th anniversary logo will be for sale. Get yours at the NCCHC store.

"Now, people take pride in their work," says Cox. "They understand that to work in corrections you have to know emergency care, you have to know chronic care, you have to work with multiple disciplines, and you have to work as a team, or you don't achieve your goals. We have evolved into a wonderful system of health care."

Alongside that evolution of professionalism has come a corresponding shift in attitudes toward the incarcerated, as well as huge advances in the health care available to them. "There is an awareness now that incarcerated people not only have the right to care, but they need the care and deserve the care. We didn't always see that sensitivity," says Eileen Couture, DO, RN, CCHP-P.

"When I first started in corrections, it was more punishment-based. You didn't see a lot of the health care that you see today," says Pauline Marcussen, DHA, RHIA, CCHP, chair of the CCHP Board of Trustees. "Now we are the patients' advocates. We make sure they are seen for their substance use disorders, their mental health problems, their HIV and HCV. We're really taking care of them."

"The difference is night and day," agrees Ralf Salke, BSN, RN, CCHP-A. "We do a lot on site that was not even contemplated back in the day, such as dialysis, specialty imaging including CTs and MRIs, and telehealth with the right equipment, connectivity, and provider networks."

"The provision of care has moved from a reactive response to emergencies toward a proactive approach that includes early identification, intervention, and treatment of both acute and chronic conditions," says Voisard. "There is a greater focus on patient education, continuity of care, discharge planning, and collaboration with community resources."

## Ready to Become a CCHP?

Take your career to the next level!

The CCHP exam and all specialty exams will be offered at the National Conference on Correctional Health Care in Chicago on Sunday, Oct. 31, 1 pm – 3 pm. Learn more and submit your application (due by Sept. 24) at [ncchc.org/cchp](http://ncchc.org/cchp).

The CCHP program has continued to evolve as well. "The tests change to keep up with changes in the field," Megargee points out. "The NCCHC standards reflect the field; the tests reflect the standards." He recalls a time when the exam included questions related to smoking and tobacco use; those are no longer relevant and have been replaced by items about substance use disorders, mental health, and other current topics.

Even the test itself has changed. Joel Kellogg, MSN, BSN, RN, CCHP, "Class of 1991," shares this memory: "The very first exam was mailed to candidates, filled out, then returned for evaluation. Open book, but extremely comprehensive and extremely time-consuming to research and answer all the questions. The completed exam turned into something like 15-20 pages of handwritten answers!"

From a take-at-home exam to one that is available online or at proctored sites, other advances include discipline-specific specialty certifications for nurses, mental health professionals, and physicians and an Advanced certification.

"CCHP is not stagnant," says Matissa Sammons, MA, CCHP, vice president of certification. "It's something that changes and evolves as much as the times." ●

## Prepare for the Exam

Before the exam, attend one of these preconference seminars for the best test prep available:

An In-Depth Look at NCCHC's Standards for Jails/Prisons  
**Sunday, Oct. 31, 9 am – 5 pm**

An In-Depth Look at NCCHC's Mental Health Standards  
**Sunday, Oct. 31, 9 am – 5 pm**

The Challenge of Correctional Nursing: Compassion, Care & Calling  
**Sunday, Nov. 1, 9 am – 12:30 pm**

Register at [ncchc.org/national-conference](http://ncchc.org/national-conference).

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For more information, visit [ncchc.org/cchp](http://ncchc.org/cchp).

## A Roundup of Correctional Health Care News

### Interested in Joining NCCHC? We're Hiring an Accreditation Manager

How would you like to join the only organization in the country dedicated solely to health care in corrections? NCCHC is seeking a full-time accreditation manager to join our team. For a full position description, go to [ncchc.org/accreditation-manager](https://ncchc.org/accreditation-manager).



### In Memoriam: Dianne Rehtine, MD, CCHP-A

The correctional health care field mourns the loss of a pioneer and dear friend, Dianne Rehtine, MD, CCHP-A. She passed away on August 6.

Throughout many years with the Florida Department of Corrections, Dr. Rehtine was a staunch supporter of quality health care for the incarcerated. She began her tenure with the Florida DOC in 1986 as a prison physician, ultimately becoming a regional medical director. In the midst of countless budget, staffing, and other difficulties, she stood as a fierce advocate for the betterment of inmate health care.

Dr. Rehtine was also program director for the Correctional Medicine Fellowship at Nova Southeastern University, where she educated, mentored, and nurtured future correctional physicians.

Her ties to NCCHC were strong and deep. She was a longtime physician surveyor and member of the Surveyor Advisory Committee. In 2009, she received the Bernard P. Harrison Award of Merit for distinguished service to the field of correctional health care.



Dr. Rehtine is remembered as a doer, giver, friend, and leader. "She was wonderfully kind and remarkably dedicated," said Deborah Ross, CCHP, chief executive officer of NCCHC. "She will be deeply missed."

### COVID Vaccines for Health Care Workers

With COVID-19 case counts rising amid the spread of the Delta variant, more than 50 health care professional societies and organizations issued a joint statement in July calling for all health care employers to require their employees to be vaccinated against COVID-19. The group includes the American Medical Association, American Nurses Association, American Academy of Pediatrics, and several other NCCHC supporting organizations.

### CDC to Distribute \$700 Million for COVID-19 Prevention in Corrections

The U.S. Department of Health and Human Services announced in July that the CDC, in partnership with DOJ's Office of Justice Programs, will distribute \$700 million to 64 state and local jurisdictions to help prevent the spread of COVID-19 in prisons, jails, and juvenile confinement facilities.

The funds will allow facilities to implement COVID-19 diagnostic and screening programs for people who are incarcerated, staff, and visitors. Funds also may be used to support contact tracing, isolation and quarantine strategies, infection control practices, and education and training.

### GAO: Align Policies for Pregnant Women in Custody With National Guidelines

A new report from the Government Accountability Office notes that the U.S. Marshals Service and the Bureau of Prisons' policies on pregnancy-related care do not always align with national guidance. GAO recommends that the Marshals Service and Bureau take steps to more closely align their policies with national guidance on pregnancy-related care to ensure pregnant and postpartum women in their custody receive appropriate treatment.

Policy recommendations include conformance with national guidance, data collection at intake, restrictions on the use of restraints, and data collection on the use of restrictive housing.

### Bill Expands Access to Substance Use Treatment in Correctional Facilities

The Senate passed the bipartisan Residential Substance Use Disorder Treatment Act of 2021 by Senators Sheldon Whitehouse (D-RI) and John Cornyn (R-TX). The bill will expand access to substance use treatment in jails and prisons around the country and help those exiting correctional facilities continue their treatment in the community.





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##### RFP DEVELOPMENT AND MONITORING

- Development of large and complex RFPs for health services
- Independent monitoring of health services contractor's compliance with a jail contract with ongoing, multifaceted oversight, analysis, and support



##### EVALUATION

- Comprehensive review of health care services of a large juvenile system
- Assessment of a large jail system's readiness for an accreditation survey
- Focused analysis of nonemergency health care services at a high-security prison
- Evaluation of suicide prevention efforts at a county jail, with examination of security, health care and facility design



##### TRAINING

- Interactive training for jail staff on opioid use disorder and medication-assisted treatment
- On-site standards training and certification examination



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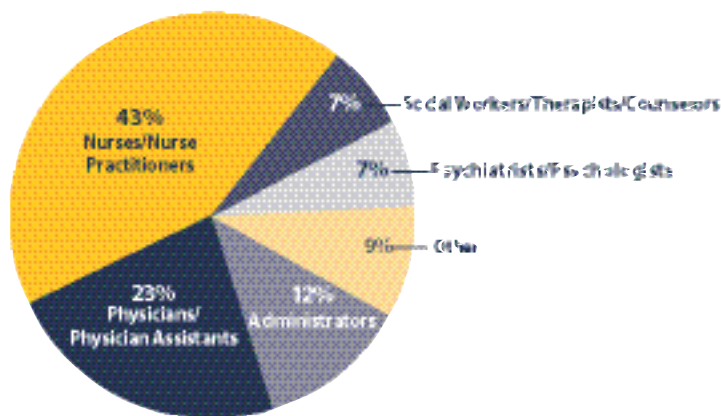


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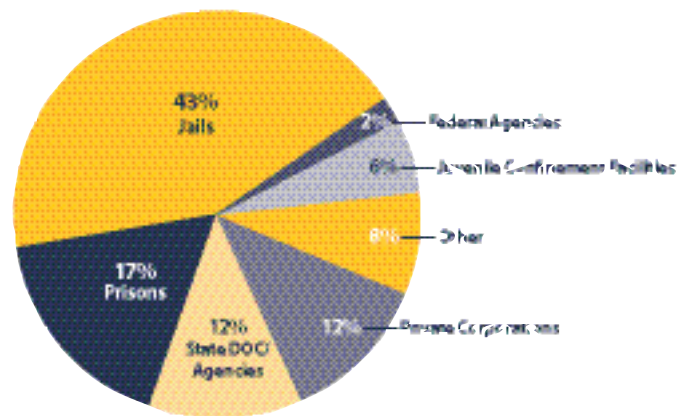
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## Expert Advice on the NCCHC Standards

By Amy Panagopoulos, MBA, BSN

### Survey After Changing Health Services Provider

**Q** We are due for our NCCHC reaccreditation survey in October but have recently changed health services vendors. Will this impact our survey?

**A** Changing a health services vendor does not impact your survey. However, it is important to archive all pertinent documentation from the outgoing vendor to ensure that facility staff have access to documentation that supports compliance.

From time to time, facilities have reported to NCCHC that a previous vendor removed all accreditation documentation when the contract ended. When this happens, the survey is compromised since the survey team cannot review a longitudinal history of work done at the facility. NCCHC surveyors will review the limited documentation retained but will require the facility to develop a detailed plan of corrective action to ensure that all components of the standards will be met going forward.

To avoid this issue, NCCHC encourages facilities to add language to all new vendor contracts stipulating that any accreditation support and documentation provided by the vendor will remain at the facility if a vendor transition occurs. Since NCCHC accredits facilities, not health care providers, it is important for the facility to retain records, data, and documentation.

### Corporate vs. Site-Specific Policies

**Q** At our facility, we use corporate policies and procedures from our health services vendor. How will NCCHC evaluate site-specific policies during our next survey?

**A** Policies and procedures are the working set of documents that staff use to illustrate what they are doing and how they are doing it – the foundation to assessing compliance with NCCHC standards.

Each survey team reviews policies and procedures to establish that those policies and procedures are applicable to the standards. They do not critique the written policies for specific wording but do review the policies to ascertain whether they are in accordance with the standards and that the facility is following them.

When the NCCHC surveyor team cites noncompliance in this area, it often has to do with corporate policies that do not reflect what is happening at that facility. For example,

some corporate policies cover services that are not offered at the facility being surveyed, without indicating which services do not apply. Those policies, therefore, are not site specific.

While corporate policies are a great starting point to support facility operations, it is important that each facility take time to review the corporate policies and adapt them to their individual setting, noting what is different and not applicable. Customization of the corporate policies can be accomplished by placing verbiage in a text box whenever there is a variance or an addendum explaining that variances can be added to the policy. If a corporate policy presents options such as “if infirmity level care is provided,” it is essential that the policy states whether infirmity level care is or is not provided at that facility.

The site-specific policies should be viewed as documents that would provide clarity as to what services are provided at the facility if read by an individual who knows nothing about your operation (e.g., new hires, attorneys, surveyors).

### Standards Regarding Inmate Workers

**Q** We are starting to use inmate workers at our jail. What do we need to do to ensure we are following NCCHC standards?

**A** Great question! To ensure compliance with the standards, incorporate the following as you build your inmate worker program:

- Standard B-02 Infectious Disease Prevention and Control describes the training each inmate worker needs if handling and disposing of biohazardous materials and spills.
- Standard B-04 Medical Surveillance of Inmate Workers describes what is needed to ensure that inmate workers' health and safety are protected. The standard lays out medical screening expectations and necessary components of a medical surveillance program.
- Standard C-06 Inmate Workers clearly states that health services must be provided by health staff and not by inmate workers and describes the limited roles inmate workers can play in health-related programs and services. ●

---

*Amy Panagopoulos, MBA, BSN, is NCCHC's vice president of accreditation. Send your standards-related questions to [accreditation@ncchc.org](mailto:accreditation@ncchc.org).*

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