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2014 Standards Make Their Debut

Newly revised, the 2014 Standards for Health Services for jails and prisons present NCCHC’s latest recommendations for managing health services delivery in adult correctional facilities throughout the nation. The standards were updated to reflect the latest evidence and best practices in meeting professional, legal and ethical requirements in delivering correctional health care services.

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Notable updated topics include continuous quality improvement, clinical performance enhancement, patient safety, initial health assessment, pharmaceutical operations and women’s health. Many of these topics will be addressed in future editions of the magazine in the Spotlight on the Standards column.

The new Standards make their debut at NCCHC’s Spring Conference on Correctional Health Care, April 5-8 in Atlanta. The preconference seminars provide in-depth instruction about the jail and prison standards, with an emphasis on “what’s new” and how to achieve compliance. Seminar attendees receive a copy of the Standards as part of their registration fee. To order your copy, visit www.ncchc.org or call 773-880-1460.

Call for Accreditation Surveyors
NCCHC is growing and looking for outstanding correctional health professionals who would like to enhance their careers by becoming surveyors, lead surveyors or physician surveyors.

Becoming an NCCHC surveyor requires at least five years of experience in correctional health care, CCHP certification (or ability to achieve within one year) and the willingness to participate in introductory and subsequent training. Surveyors must be health care professionals (MD, DO, DDS, DMD, NP PA, RN) or have a master’s degree.

Most importantly, NCCHC surveyors need dedication and commitment to improving the quality of correctional health care. Surveyors receive stipends and travel expenses. Surveyors find the experience very rewarding and a unique opportunity for professional growth, with benefits such as the following:

• Learn from visiting a variety of facilities
• Mentor health care practitioners on NCCHC standards
• Help raise the level of correctional health care nationally
• Teach providers how to succeed in the unique correctional environment
• Contribute to the professionalism of the field

Paulette Finander, MD, CCHP, says, “I choose to be a surveyor to learn best practices and avoid ‘not so good’ practices, for the intellectual stimulation, to meet new colleagues, to travel and have new experiences and to give back to NCCHC, for which I have the highest regard for its work to improve health care and conditions for one of the most vulnerable populations in this country.”

To learn more, visit www.ncchc.org/accreditation or email us at accreditation@ncchc.org.

Calendar of events

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<td>CCHP exam, regional sites</td>
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<td>July 18-19</td>
<td>Correctional Health Care Leadership Institutes, Broomfield, CO</td>
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For the complete list of CCHP exam dates and sites, see www.ncchc.org/cchp/calendar.

Exceptional Opportunity for an Exceptional Leader
As announced in the Fall 2013 issue, NCCHC’s president and CEO, Edward Harrison, has announced his retirement pending the appointment of a successor. The NCCHC search committee is seeking a strong leader who can take the organization to the next level of success. To learn about this opportunity, see page 21.

NCCHC Guidelines and Position Statements
At its October 2013 meeting, NCCHC’s board of directors adopted two new guidelines for disease management and one revised position statement. The alcohol detoxification guideline appears on page 6. The guideline on adolescent attention-deficit/hyperactivity disorder was summarized in the Fall 2013 issue. The revised position statement addresses prevention of violence in correctional settings. All can be found in the Standards and Guidelines section at www.ncchc.org.

Visit Us at the AJA Conference!
If you are attending the American Jails Association conference, April 27-30 in Dallas, be sure to attend our free Sunday seminar on the NCCHC standards, presented by accreditation manager Tracey Titus, RN, CCHP. And stop by our booth #130 to enter a raffle to win free registration to upcoming NCCHC conferences!
Segregation: Challenging the Status Quo

by Thomas White, PhD

Dr. Dean Aufderheide’s recent CorrectCare article, Mental Illness in Administrative Segregation (Spring 2013), provided insightful recommendations about protecting yourself from lawsuits related to mentally ill inmates in segregation or special housing units. The risk management issues notwithstanding, it must be emphasized that this is not a new problem. For decades civil rights lawsuits involving mentally ill inmates in SHU have criticized the delivery of mental health services, most commonly citing excessive use of administrative segregation and the lack of timely and meaningful access to adequate care.

Yet, despite decades of grappling with this seemingly straightforward issue, our use of long-term SHU to manage the mentally ill is growing and the lawsuits continue. It seems fair to ask why so little progress has been made. One obvious reason may be that we have not addressed some fundamental issues about providing services in SHU that have undermined even our most reasoned and well-intentioned efforts.

No Viable Housing Alternatives

As prison populations began growing several decades ago, administrators relied heavily on their SHUs to routinely manage and separate more and more problem inmates. For violent, predatory inmates who simply refuse to follow the rules, this was an effective strategy that may still be a viable and reasonable option. However, also caught up in this process were many mental ill inmates who were nonviolent but displayed unpredictable cycles of crisis and adjustment, causing them to “ping-pong” between the general population and SHU. As a result, many chronic, mentally ill inmates today spend months and sometimes years in long-term, single-cell isolation simply because our reliance on SHU has crowded out the development of other housing options for the mentally ill.

Limited Clinical Contact

As mentally ill populations grew, fulfilling even basic policy requirements in large, diverse SHUs became difficult, if not overwhelming, for clinicians. To maximize time and resources, a number of practices evolved to compensate for the demands of the 24/7, lockdown environment. Perhaps most prominent was the traditional SHU rounds. In every facility on most days, clinicians can be found walking the SHU range talking to inmates through the closed door of their cell. In fact, this practice is so universally accepted it has become the de facto standard of care for noncrisis SHU contacts. But despite its practicality, conducting interviews at the cellfront is obviously less than ideal because it offers little privacy and almost no meaningful interaction, and limits any useful therapeutic involvement.

Although it is efficient, this practice can have serious unintended consequences. Some high-risk inmates can and do go for long periods of time receiving little individual, one-on-one attention unless they experience psychotic episodes or engage in outbursts of violence or self-injury, or in some cases attempt suicide. At that point, everyone responds to the crisis. But even then, there are typically few permanent housing options available other than SHU, so the cycle starts again.

Recommendation for Breaking the Cycle

Given the industry’s stated recognition of these long-standing problems, the federal courts are becoming less tolerant about our inability to provide meaningful remedies and the issue has even spurred recent congressional hearings. This may be signaling an end to the status quo as well as new pressures to provide real, ongoing treatment to our growing mentally ill population. In an era of diminished funding, change must be accomplished without greatly expanded resources, but complicated problems do not necessarily require complicated or expensive solutions.

For example, to address the need for alternative housing, some units can be designated for inmates who need less restrictive housing than SHU. Such a unit would also serve as a transition point for inmates going to or being released from SHU to assess their stability and provide treatment.

For SHU itself, a greater mental health presence can be accomplished by assigning permanent clinical staff to the unit. This would enable clinicians to conduct more frequent and/or focused daily rounds for identified high-risk inmates. Other low-cost adaptations might include developing a “mental health range” in SHU to facilitate better access and rapport with inmates and allow more out-of-cell time for selected inmates. Another clinical improvement would be to ensure that adequate time and space are available to permit direct and private engagement with inmates.

Finally, it seems time to develop mechanisms for sharing management responsibility between security and mental health professionals to maximize continuity of care and minimize long-standing antitherapeutic criticisms.

A New Paradigm

Introducing even moderate, incremental change in any institution can be difficult and entails some degree of risk and the possibility of failure. But that should not prevent us from trying. The most fundamental challenge for most institutions will be a willingness to modify the self-justifying

continued on page 4
**New Guidance on Testing, Treating HCV Infection**

Because guidance for hepatitis C treatment changes frequently as new therapies are approved and new research is reported, the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America have launched a web-based process for the rapid dissemination of evidence-based, expert-developed recommendations for hepatitis C management. The site features an ongoing summary of recent changes and updates.

- [http://hcvguidelines.org](http://hcvguidelines.org)

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**Successful Heroin Addiction Treatment at County Jail**

In a program said to be the first of its kind, the Washington County (MD) Detention Center is using Vivitrol to treat heroin addicts at the jail. The county health department received a federal grant to administer the drug, which attaches to receptors in the brain and blocks the euphoria caused by heroin and other opioids. A county health department study of 21 people who received the monthly treatment showed 92 continued treatment after their release. The rate was about 50% with other treatments.


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**Segregation (continued from page 3)**

lockdown strategy we have relied on for years that hampers innovative treatment approaches for nonviolent mentally ill inmates. Nevertheless, to have a chance at success, such bold and deliberative action will be necessary and must come from the very top.

The purpose here is not to simply criticize the status quo or rehash old problems. Rather, it is to stimulate candid dialogue about ways to fix long-standing issues associated with housing mentally ill inmates in segregated housing, and to encourage practitioners and decision-makers alike to engage in that discussion sooner rather than later, before expensive and disruptive change is forced upon us by the courts.

Thomas White, PhD, is a principal with Training and Consulting Services, Shawnee Mission, KS. He retired as regional administrator of psychology services from the Federal Bureau of Prisons and now provides consulting, training and litigation support services in the public and private sectors. To reach him, visit [www.SuicideConsultant.com](http://www.SuicideConsultant.com).
Nursing assessment protocols are used quite frequently in jails, prisons and juvenile detention facilities across the country as a tool to guide nurses in the assessment of patients. Standard E-11 provides guidance for the proper use of these protocols, which are defined as written instructions or guidelines that specify the steps to be taken in evaluating a patient’s health status and providing intervention.

Protocols may include acceptable first-aid procedures for the identification and care of ailments that would ordinarily be treated with over-the-counter medicine or through self-care. They may also address more serious symptoms such as chest pain or shortness of breath. Protocols specify a sequence of steps to be taken to evaluate and stabilize the patient until a clinician is contacted and orders are received for further care.

Management of Nursing Assessment Protocols

Once developed, protocols must be reviewed annually by the nursing administrator and responsible physician. A signed declaration by both parties is often used to indicate that this review has been completed. When protocols are changed, they must be individually signed by the nursing administrator and responsible physician.

Nurses must be trained in the use of protocols during orientation and when protocols are introduced or revised. The training must include a demonstration of a nurse’s knowledge and skills in protocol use. There must also be an annual review of skills for all nurses who use the protocols. The annual review is intended to be more than a staff in-service where all protocols are reviewed and staff sign in to show proof of attendance. Rather, the annual review is to be an individual evaluation of a nurse’s skill in use of the protocols. Individual evaluations may be accomplished by the administration of written tests, documentation review and/or demonstration of knowledge and skills. The annual review must also be documented and kept on file for each nurse.

Pushing the Limits

Although standard E-11 clearly defines how nursing assessment protocols should be used, the environment of correctional health care sometimes lends itself to their misuse. One example would be to permit nonhealth staff to use the protocols. Nursing assessment protocols are meant for nurses and must be appropriate to the level of skill and preparation of the nursing personnel who will carry them out. They must also comply with relevant state practice acts. They are not meant to be used by custody staff or child care workers in the absence of nurses.

Another common misuse of nursing assessment protocols is the inclusion of standing orders, which are written instructions that specify the same course of treatment for each patient suspected of having a given condition and that specify the use and amount of prescription drugs. For example, all patients who present at sick call with a suspected ear infection are given the same antibiotic without consulting a provider. Often these standing orders include a blanket statement to call a provider before initiating the treatment, but this practice may lead to nurses using the standing orders freely, without consulting a provider first. This potentially places nurses in a situation where they are acting beyond their scope of practice. Treatment with prescription medication should be initiated only on the written or oral order of a licensed clinician.

Standard E-11 does permit the use of prescription medication such as nitroglycerin or epinephrine in emergency, life-threatening situations. The types of emergency medications to include in nursing assessment protocols is a decision that must be made by the facility’s responsible physician, and the assessment protocols should clearly outline the findings that could lead to the administration of emergency medication. A subsequent clinician’s order is required when emergency medication is used.

Finally, standing orders may also be used for preventive medicine practices such as immunizations.

It is important to note that treatment protocols or algorithms used by clinicians such as physicians, physician assistants and nurse practitioners are not addressed in this standard.

The intent of standard E-11 is to ensure that nurses who provide clinical services are trained to do so under specific guidelines. When used properly, nursing assessment protocols can be very helpful in the clinical management of patients.

Tracey Titus, RN, CCHP, is NCCHC’s accreditation manager. To contact her, write to accreditation@ncchc.org.

About ‘Spotlight’

The articles in this series shed light on the nuances of NCCHC’s Standards for Health Services, exploring the rationale behind various standards, the intended outcomes, compliance concerns, the impact on the accreditation process and more. The complete series is available in the Standards and Guidelines section at www.ncchc.org, along with an archive of questions from the Standards Q&A columns.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s annual spring and fall conferences.
Guideline Addresses Significant Care Gap in Alcohol Withdrawal Treatment

In October 2013, NCCHC adopted a new Guideline for Disease Management addressing alcohol detoxification. It appears here in its entirety except for the list of recommended resources to support evidence-based practice and quality improvement. NCCHC’s guidelines can be found in the Standards and Guidelines section at www.ncchc.org.

Although clinical guidelines are important decision support for evidence-based practice, to leverage the potential of guidelines to improve patient outcomes and resource use, NCCHC recommends that health care delivery systems also have components including primary care teams, other decision support at the point of care (such as reminders), disease registries, and patient self-management support. These components have been shown to improve outcomes for patients with chronic conditions. In addition, we recommend establishment of a strategic quality management program that supports ongoing evaluation and improvement activities focused on a set of measures that emphasize outcomes as well as process and practice. For information on the chronic care model, model for improvement, and outcomes measures, see the complete guideline.

Alcohol Detoxification in Corrections

If not recognized and adequately treated, alcohol withdrawal syndrome can progress to delirium tremens and death. AWS is prevalent among those entering holding centers and jails, often beginning during the first 24 hours following the person’s last drink. It complicates management of medical and psychiatric problems and is associated with increased suicide risk. National surveys show significant gaps in quality for management of AWS in corrections, including underuse of recommended protocols for detoxification. Thus, AWS represents an important preventable cause of death in corrections. The general approach to AWS comprises four essential components:

• Universal screening. All inmates should be screened for potential AWS symptoms upon entry into the facility from the community.
• Medical evaluation. All inmates who screen positive should be referred for medical clearance and formally assessed for AWS using a standardized instrument.
• Detoxification. All inmates with clinically significant AWS should be treated with effective medication.
• Referral for substance abuse treatment. All inmates with AWS should be educated about their disease and referred for substance abuse evaluation and treatment following detoxification.

Universal Screening

All persons entering correctional facilities from the community should be screened for AWS risk upon admission. Screening requires appropriately trained staff and standardized questionnaires. Staff should provide a rationale to the person being screened (e.g., “We ask these questions to identify persons needing treatment for alcohol [drug] withdrawal”) before asking about use to encourage honest responses. Screening includes questions regarding type, amount, frequency, duration of use, and history of prior withdrawal symptoms. Standardized screening instruments (e.g., Simple Screening Instrument for Substance Abuse) are available. Persons who screen positive from the SSI-SA or who report heavy, regular use of alcohol [or sedatives/hypnotics] or have a history of AWS or who show observable signs (alcohol on breath, unsteady gait, tremor, confusion) should be referred for immediate medical evaluation.

2014 STANDARDS for Health Services in Jails or Prisons

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Medical Evaluation
Given the appreciable mortality risk associated with AWS, the medical evaluation should be conducted by a health professional trained in assessment and treatment of AWS. Evaluation includes a history of alcohol use (amount, quantity, duration, last use, and prior withdrawal symptoms); assessment for medical and psychiatric comorbidity such as gastrointestinal hemorrhage, trauma (particularly to the head), liver disease, seizures, pancreatitis, and suicidal ideation; concurrent drug use; and prescribed medications. Heavy alcohol use, long-term heavy drinking, and previous AWS increase the risk for DTs. The physical exam should pay particular attention to unstable vitals, patient somnolence, and mental status, and neurological, cardiovascular, and pulmonary systems. Laboratory testing should include complete blood count, comprehensive serum chemistry, and urine toxicology (drug use), and pregnancy test for females. Results of breathalyzer testing and/or blood alcohol should be documented in the medical record.
Validated withdrawal assessment instruments should be used such as the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised. It can be administered in 2 minutes by a nurse trained to use it. Withdrawal risk should be stratified into three groups: low, moderate, and high risk.
- Low risk includes patients who are asymptomatic or have minimal symptoms (CIWA-Ar < 10) and have no prior history of significant AWS and no complicating major medical or psychiatric morbidity. They should be monitored for symptoms, described below.
- Moderate risk includes patients with a history of significant AWS, concurrent medical or psychiatric morbidity, or moderate AWS symptoms (CIWA-Ar 10-15). They require more intensive monitoring and aggressive treatment, described below.
- High-risk patients include those with a history of severe AWS, seizures, DTs, suicidal ideation, or pregnancy, or patients with CIWA-Ar scores > 15 or those who show rapid escalation in scores. High-risk patients should be referred to a facility, such as a hospital, equipped for intensive management of complex and/or severe AWS.

Detoxification
Detoxification reduces patient symptoms, morbidity, and mortality. Standardized withdrawal scales (e.g., CIWA-Ar) should guide detoxification. Low-risk persons scoring < 10 often do not require detoxification with medications, but should be monitored every 4 to 8 hours for at least 72 hours, ideally using the CIWA-Ar. Patients at moderate risk should be monitored every 2 to 4 hours and treated when CIWA-Ar scores reach 10 (or lower when other risk factors are present). Patients with severe withdrawal (i.e., scores > 15) should be transported immediately to the hospital. Induction begins with a standard dose of a short-acting benzodiazepine (e.g., lorazepam) that is titrated upward, through either a fixed-dose escalation schedule or through symptom-triggered treatment. Symptom-triggered treatment allows the dose to be tailored to the CIWA-Ar score, minimizing risk of under- or overdosing, and reduces the duration of detoxification. If fixed doses are given for detoxification, it is important to provide additional doses of the drug if symptoms are not controlled on the fixed schedule. Once symptoms begin to abate, a longer-acting benzodiazepine may be substituted based on results from renal and hepatic function and potential drug–drug interactions. Uncomplicated detoxification for AWS may be completed in 3-5 days. Stabilization refers to the subsiding of withdrawal symptoms. This typically occurs within the first 24-48 hours. Delirium tremens usually occur with 72 hours, but may occur up to 7-10 days following last drink, underscoring the need for monitoring after detoxification is completed.

Carbamazepine represents an alternative drug for treating AWS in those with moderate symptoms and no major comorbidity. Beta blockers may reduce autonomic symptoms but do not have anticonvulsant activity. Neuroleptic agents (e.g., haloperidol) reduce agitation but do not prevent DTs and may lower seizure threshold. Thiamine 100 mg should be given for at least 10 days to all patients with AWS to prevent Wernicke’s disease. Daily folic acid 1 mg and multivitamins address nutritional deficiencies commonly seen with alcohol disorders.

Alcohol Disorder Treatment
Detoxification does not treat the underlying disease of addiction. All patients with an alcohol disorder and/or AWS should be educated about their condition and the risks associated with AWS and offered alcohol treatment. Depending on circumstances, the patient should be offered enrollment in treatment programs within the facility or referred upon release to comprehensive treatment programs that offer both behavioral and pharmacological treatment. Engagement in community treatment should be done quickly because correctional release often triggers relapse.

Quality Improvement Measures
The following quality improvement measures are suggested, but they are not intended to be a complete list necessary to ensure a successful alcohol detoxification program in a correctional setting. We recommend that the improvement measures for a patient population be reported at a facility level and at a provider or team level.
- Percentage of new inmates who are screened for AWS upon entry from the community
- Percentage of new inmates who screen positive for AWS risk who are referred for medical evaluation
- Percentage of new inmates who screen positive for AWS risk who are seen by an appropriate health professional for medical evaluation within 2 hours of admission
- Percentage of patients who screen positive who are assessed for AWS using a formal scale (e.g., the CIWA-Ar) within 2 hours of entry
- Percentage of patients who are subsequently diagnosed with AWS who were not identified through screening or evaluation
- Percentage of new inmates with AWS (or an alcohol disorder) who are referred for substance abuse treatment on release from the facility
- Any patient death involving AWS
Jason Ray Brown, age 26, died while confined in the county jail. His death was needless and tragic. The physician who was under contract with the jail to provide medical care and supervise the nursing staff is the central defendant in this appeal. The physician successfully dons the cloak of qualified immunity and manages to fend off liability.

A strong dissent to this grant of immunity to the physician is filed by Circuit Judge Dennis.

I will review the facts and then provide an analysis of the majority's views on deliberate indifference and medical malfeasance.

**Facts**

On Thursday, July 22, 2004, around 3 p.m., Brown was arrested and brought to the county jail. Brown told the booking officer at the jail that he was under the care of a local specialist for several serious medical conditions, including autoimmune chronic hepatitis, esophageal varices (enlarged veins in the lower part of the esophagus), anemia, jaundice and splenomegaly (an enlargement of the spleen). Brown was placed in the jail's general population.

At 4 p.m., Brown complained that he felt nauseous and had vomited a small amount of blood. A jail nurse contacted Brown's pharmacist, who gave her Brown's list of prescribed medications, which were prescribed to be taken every few hours. The pharmacist also told her that Brown had not picked up his medications in several months. The nurse attempted to reach Brown's specialist in the community. The nurse then spoke with her supervisor, who told her not to order the medications until the patient was seen by the jail's physician.

The following day, July 23, shortly before midnight, Brown vomited a large amount of blood. Other inmates contacted officers for help. Two of the jail's correctional officers responded. Next to Brown they found a large puddle of blood, which they described as covering an area 1 to 1.5 feet in width and 2 to 2.5 feet in length. Brown told the correctional officers that he had gastric ulcers, that he took a significant amount of medications each month and that he had received 27 units of blood transfusions over the preceding six months. The officers called one of the nurses who worked at the jail, and explained the situation to her. She told him to give Brown a tube of liquid antacid per "standing orders."

Brown took the antacid but soon other inmates alerted the officers that Brown was complaining that he was in a lot of pain. One of the correctional officers called the nurse again and she asked whether anyone actually saw Brown throw up blood. The officer told her, "I had to clean it up." The nurse told the officers to give Brown a Phenergan suppository for the nausea from the physician's standing orders. Around 2:25 a.m. (now July 24), the officers returned to Brown's cell to administer the suppository but found Brown moaning and incoherent. The officers called the nurse at home again and told her that Brown was incoherent. She advised that she was on route.

When the nurse arrived at the jail, Brown was largely unresponsive. The nurse had Brown moved to medical solitary and administered the suppositories. During a cigarette break, the nurse asked the correctional officer, "Do you know what kind of ass chewing I would get from Dr. Bolin if I sent him to the hospital in the good health that he is in?"

On Saturday, July 24, between 3:12 a.m. and 11:30 p.m., detention officers allegedly monitored Brown through a slot in the cell door. At approximately 11:30 p.m., Brown was found unresponsive and without a pulse by the two officers. The nurse advised them to call emergency services.
The legal morass

Brown clearly had a right to adequate medical care for his serious medical conditions. As a pretrial detainee, the source of his right is the 14th Amendment, while the Eighth Amendment is the source for prison inmates. The actual rights, however, are identical and the lynchpin to those rights is to show deliberate indifference on the part of those whose duty it is to provide care.

The central figure on this appeal, as noted earlier, the physician. It is vital to note that the physician did not directly provide care the quality of which is challenged. Neither is it charged that the physician explicitly blocked hospital care or needed medication. It is the nurse, the equivalent of an LPN, who was acting as the physician’s agent and the allegation is that the physician intimidated nurses to prevent them from calling him and, furthermore, he placed inadequately trained and licensed nurses in a position where he had to know they would make critical medical decisions without guidance, training or supervision.

The majority strides into analysis of the case with a redundant exercise demonstrating that this is not a case involving systemic failure, to which I respond, obviously and—so what?

This is a case the court refers to as an “ episodic acts” case and in so designating it, conveys an ephemeral quality. There is a clear constitutional right here and after that is established in a qualified immunity case, the issue is whether the right was clearly established and, if so, was the breach done with deliberate indifference.

The hulking giant in every room with deliberate indifference is actual knowledge of a serious risk that then led to serious consequences. The majority finds that the nurse undoubtedly was deliberately indifferent. In order to link her behavior to the physician, there must be evidence that the physician was aware that his failure to train and supervise the nurses created a substantial risk of harm to detainees. This is the core of the panel’s finding and the critical difference with the dissent.

The majority, in effect, rules that the physician had to know specifically of Brown’s problems before he died. If I may interject here, this is where the panel is (so to speak) dead wrong.

For example, if a warden knows that the drinking water in his prison is polluted and inmate Jones dies as a result, must the warden have known that Jones, in particular, was at risk, or is it more logical to find deliberate indifference toward those in the at-risk pool?

Suppose a medical director knows that his staff is using the same needle for multiple inmate injections. Smith became infected out of a pool of 12 such injected inmates. Must it be shown that the director knew Smith was at risk? Hardly; only that he was part of a known at-risk pool.

The core issue on deliberate indifference and actual knowledge of risk here involves what I have termed the “unidentified victim,” or referred to here as actual knowledge of a high degree of risk to a “risk pool.”

Judge Dennis, in dissent, agrees with my logic and goes further into the intimidation claim, stating, “The majority holds that, although [the nurse] was deliberately indifferent to Brown’s obviously evident medical circumstances, [the physician] should not be held liable because there was insufficient evidence that he knew his policy of nighttime inaccessibility for medical advice or authorization of emergency hospitalization would cause substantial risk of harm to prisoners due to their inadequate medical treatment at the jail. In my view, a jury could reasonably find that [the physician] had a practice of intimidating nurses to prevent them from calling him or sending inmates to the hospital when they became dangerously ill; and that as a medical doctor, [the physician] must have known that the effect of his conduct would be to endanger the lives of those detainees, but was deliberately indifferent to that risk. I would therefore reverse the judgment of the trial court and remand the case to allow a jury to decide whether [the physician] should be held responsible for Brown’s death.”

Comment

This is an ugly result from a misguided majority of the Fifth Circuit panel. Keep in mind, by upholding immunity and summary judgment, the majority has ruled that even if everything plaintiffs allege is true and proven, they cannot prevail.

Bad law; very unfair outcome. Bravo Judge Dennis.

Fred Cohen, LLM, is the editor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2014 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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For several years now, health care administrators at jail and prisons have been hearing the drumbeat: “The Affordable Care Act will bring great opportunities—and challenges—to correctional health care operations. Get prepared for the changes that will come on Jan. 1, 2014!” Some have heeded that call, and many have a lot of catching up to do. So where are we today? What is being done, and what remains to be done?

Although the new law may impact facilities in a variety of ways, this article will focus on the two new funding sources: Medicaid expansion and the individual mandate to obtain health insurance.

Expanding Eligibility for Medicaid

Medicaid expansion extends health coverage to a large population of uninsured persons, including those who are incarcerated in jails and prisons. It is important to note, however, that states are not required to participate in the expansion, and as of early February, 25 had opted out, at least for the time being. In those states, other components of the ACA will apply, including the individual mandate.

In participating states, Medicaid expansion has the potential to be a significant source of funding for correctional health care. Before 2014, only 7% of inmates were enrolled in Medicaid, with another 8% eligible. Now, the remaining 85% are also eligible for Medicaid. Since Medicaid covers inpatient care that inmates receive in the community (provided that the stay is more than 24 hours), virtually all of these costly inpatient visits could be reimbursed. Through 2016, 100% of the costs incurred by people who are newly eligible will be be paid by federal tax dollars, with the rate dropping to 90% by 2020. In addition, Medicaid now provides 100% coverage for inpatient treatment of diagnosed substance abuse disorders.

As before the expansion, any inmate health services that are provided within jails and prisons are not covered by Medicaid.

Medicaid expansion has other advantages for our inmate-patient population, as well. As these individuals return to the community (assuming they are enrolled in Medicaid), they will have access to continuity-of-care services, behavioral health care services and prescription drugs.

There is much to applaud in these new changes, but many questions and challenges remain
technology use, in turn, will result in better, more efficient and more cost-effective care for the patient.

**Individual Mandate**

For jails, the other funding opportunity comes from the ACA’s requirement that individuals must obtain minimum “essential” (i.e., medical) health coverage or pay a penalty tax. The most feasible option for many low-income people will be to enroll through their state’s health insurance exchange, a competitive online marketplace of insurance plans. The exchanges include plans willing to cover inmates. The plans also include prescription drug coverage.

The individual mandate means that more people will be arriving to jail with coverage, which provides an opportunity to coordinate benefits or to determine who is financially responsible for the detainee’s health care. This applies only to pretrial detainees, as inmates forfeit their coverage through the health insurance exchanges once they are sentenced. However, about 60% of jail inmates are awaiting trial, according to the Bureau of Justice Statistics, and those with health coverage will remain covered as long as the premiums continue to be paid.

**Concerns, Challenges and Unknowns**

Although there is much to applaud in these new changes, many questions and challenges remain as facilities work to take advantage of the opportunities. For example, who will process and pay the claims? How will managed care plans affect the delivery of care on site? Will any services inside the facility be covered by health plans? Should maintenance medications be refilled through the current prescription?

Correctional facilities must also be alert to potential legal or regulatory concerns. For example, is there potential for exposure to the False Claims Act, which establishes liability when an entity improperly receives payment from the federal government? Might a facility run afoul of the Stark law or HIPAA challenges related to electronic health records and information sharing with community providers.

**Implementation in Action**

News reports of state and county correctional institutions that are taking advantage of the new Medicaid expansion and health insurance exchanges on behalf of inmates are appearing with increasing frequency.

In San Francisco, the county sheriff proposed legislation to the county Board of Supervisors that would require the jail to help all arrestees apply for health insurance that they would take with them upon release. The sheriff points to the public health benefit of former inmates receiving mental health and substance abuse treatment in the community, and the subsequent reduction in recidivism.

In Ohio, the prison system has begun enrolling inmates in Medicaid when they become ill and prior to release. By shifting the cost of hospital inpatient care to the federal government, the state expects to save nearly $18 this year alone, and more than $30 million in following years.

At Cook County Jail in Chicago, inmates are being enrolled in Medicaid as part of the intake process; as of early March, the county had submitted more than 1,000 applications for inmates.

In the Portland area, more than 1,200 inmates have enrolled through the state exchange, Cover Oregon. The county’s director of corrections health says that the estimated annual savings to the county by having the federal government pay inmate hospital expenses is $1 million.

In Colorado, state prisoners are being signed up when they need extended hospitalization. There, applications for inmates totaled 93 and for parolees 149 as of early March. In addition to anticipated savings of “several million dollars” per year, the prison system’s executive director points to the value of being able to coordinate care for prisoners after their release.

Finally, much has been said about a probably shortage of providers due to greatly increased demand for care. Will this present problems in hiring and in patient access to care?

**Your Role**

To get the most out of these promising new changes, jails and prisons need to be well-versed in the Medicaid program and health insurance exchange as they operate in their state and establish the necessary systems for processing applications for inmates and submitting claims for reimbursement. This will require close coordination with the state Medicaid office to ensure a smooth process flow and remediation of any technical issues related to enrollment and processing of the inmate population. It will likely also require additional on-site resources to process enrollments.

It’s also important to have systems for discharge planning and “warm hand-off” meetings for continuity of health care. This again requires close coordination with Medicaid officials as well as any medical providers involved with delivery of care to these patients.

M. Therese Brumfield, MBA, CCHP, is the vice president of provider operations and purchasing for Corizon, Brentwood, TN, Jaime Shimkus is the editor of CorrectCare.

**ACA Backgrounder**

The Patient Protection and Affordable Care Act is a complex piece of legislation with multiple facets. Here we review key elements that affect correctional health care.

- Expands health coverage to the uninsured through Medicaid expansion and the individual mandate.
- Extends Medicaid eligibility to all uninsured persons earning less than 138% of the federal poverty level, including the incarcerated.
- Through health insurance exchanges, offers coverage plans for those earning between 100% and 400% of the federal poverty level.
- Offers tax subsidies on plan premiums for those earning between 100% and 400% of the poverty level.
- Implementation and processes vary by state and will evolve over time.
- Increases connectivity through incentives to use health information technology.

**States Participating in Medicaid Expansion**

(As of Feb. 7, 2014)

- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Hawaii
- Illinois
- Iowa
- Kentucky
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Nevada
- New Jersey
- New Mexico
- New York
- North Dakota
- Ohio
- Oregon
- Rhode Island
- Vermont
- Washington
- West Virginia
Correctional Nursing: A New Scope and Standards of Practice

by Catherine M. Knox, MN, RN, CCHP-RN, and Lorry Schoenly, PhD, RN, CCHP-RN

Correctional nursing was first recognized in 1985 by the American Nurses Association as a distinctive specialty in the field of nursing. This is when the ANA published the Standards of Nursing Practice in Correctional Facilities, which was the first publication to define correctional nursing, describe the distinguishing features of the specialty and delineate the basic principles guiding practice in the United States.

A new edition of Correctional Nursing: Scope and Standards of Practice was published in 2013 by the ANA. As it has done in the past, the ANA assembled a work group of correctional nurses representing a variety of settings, backgrounds and organizations to spend the next 18 months reviewing, revising and editing the resulting edition.

Work group chairperson Patricia Voermans, MS, APRN, CCHP-RN, describes this edition as “expanding the description of the patient population and addressing challenges of delivering evidenced-based care in the correctional setting. It also discusses the evolving role of nurses in coordinating care, developing policy and leadership in correctional health care.” (Voermans served as the ANA’s liaison on the NCCHC board of directors during the revision.)

The Scope of Correctional Nursing Practice

The ANA defines correctional nursing as “the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, advocacy, and delivery of health care to individuals, families, communities, and populations under the jurisdiction of the criminal justice system.”

Correctional nursing takes place in a unique setting—the criminal justice system. Although the majority of nurses practice in jails, prisons and juvenile detention facilities, the new scope and standards also acknowledge that correctional nursing takes place in other settings such as parole, probation, community halfway houses, specialty units within hospitals, joint mental health–department of corrections hospitals and DOC-managed nursing homes.

Correctional nurses are often the primary health care provider in a correctional facility, with medical and other health care staff present in the facility only during limited hours. Because nursing practice in the correctional setting is so independent compared to other nursing specialties, correctional nurses must ensure that their practice does not go beyond state practice laws and licensure stipulations. More than any other nursing specialty, the specifics of nursing practice in the correctional setting have also been shaped by the protections arising from the Eighth and 14th Amendments to the U.S. Constitution.

Correctional nurses must be generalists, capable of recognizing and managing care of patients with a wide array of health conditions and illness pathways. The health needs of this population are characterized by disproportionate rates of mental illness, alcohol and drug dependence, victimization, traumatic injury and both infectious and chronic disease.

The Standards of Professional Nursing Practice

There are 16 standards of correctional nursing practice in the new edition (see box below). The first six standards delineate the steps used in the nursing process. The next 10 standards define the professional role of nurses in the correctional setting. This edition emphasizes the importance of communication and collaboration in the delivery of safe and effective patient care. A standard on environmental health has been added and targets the assessment and control of environmental factors that affect health.

This edition is the first to identify the competencies that registered nurses and graduate-level-prepared or advanced practice registered nurses are expected to demonstrate in meeting the standard. Competency is defined as the integration of knowledge, skills, abilities and judgment needed to achieve an expected level of performance. For example, some of the competencies to meet Standard 11 on Communication are as follows:

• Conveys information in formats that promote accuracy, understanding, confidentiality and compliance with security regulations.
• Questions the rationale supporting care processes and decisions when they do not appear to be in the best interest of the patient.
• Discloses observations or concerns related to hazards and errors in care or the practice environment to the appropriate level.
• Maintains communication with other correctional professionals to minimize risks associated with transfers and transition in care delivery.
These 16 standards provide the framework for professional correctional nursing practice. They are broad parameters that transcend geographic location, type of employer or setting (public, private, jail, prison, detention center) and the various populations served in correctional health care (sentenced, unsentenced, male, female, juvenile). The following sections describe how the ANA Scope and Standards of Practice have been applied in specific correctional health care organizations.

Orientation
Basic nursing education and traditional clinical experience do not prepare nurses to practice in the correctional setting. Nursing leaders in the Correctional Managed Health Care program of the Connecticut Department of Correction have developed an orientation, mentoring and professional development program that is competency-based and linked to the ANA Correctional Nursing: Scope and Standards of Practice. Nurses are provided with materials about the ANA standards of professional performance and review their role and responsibilities for competent practice, communication, collaboration, problem solving and ethics before their first day working in a correctional facility. The table below lists the areas covered during the nurse’s initial four to six weeks at the facility while under close supervision. The corresponding ANA standard is listed in the column on the right.

Job Description
The Washington State Department of Corrections revised its position description for registered nurses to coincide with the ANA standards. Including more description of the processes used to make clinical judgments provided better direction for nursing staff and a more robust performance improvement tool for managers. The essential job functions of the registered nurse are listed on page 14 with the corresponding ANA standard in the righthand column.

Policy and Procedure
ANA standards should be referenced in policy and procedure concerning subjects where nurses have a major role, apply nursing process or articulate an important ethical principle. This includes subject areas such as initial screening, sick call access, transfer, informed consent, refusal of care, collection of forensic information and professional development. At the Green Bay Correctional Institution, nurses identify the applicable ANA standards of correctional nursing practice in the review and discussion at staff meetings of Wisconsin Department of Corrections policy. For example, the ANA standards concerning outcomes identification, evaluation and collaboration provided guidance for nurses’ implementation of the agency’s revised policy and development of facility procedure on medication adherence.

Performance Review and Professional Development
The standards of practice can serve as criteria for prospective and retrospective performance review. The simplest application is for the nurse to assess his or her own practice

continued on page 14
in relation to each of the standards and identify areas that would benefit from further training, experience or coaching. This information provides a foundation for developing a plan to achieve the needed competencies. For example, most correctional nurses will need to develop the knowledge and skill set to be competent in environmental health since this is a new standard.

The standards also can be used retrospectively to review one or more patient care episodes to identify areas for improvement. In addition, the standards can be incorporated into more formal peer review. Evaluating performance of nursing staff against the standards can identify priorities for a professional development program or a systemwide quality improvement initiative.

Definitions and Expectations

The ANA Correctional Nursing: Scope and Standards of Practice define the professional practice of correctional nursing and set forth what is expected of nurses practicing in the criminal justice system. The standards provide the framework for measuring the competency of the individual professional nurse and guide nurses in making decisions about their practice amid the day-to-day challenges present in the correctional setting. The Scope and Standards of Practice provides the basis for an organization’s policies, procedures and protocols; position descriptions and performance appraisals; quality improvement; and professional development.

Catherine M. Knox, MN, RN, CCHP-RN, and Lorry Schoenly, PhD, RN, CCHP-RN, served on the American Nurses Association workgroup that revised the second edition of Correctional Nursing: Scope and Standards of Practice.

With 29 years of experience in correctional health care, Knox is an independent consultant based in Portland, OR. Schoenly is a nurse author, educator and consultant specializing in the field of correctional health care and is based in Geneseo, PA. Contact them at cmknoxxlc@msn.com and lorryschoenlyphd@gmail.com, respectively.

The Correctional Nursing: Scope and Standards of Practice book is one of the recommended study materials for the CCHP-RN certification exam. It is available through the NCCHC publications catalog. Visit www.ncchc.org to order and to see all of the publications available.

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### Essential Job Functions of the Registered Nurse

<table>
<thead>
<tr>
<th>Essential Job Functions of the Registered Nurse</th>
<th>Corresponding Standard</th>
</tr>
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<tbody>
<tr>
<td>1. Practices nursing in the correctional setting so that patient care provided is safe, effective, efficient and clinically appropriate. Practice includes:</td>
<td>1. Assessment</td>
</tr>
<tr>
<td>a. Assesses, monitors and interprets objective and subjective data collected by interview, observation, inspection and examination.</td>
<td>2. Diagnosis</td>
</tr>
<tr>
<td>b. Makes diagnosis and determination of the outcomes to be achieved as a result of nursing intervention.</td>
<td>3. Outcomes Identification</td>
</tr>
<tr>
<td>c. Plans the delivery of health care, defines time frames and methods for delivery of services; ensures continuity of care.</td>
<td>4. Planning</td>
</tr>
<tr>
<td>d. Implements the plan of care, provides direct patient care, directs others and determines when the plan needs to change.</td>
<td>5. Implementation</td>
</tr>
<tr>
<td>e. Analyzes and evaluates service delivery as well as outcomes achieved; revises the plan accordingly.</td>
<td>6. Evaluation</td>
</tr>
<tr>
<td>2. Delegates and assigns responsibility to others. Teaches, instructs, monitors, supervises and evaluates the care assigned to other personnel.</td>
<td>12. Leadership</td>
</tr>
<tr>
<td>3. Evaluates own practice, obtains education or training based upon plan for improvement and informs immediate supervisor of areas unable to perform competently.</td>
<td>8. Education</td>
</tr>
<tr>
<td>4. Communicates effectively to identify problems and develop solutions so that care delivered is safe, timely and clinically appropriate.</td>
<td>14. Professional Practice Evaluation</td>
</tr>
<tr>
<td>5. Counsels, teaches and assists patients to reduce health risks, improve self-care, manage symptoms and side effects, participate in treatment and make informed decisions about health care and treatment.</td>
<td>11. Communication</td>
</tr>
<tr>
<td>6. Provides information to groups, including colleagues and correctional personnel, so that good clinical practices and healthy behaviors are promoted and health risks are reduced.</td>
<td>13. Collaboration</td>
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Sunovion Pharmaceuticals Inc. is dedicated to developing new treatment options for patients and their families living with mental illness.
Management Mistakes That Increase Suicide Risk Among Incarcerated Vets

by Alexandra Pajak, LMSW, CCHP

Bartholomew Ryan, 32, committed suicide at the Nassau County Correctional Center, East Meadow, NY, in February 2012. The decorated Marine, who had served a year in Al Taqaddum, Iraq, hung himself with a sheet one day after incarceration at the jail. The New York Civil Liberties Union filed a lawsuit against Nassau County alleging that Ryan was improperly assessed for suicide risk and was improperly monitored despite jail staff knowing that Ryan had diagnoses of post-traumatic stress disorder and drug addiction. Ryan’s family also filed a federal wrongful death lawsuit against Nassau County and the jail’s medical provider, alleging that the jail does not meet the special needs of combat veterans.

In a five-page report on the death, the New York State Commission of Correction concluded that Ryan received inadequate medical assessment and treatment while at the jail. Two assessments were performed upon intake, one by an officer and a second by a licensed nurse. Ryan was then moved to a mental health housing area due to his history of psychiatric treatment.

The third suicide assessment, this time conducted by a doctor, was deemed inadequate, according to the report.

Officers found and attempted to revive Ryan by defibrillation and called an ambulance after their efforts at resuscitation. However, public access defibrillation procedure, recommended by the report, involves calling an ambulance during a resuscitation attempt, not afterward.

The report recommended that Nassau County jail’s contracted medical provider give specialized training to mental health staff regarding the mental health needs of incarcerated veterans. The report also recommended that the Nassau County Sheriff’s Department train all staff in public access defibrillation protocol.

Rising Suicide Rates

Starting in 2003, about 2 million military personnel were deployed through Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom in Iraq. As our troops return home, they face readjustment to society against the backdrop of a poor economy and high rates of PTSD following the guerilla warfare of the OEF/OIF conflicts. In addition to economic and mental health risk, the Institute of Medicine in 2006 identified incarceration risk as a significant challenge for OEF/OIF veterans. Correctional health care professionals are likely to encounter this at-risk population, so knowledge of suicide risk and effective management for this demographic is imperative to patient care, to community health and to our profession.

Research indicates that suicide rates are rising among active duty service members. In February 2013, the Veterans Administration released the statistic that 22 veterans commit suicide each day, equal to one suicide every 65 minutes and just over 8,000 suicides per year. This is a marked and troubling increase from the 2007 estimate by the VA Office of Inspector General that 5,000 veterans die by suicide each year. Research suggests that the highest suicide rates were observed in the Army and Marine Corps, with somewhat lower rates in the Navy and Air Force.

The Mental Health Connection

Veterans with mental health disorders are at an elevated risk for suicide. Common mental health diagnoses among OEF/OIF veterans include PTSD, depression and traumatic brain injury. PTSD and TBI may indirectly lead to criminal behavior due to some of the very symptoms that define PTSD and TBI, including hypervigilance, anger, violence, irritability and agitation.

Correctional health care workers must be aware that veterans returning from combat often are reluctant to access mental health treatment out of fear that a record of mental health problems will harm their professional career. Additionally, veterans may be reluctant to disclose suicidal ideation due to shame, viewing suicidal ideation as a sign of weakness, and out of fear of forced mental hospitalization. In one study, nearly half (46.8%) of Veterans Health Administration patients who committed suicide were never diagnosed with a mental disorder, which indicates that a significant number of veterans who committed suicide had no documented symptoms of mental illness.

Rising suicide rates in correctional settings are linked to the mentally ill being treated in jails and prisons rather than hospitals. And mental health problems that go unidentified and untreated may further increase veteran suicide rates in correctional settings.

Veterans who commit suicide often share certain characteristics. Males, Whites, younger veterans (defined as age 18-44) and veterans with substance abuse problems are at greater risk of suicide. Young veterans often have elevated blood alcohol content at the time of suicide. The mental health disorders most commonly associated with increased risk of veteran suicide are TBI, PTSD, depression, schizophrenia, bipolar disorder and alcohol/drug use disorders. The most common form of suicide among veterans in the free world is by firearms, followed by hanging.

Management Mistakes

In the past five years, academic journals have published peer-reviewed research articles that shed light on management mistakes that may increase risk of veteran suicide in VA hospital emergency rooms. As jail often serve as crisis intervention locations in the community, this research is
highly applicable to correctional settings. The same research also suggests management tactics that may help prevent veteran suicide in inpatient settings. It is critical that correctional health care professionals know the systemic factors that may assist in suicide prevention among OEF/OIF veterans in order to best serve this vulnerable population.

Management mistakes that appear to increase risk of veteran suicide in inpatient settings center around poor coordination of care and poor oversight of environmental hazards. Poor coordination of care includes having insufficient staff, incomplete or poor suicide assessments and poor communication of documented suicide risk among providers. Poor communication of risk often takes the form of medical staff simply not communicating risk to the appropriate team members and to providers on other shifts. Poor coordination of care also takes the form of difficulties in scheduling veterans with timely referrals and appointments with mental health providers.

Environmental hazards can contribute to increased risk of veteran suicide in inpatient settings. Results of a 2011 study of OEF/OIF veteran suicide in VA emergency rooms indicated that cutting, hanging and strangulation were the most common suicide methods. Most cutting occurred with razors. A similar study found that of completed suicides by cutting, the majority were with sharp objects brought into the facility by the patients. Those veterans who committed suicide by hanging most often used bedding or sheets as lanyards and doors as the anchor point. Therefore, poor oversight of access to tools used in suicide is a central factor that may increase suicide risk.

**Strategies for Prevention**

Important for correctional health care professionals to know, the same researchers make recommendations for management tactics to help decrease the rate of completed suicide among veterans. It is recommended that management staff instruct providers to take all endorsements of suicidal ideation seriously and respond immediately.

Educating staff about circumstances during which veterans are especially vulnerable to suicide is also likely helpful. Specifically, suicide risk increases among veterans with PTSD and veterans in VA depression treatment following medication change, psychiatric hospitalization and changes in psychotropic drug dosage.

To address the poor or incomplete suicide assessments, several researchers recommend more frequent and thorough suicide assessments. Researchers also highlight the importance of face-to-face contact with veterans in suicide screenings instead of the more impersonal suicide screenings that some facilities computerize.

As OEF/OIF veterans have a higher rate of PTSD than other veterans of other eras, additional suicide screenings and timely referrals for treatment are crucial, particularly as mental health problems are often missed during initial screenings. Furthermore, PTSD symptoms are likely to develop several months after return from deployment. The Center for Mental Health Services’ National GAINS Center Forum on Combat Veterans, Trauma, and the Justice System recommends specific screening instruments, including screens for combat exposure and PTSD. These screening tools are available for download or order at www ptsd.va.gov/professional/assessment/overview.

Stressing the importance of staff communication and encouraging staff training in effective communication are also recommended to improve communication among providers, particularly between different shifts. Likewise, emphasis and training in timely follow-up and provider scheduling is recommended as a focus of management overseeing medical staff.

Several researchers ultimately recommend a standardized checklist and protocols to ensure appropriate and effective oversight of the mental health holding area. Continuous observation of suicidal patients whenever possible is also recommended combined with contraband searches. Housing suicidal patients in areas without door anchor points nor access to bedding and sheets is also advised. It is best that holding locations be located away from escape routes and away from medical sharps.

Although the majority of VA emergency room suicides occurred by hanging and cutting, the frequency of veteran suicide by firearm also warrants correctional health care and security staff to house suicidal veterans away from access to firearms present in correctional settings.

Alexandra Pajak, LMSW, CCHP, has four years of experience doing mental health counseling in a jail.
Although patient satisfaction surveys are routine in the community, they are relatively rare in correctional health settings, according to an article in the April issue of the Journal of Correctional Health Care. Authors Sandra Tanguay, MS, RN, CCHP; Robert Trestman, PhD, MD, and Connie Weiskopf, PhD, APRN, CCHP, describe statewide implementation and initial results of a patient satisfaction survey at the Connecticut Department of Correction. The survey was developed at the University of Connecticut Health Center’s Correctional Managed Health Care division, which provides all medical, mental health, pharmacy and dental services in the CDOC’s integrated jail and prison system. The aim was to obtain and use data “to understand the current reality and to work toward improved processes and outcomes.”

During the planning phase, concerns were raised about how the survey would be received by health care staff, inmates, custodial staff and even the community. To reduce staff concerns, administrators and staff were encouraged to see this project as an opportunity to learn and were invited to review the questionnaire and to express their feelings.

**Findings and Corrective Actions**

In calculating the results, the researchers combined the “yes” and “unsure” responses. At the low end of satisfaction, 43% of respondents indicated that “I am satisfied with the health care I receive in prison.” On the high end, 79% were satisfied with respect for privacy and knowledge of self-care. No statistically significant differences were seen by gender or by facility type.

Staff feedback indicated that the findings were better than staff members had expected. They also acknowledged the credibility of the inmates’ responses and felt that the survey concept was nonthreatening. Staff also considered how satisfaction may be influenced by factors such as inmate age, length of sentence, health needs and so forth.

**Design and Implementation**

The 10-question survey was written for the 4th to 5th grade reading level and used a three-point scale with cartoon images representing “yes,” “unsure” and “no.” The questions were derived from a 2001 Institute of Medicine report on health care quality and from a review of existing surveys. Topics addressed overall satisfaction as well as factors such as access to care, waiting time, perceived courtesy and competence of health staff, privacy and knowledge of self-care.

The anonymous survey was administered at all of the CDOC’s 17 facilities over 18 months, in a manner designed to involve the maximum number of patients having health care encounters on the day of the survey. The survey was conducted not by facility staff but by central office staff to minimize perceived bias.

Initially, inmates were reluctant to participate. As surveyors improved in the role of educators about the purpose of the survey and as the program rolled out to the other facilities, more inmates agreed to participate. Ultimately, 2,727 (16%) of the total population of 17,100 inmates took the survey.

Each issue offers continuing education credit through an online self-study exam. Members of the Academy of Correctional Health Professionals receive JCHC (print and online) as a member benefit. To obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100; order@sagepub.com; http://jchc.sagepub.com.
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Specialty Certification: Why Take That Next Step?

by Matissa Sammons, CCHP

The Certified Correctional Health Professional program is in its 23rd year of providing recognition for those who demonstrate mastery of national standards and the knowledge expected of leaders in this complex field. Today, new CCHPs join more than 3,000 colleagues in sharing a common bond through certification.

The program, much like the standards and the field itself, has evolved and progressed over time. To better serve our constituents, we now also offer three exclusive certifications, each unique to the purpose and specialties it was designed for. One might argue that the correctional health care field is a specialty in and of itself. But CCHP specialty certification is a symbol of achievement in a professional discipline within our specialized field.

Below, three individuals who have attained these special credentials share their thoughts on what these certifications mean and why they are important.

CCHP-A: Setting an Example for Others

CCHP-Advanced certification has been offered since 1993 to recognize CCHPs who have demonstrated excellence, commitment and contribution to the field of correctional health care and their specific discipline or profession. If you set an example for others and encourage colleagues to strive for a high standard of quality and professionalism, then you should take the next step and pursue advanced certification, says CCHP trustee Steve Shelton, MD, CCHP-A. “It means something very personal to me because of the esteem I have for the dedication, contributions and caring of the other holders of CCHP-A status,” Shelton says. Activities of advanced leaders include presenting at conferences, writing articles, teaching, consulting with other organizations and serving on boards and committees. Shelton points out that achieving advanced certification also can inspire others to contribute to the field.

CCHP-RN: A Standard of Excellence in Nursing

Introduced in 2009, CCHP-RN certification is designed for correctional registered nurses. “Many nurses now feel that earning a certification in a nursing specialty is a standard of excellence,” says Susan Laffan, CCHP-RN, CCHP-A; a trustee on the CCHP board and vice-chair of the CCHP-RN subcommittee. Laffan adds that specialty certification is often a prerequisite for managerial positions. But it also is a source of professional pride, she says. “The CCHP-RN credential shows personal accomplishment, professional growth and commitment to the correctional nursing specialty.” Often, CCHP-RNs encourage and mentor other nurses to obtain certification. Patients benefit, as well: “Our patients might not understand the time and commitment certified nurses have devoted, but they might well notice the quality nursing care delivered.”

CCHP-MH: Recognition for a Unique Skill Set

“Understanding and navigating the correctional setting as a mental health provider takes time, patience and a set of skills that are quite unique,” says Sharen Barboza, PhD, CCHP-MH. “Providing care in this setting is like practicing in a different cultural context.” A member of the task force that developed the CCHP–Mental Health program, which launched in 2013, Barboza says the certification enables mental health professionals to demonstrate to colleagues, employers and patients that they possess a mastery of the NCCHC mental health standards and related topics. “This mastery supports our ability to provide quality mental health services within corrections,” she emphasizes. No a member of the CCHP-MH subcommittee, Barboza says that obtaining specialty certification is a foundation that holds clinicians to a high set of standards in service delivery.

What Are You Waiting For?

Gain recognition for your specialized education, knowledge and experience by taking the next step in achieving excellence in your chosen field and professional specialty. For more information, visit www.ncchc.org/cchp.

Matissa Sammons, CCHP, is NCCHC’s director of certification.

CCHP Participation Grows in Fourth Quarter

The certification program welcomed 104 professionals who passed the CCHP exam in the last quarter of 2013, plus 8 CCHP-RNs. In addition, the first round of exams for mental health specialty certification resulted in 17 CCHPs earning CCHP-MH. These certifications took effect Jan. 1. For lists of these individuals, see the Recent News page at www.ncchc.org/about.

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 24</td>
<td>Cottage Grove, OR</td>
</tr>
<tr>
<td>June 7</td>
<td>Regional sites</td>
</tr>
<tr>
<td>July 19</td>
<td>Broomfield, CO</td>
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<tr>
<td>August 16</td>
<td>Regional sites</td>
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</tbody>
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We are seeking sites for regional exams as well as CCHPs to proctor the exams. To participate, contact the certification specialist at 773-880-1460 or cchp@ncchc.org. See the complete calendar at www.ncchc.org/cchp/calendar.
Exceptional Opportunity for an Exceptional Leader

The National Commission on Correctional Health Care is committed to a mission to improve the quality of health care provided in jails, prisons and juvenile confinement facilities. For more than 40 years, our team has set the standards for delivery of medical and mental health care in correctional facilities. We currently seek a visionary to lead and expand NCCHC’s position as the premier body providing health care accreditation, certification, technical assistance and educational services for the leadership and staff of the nation’s county, state and federal correctional systems.

Responsibilities
As chief executive, the candidate selected will be a member of our board of directors and will be responsible for:
• Effectively managing the organization to achieve high customer satisfaction, retention and growth; and to fulfill NCCHC’s mission
• Advocating for NCCHC’s interests; actively promoting the organization, its policies and programs
• Providing support to the board of directors; managing the board’s governance process so that board members perform their fiduciary, policy, fiscal and national leadership responsibilities with knowledge
• Proactively maintaining the standards and policies established by the board and its committees; ensuring congruence of the goals of the organization with its activities; recommending to the board major new programs and initiatives for implementation; coordinating the implementation and evaluation of organizational activities
• Overseeing effective communications strategies to engage and inform health care professionals in all disciplines, correctional system leadership, policy makers and other key constituents

Qualifications
Qualifications for this position of national prominence and high visibility include broad-based business acumen as well as:
• Advanced professional degree, certification or equivalent work experience with at least 10 years of progressively responsible management experience including a minimum of 7 years at the executive level with a premier brand
• Strong financial management track record with successful P&L accountability
• Demonstrable strategic planning/execution abilities
• Proven background in motivating/inspiring top performance among diverse team members
• Excellent verbal and written communications with the ability to effectively interact at all levels

Additional desirable qualifications include expertise in not-for-profit board relations; health care executive background; proficiency in marketing, proposal writing, project management and justice system leadership; and experience/knowledge of public health, national policy formulation, accreditation and training

NCCHC offers industry- and location-competitive compensation and benefits. If you’re ready for an opportunity to apply your entrepreneurialism, vision and leadership to delivery of world-class services, we would welcome your response. For prompt confidential consideration, please send cover letter (salary history must be included) and resume to Carol Barber, Consultant, NCCHC Search Committee, Carol@NHCNnetwork.org. NCCHC is an equal opportunity employer.
Exhibitor Opportunity

National Conference on Correctional Health Care
October 18-22 • Paris Hotel, Las Vegas

Exhibit at the National Conference on Correctional Health Care! With nearly 2,000 participants, it is one of the world’s largest gatherings of professionals and experts covering all aspects of correctional health care. Attendees will come from all segments of the correctional health care community: administrators, medical directors, physicians, nurses, mental health professionals and more to share insights, find solutions and identify best practices. Connect with more decision makers than you could in months of knocking on doors and sending emails. Sign up for a cost-effective exhibition booth today!

Who Attended in 2013?
Nurse 43%
Physician/physician assistant 21%
Administrator 12%
Psychiatrist/psychologist 8%
Social worker, therapist, counselor 5%

Decision Makers With Authority
State medical director 7%
Medical director, director of nursing, other directors 20%
Health services administrator 11%
Department manager/supervisor 27%
Health services, dental or mental health staff 35%

Who Do Attendees Represent?
Jail facility 40%
Prison facility 22%
Private corporation 18%
State DOC/agency 14%
Juvenile detention or confinement facility 5%
Federal agency 1%

Categories Attendees Recommend or Buy
• Dental care and supplies
• Disaster planning
• Electronic health records
• Health care staffing
• Information technology
• Medical supplies
• Mental health services
• Pharmaceuticals
• Safety equipment
• Suicide prevention

Exhibitor Benefits
• 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)
• Direct access to attendees for premium face time
• 50-word listing in the Final Program (deadline applies)
• Electronic attendee lists for pre- and postshow marketing
• Ad discounts for the meeting programs and CorrectCare
• Opportunity to participate in raffle drawings
• Priority booth selection for upcoming conferences
• Opportunity to attend sessions and earn CE credits
• Exclusive opportunity to become a sponsor or advertiser

Sponsorship Opportunities
Your brand will take center stage with these sponsorship opportunities. These high-profile options ensure branding and recognition throughout the event and are orchestrated to provide maximum exposure for your company. Plus, you gain extra exposure when attendees return home with these meeting mementos. Ask the NCCHC sales representative to help you maximize your marketing exposure!

• Exhibit hall reception, lunch
• Educational programming
• Internet kiosks
• CCHP lounge host
• Conference bags
• Product Theater lunch
• Show bag inserts
• Exhibit hall aisle drop
• First timers’ reception

Become an Exhibitor Today!
The National Conference is the premier event 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 sales@ncchc.org or call 773-880-1460, ext. 298. Be sure to ask about sponsorships and advertising.
EMPLOYMENT

Academy CareerCenter
The #1 Career Resource for Professionals in the Correctional Health Community
Looking for a job? This benefit is free to job seekers. Post your resume online and showcase your skills and experience to prospective employers to find the best job opportunities.
Hiring? Receive member discounts on job postings and access the most qualified talent pool to fulfill your staffing needs.
Hosted by the Academy of Correctional Health Professionals. For information or to access listings, visit http://careers.correctionalhealth.org.

MARKETPLACE

Special Savings! 10% discounts for Academy members (single copies) and for bulk purchases of a single item (five or more). Find the complete catalog at www.ncchc.org and place your order at 773-880-1460.

New! 2014 Standards for Health Services for Jails or Prisons
Newly revised by a task force of leaders in health, law and corrections, the NCCHC standards have been updated to provide our latest recommendations for managing health services delivery in adult correctional facilities. The Standards address nine general areas: health care services and support, inmate care and treatment, special needs and services, governance and administration, personnel and training, safety, health records, health promotion and medical-legal issues. New areas of emphasis include continuous quality improvement, clinical performance enhancement, the Prison Rape Elimination Act, pharmaceutical operations, women’s health and patient safety.
Take advantage of the field’s top experts and stay current, meet constitutional requirements and be better prepared for the challenges you face every day. $79.95

New! CCHP-MH Study Package
This discounted package contains the essential materials for the CCHP-Mental Health specialty certification exam:
• Correctional Mental Health: From Theory to Best Practice
• How to Identify Suicidal People—A Systematic Approach to Risk Assessment
• Standards for Mental Health Services in Correctional Facilities
Save 18%! A $167 value if purchased separately, the package is only $137.

New! Communication, Collaboration, and You: Tools, Tips, and Techniques for Nursing Practice
This practical resource will help RNs to improve their communication skills as an interprofessional team player and better contribute to a healthy work environment. It is filled with valuable insights for promoting collaboration through communication: addressing difficult conversations and situations; assessing and understanding communication styles; meeting the challenges of interprofessional communication issues distinctive to nurses; recognizing and resolving issues that arise from workplace conflict and a multigenerational workforce; and using standardized communications tools such as SBAR, checklists and mindful communication. Numerous tips are presented as questions to aid in self-examination and group discussion. By Meaghan O’Keeffe, RN, BSN, and Cynthia Saver, MS, RN. American Nurses Association (2014). Softcover, 32 pages. $14.95

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, submit a request online at www.ncchc.org or by email 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.

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www.ncchc.org
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP

Time Frames for Task Completion

Q I need clarification on time frames that are required by the Standards. For instance, if a facility has seven days to test for tuberculosis, is the day of booking counted as day one?

A Yes, if a standard gives a time frame in which a task must be completed, then the day of booking is counted as day one.

Nonemergency Requests for Dental Care

Q If an inmate wants to see the dentist for a cleaning or filling and is experiencing no pain, and thus does not want or need a nurse to evaluate the need, do the standards require the nurse to see the patient before letting the patient see the dentist?

A There are a couple of standards that must be considered. Standard J-E-06 Oral Care requires that oral treatment, not limited to extractions, is provided according to a treatment plan based on a system of established priorities for care when, in the dentist’s judgment, the inmate’s health would otherwise be adversely affected. Standard J-E-07 Nonemergency Health Care Requests and Services requires that oral or written requests for health care are received daily by qualified health care professionals and triaged within 24 hours. Based on physician-approved protocols, qualified health care professionals schedule inmates, when indicated, for sick call or the next available clinician’s clinic. Not every sick call request requires a sick call appointment; however, when a request describes a clinical symptom, a face-to-face encounter between the inmate and the health care professional is required.

If the request you described does not include a clinical symptom, then a face-to-face visit would not be required by the Standards. I would advise working closely with the dentist at your facility to determine the appropriate response to requests for fillings or cleanings.

Requests for Bland Diets

Q We are receiving multiple requests from patients asking for bland diets, we believe in attempt to avoid the regular meals provided by the facility. Our providers have offered medications for heartburn issues. Do the Standards require us to provide a bland diet?

A Standard F-02 requires that medical diets are provided that enhance a patient’s health and are modified when necessary to meet specific requirements related to clinical conditions. Its intent is that the diet-related health needs of the individual are met. Medical diets are defined as special diets ordered for temporary or permanent health conditions that restrict the types, preparation and/or amounts of food. Examples of such diets include restricted calorie, low sodium, low fat, pureed, soft, liquid and nutritional supplementation diets. The type of diet that is medically necessary is a decision that must be made by the providers at your facility. The Standards do not specify which diets must be available, only that they are provided when required by their clinical condition.

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Tracey Titus, RN, CCHP, is NCCHC’s manager of accreditation services. If you have a question about the NCCHC Standards, write to accreditation@ncchc.org or call 773-880-1460. For an archive of past Standards Q&A columns, visit the Standards and Guidelines section at www.ncchc.org.

To learn more about standards interpretation, attend the preconference seminars offered at NCCHC’s Spring and Fall conferences on correctional health care. For conference information, visit www.ncchnch.org.
For all professionals working in correctional health, including administrative and support staff

CCHP The NCCHC Certified Correctional Health Professional program recognizes your mastery of national standards and the knowledge expected of leaders in this complex, specialized field. The CCHP credential is a symbol of achievement and leadership that provides immeasurable benefits, including professional recognition and pride. It is also a stepping-stone (and an eligibility requirement) toward advanced and specialty certifications.

Specialty certifications for qualified mental health professionals and registered nurses

CCHP-MH 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 recognizes dedication to quality service delivery. Eligibility is extended to qualified mental health professionals as defined by NCCHC’s Standards for Mental Health Services.

CCHP-RN Specialty certification makes a difference—to the patients whose care is provided by certified correctional nurses, to employers who desire top-notch nurses on staff and to the nurses who attain the credential. CCHP-RN certification recognizes registered nurses who have demonstrated the ability to deliver specialized nursing care in correctional settings.

Advanced certification for seasoned professionals

CCHP-A The CCHP-Advanced program recognizes CCHPs who have demonstrated excellence, commitment and contribution to the field of correctional health care and their relative discipline or profession. Advanced certification requires at least three years of participation in the certification program, completion of a detailed application and demonstration of extensive experience in and 360-degree knowledge of correctional health services delivery.

Exams are administered several times throughout the year. Apply today and join the thousands of correctional health professionals who have earned the distinction of certification from NCCHC.

For more information, visit www.ncchc.org/CCHP.
We founded MHM in 1981 to provide acute care hospitals a better management solution for their inpatient psychiatric units. In the 1990's we transitioned into the corrections market, and became the leading national provider of correctional behavioral health services. Today, we see needs in the broader correctional healthcare spectrum for a better managed care solution.

The Changing Landscape of Correctional Healthcare
National healthcare reforms and continued budget pressures will make the challenge of staffing and efficiently managing correctional healthcare programs more difficult than ever before. Correctional agencies will need a healthcare system that delivers the level of expertise and proven results in staffing, clinical operations, and client satisfaction that MHM is known for, coupled with a new level of managed care resources to contain costs - a level historically unavailable in correctional settings.

Introducing Centurion
MHM formed Centurion in 2011 in partnership with Centene Corporation, a Medicaid managed care company with over 3 million covered lives in 18 states. Centurion offers elements of managed care perfected in state Medicaid programs. Combined with some of the correctional industry’s most experienced healthcare managers.

A Winning Solution
The marketplace is responding favorably to our Centurion model. We are proud to announce new correctional medical contracts in Massachusetts, Minnesota, and Tennessee. We look forward to demonstrating the “Centurion difference” in the coming months.