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New and Updated Resources Now Online

The National Commission develops position statements to augment the Standards for Health Services or to express NCCHC’s expert opinion on important issues that are not addressed in the Standards. Along with the Standards, these position statements may assist correctional facilities in designing policies and procedures on such matters. In October, the NCCHC board of directors approved several new and updated position statements.

One of the new statements is titled Optimizing Insurance Coverage for Detainees and Inmates Postrelease. Most prison inmates and a large proportion of jail detainees and inmates lack health insurance, yielding worse health care access postrelease, disruptions in continuity of care for serious conditions and worse health outcomes. Lack of insurance coverage, particularly for mental health and substance abuse services, increases the risk of rearrest, resulting in a vicious, costly cycle of recidivism. The Affordable Care Act has created unprecedented opportunities for improving health care coverage for correctional populations postrelease. The new position statement articulates our stance on optimizing health insurance coverage and continuity as a means for improving health care.

The second new statement is titled STD Testing for Adolescents and Adults Upon Admission. Sexually transmitted diseases are highly prevalent among persons entering jails and juvenile facilities. Studies have identified stratified risk factors for individual diseases based on geographical location, age and gender. Identification and treatment of STDs offers a cost-effective opportunity to prevent complications and reduce transmission of STDs in jails, juvenile facilities, prisons and the community. NCCHC’s position statement presents our recommendations for STD screening and testing services.

In addition, three position statements were revised. Administrative Management of HIV in Correctional Institutions was updated throughout and, most notably, offers an expanded discussion on opt-out testing. Women’s Health Care in Correctional Settings was extensively revised and augmented, with lengthier discussions of pregnancy and postpartum care and a new section on family planning.

Finally, Health Care Funding for Incarcerated Youth notes that although the number of juveniles in custody has decreased significantly over the past decade, youth in custody have substantial physical and emotional problems. The statement updates our recommendations for ensuring that this vulnerable population remains eligible for all public and private health care coverage consistent with state and local eligibility requirements.

Guidelines and Other Resources

The NCCHC website also features our Guidelines for Disease Management, all of which were reviewed in 2014 and updated as necessary. Finally, a new section called Other Resources serves as a repository of valuable information from experts in a variety of topics, such as detoxification protocols, suicide prevention, nurses’ scope of practice and more. Appendices formerly published in the NCCHC Standards are now online to allow for timely updates.

NCCHC Board Announces New Officers and New Member

NCCHC is pleased to announce several changes to its board of directors. The changes took effect Oct. 19 during the annual board meeting.

Patricia Reams, MD, CCHP, is now board chair after serving one year as chair-elect. Dr. Reams has served as the American Academy of Pediatrics’ liaison to the board since 2002. See the profile on page 3 for more information about Reams. Jayne Russell, MEd, CCHP, A, has been elected chair-elect. She has been the liaison of the Academy of Correctional Health Professionals since the Academy became a supporting organization in 2006. Like Reams, she has served on every NCCHC committee, as well as the CCHP board of trustees. After a long career in correctional health care administration in both jail and prison settings, she now works as an independent consultant.

Thomas Fagan, PhD, CCHP-MH, liaison of the American Psychological Association, has been elected treasurer for 2014-2015. Now a professor of psychology for Nova Southeastern University, Dr. Fagan had a long career with the Federal Bureau of Prisons. He has been on the NCCHC board since 1996. Barbara Wakeen, RD, CCHP, was elected secretary. Ms. Wakeen has been the Academy of Nutrition and Dietetics’ liaison to the board since 2001. She is the principal of Correctional Nutrition Consultants, Ltd.

The National Association of Counties has a new liaison on the board. Christopher Rodgers, MPA, serves on the Douglas County, NE, board of commissioners and was NACo’s first vice president from July 2010 to July 2014. He is the director of community and government relations at the University of Nebraska at Omaha, where he previously directed a privately funded initiative to serve prison inmates and prevent recidivism.
As a young girl, Patricia Reams knew she wanted a career helping people. It was a weary hospital nurse who steered the 14-year-old candy stripers toward medicine: “Don’t go to nursing school, kid; go to medical school.” Advice taken, Reams gravitated to pediatrics and spent a few years in private practice. But with two small children, being on call was difficult, so when a friend told her about a position in the juvenile justice system, she gave it a try. She found that she truly enjoyed the work. “At that time, juvenile justice administrators were very supportive of providing good care for the child,” Reams says. The philosophy was to work for the good of the children, to prevent them from becoming adult criminals. Later, across the country, the administrative mind-set shifted to a more punitive approach, she adds, noting that the pendulum is now swinging back in the other direction.

When the state of Virginia created its Department of Youth and Family Services, Reams was tapped to serve as chief physician. She had to establish policies for the department, and that’s when she became aware of NCCHC. “I was searching for the means to improve access to immunizations and improve safety in my adolescent facilities,” Reams explains. “The NCCHC standards, in addition to the educational programs and networking, enabled me to find a way to persuade administrators and politicians to provide funding and needed resources.”

Reams left her juvenile justice position in 1995 but she maintained her interest in the field. After she resigned she called NCCHC to inquire about becoming a surveyor. She became more involved with the Commission and in 2002 joined the board of directors as liaison of the American Academy of Pediatrics. She has worked tirelessly on many committees and task forces to advance the cause of improved health care for incarcerated populations.

Change Agents
Reams points to the notion of “change” as critical to the work we do in corrections. “The word ‘corrections’ implies a goal of change in behavior of those who are incarcerated,” she says. “We owe the public and our clients/patients the opportunity to change their lives. The challenge is to create a system within each facility that reflects the standard of health care enjoyed in the community while competing against other priorities.”

Another key concern for Reams is patient-centered care. “Since the patient is most important, it make sense to organize activities around patients rather than what works best for the organization. Otherwise, patients will fall through the cracks.” This also means improving integration with the public health system so that releasees get appropriate follow-up and care in the community.

That goal is a chief reason that Reams sought to become NCCHC board chair: “I would like to see NCCHC’s influence expanded in the community to demonstrate that our standards help to provide a greater measure of public health and public safety, and I will work to that end.”
NCCHC's annual awards pay tribute to leaders and innovators that have enriched the correctional health care field. We applaud this year's recipients of the most prestigious awards in this field. The awards were given Oct. 20 at the opening ceremony of the National Conference on Correctional Health Care in Las Vegas.

**Hats Off to the 2014 Winners of the Most Prestigious Awards in Our Field**

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

**Edward A. Harrison, MBA, CCCHP, and R. Scott Chavez, PhD, MPA, CCHP-A**

*For visionary leadership in the field of correctional health care*

The year was 1987. In September, Edward Harrison, MBA, joined the small but robust not-for-profit organization headed by his father, Bernard Harrison, who sought out his son for his business, marketing and health management expertise. In November, R. Scott Chavez, MPA, became a member of the National Commission’s board of directors, serving as liaison of the American Academy of Physician Assistants. Thus was born a relationship that would have an immense and enduring impact on the Commission, one that was solidified when Dr. Chavez joined the staff as director of accreditation in January 1989.

After Bernard Harrison retired, his successor promoted Edward to vice president, and in 1993 the board of directors named him as president. He retired in 2014, after a 27-year career in correctional health care. Dr. Chavez (he earned a PhD in 2003) left the organization for five years to work in academia, but rejoined in 1998 as its vice president, a position he held until his death in 2013.

The awards committee was highly enthusiastic about this dual nomination, agreeing that the pair worked together as an extraordinarily effective and complementary team. Under Mr. Harrison’s leadership and with Dr. Chavez as his steadfast lieutenant, the National Commission made great strides in furthering its mission. Aided by a dedicated board of directors and countless volunteers, they succeeded in raising awareness of correctional health care as a vital component of public health through constant outreach and works such as the groundbreaking Health Status of Soon-to-Be-Released Inmates Report to Congress. During their tenure, the correctional health care field was elevated and recognized as distinct practice area with its own certifications. With each edition of the NCCHC Standards, the quest for quality became more tangible, driven by performance data and evidence-based practices. Accreditation and education, always core strategies, expanded in scope and depth.

Mr. Harrison and Dr. Chavez brought different strengths to NCCHC, says close collaborator and longtime board member Ronald Shansky, MD, MPH. Mr. Harrison “created sense of security for the organization; whatever challenges arose, there was an underlying confidence that he would be able to steer the ship and come up with appropriate responses.” He also generally preferred to work outside of the limelight. Dr. Chavez, however, relished his role as the face of the Commission in working with professionals in the field. “Scott’s greatest strength was his responsiveness to the field. People really relied on him and trusted him,” says Dr. Shansky.

With different roles and styles and yet united by a common vision, Mr. Harrison and Dr. Chavez together shaped the National Commission into the leading force for quality improvement in correctional health care.

**B. Jaye Anno Award of Excellence in Communication**

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

**Lynn Sander, MD, FSCP, CCCHP**

*For published works and communications that have advanced the field of correctional health care*

CorrDocs was already a well-regarded specialty publication when Lynn Sander, MD, FSCP, CCCHP, became its editor in 2007. But under her resolute stewardship, the quarterly newsletter of the Society of Correctional Physicians evolved and matured into a different sort of periodical. “It was only through Lynn’s relentless prodding and pushing it forward that CorrDocs became the vibrant force for education and change that it still is today,” says Michael Puerini, MD, CCHP-A, the immediate past president of SCP.

Dr. Sander worked in correctional health care for nearly 30 years before she died in November 2013. She spent 16 years at the Denver County Jail system, serving as its medical director for the last 10. She then worked a few years as corporate medical director for a correctional health care provider before beginning a consultant practice in 2007. That coincided with the end of her two-year term as SCP president and the start of her volunteer job as CorrDocs editor.

Given Dr. Sander’s passion for education and advocacy, she was perfect for the job. “Lynn was one of my first professional colleagues in correctional medicine and impressed me with her advocacy for the patient balanced with her knowledge and respect for public health, security concerns and evidenced-based medicine,” says Rebecca Lubelczyk, MD, FSCP, CCCHP, the current SCP president. “She brought all those strengths and passions when she became president of the Society and when she became the editor of CorrDocs.”

Dr. Sander was a lifelong educator who promoted careers in correctional medicine through a teaching program at the Denver County Jail. She presented at many conferences...
and was instrumental in developing the curriculum for NCCHC’s first Medical Director Boot Camp, which evolved into the Correctional Health Care Leadership Institutes.

Through CorrDocs, Dr. Sander was able to “give expression to her passion for the profession,” says Dr. Puerini. “Lynn worked vigorously on the publication while undergoing treatment for the illness that would come to take her life. Nothing could have slowed her down from her work on CorrDocs, one of her many professional legacies and, in my opinion, her finest.”

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

Casper Re-Entry Center, Casper, Wyoming
Although it serves two separate populations, each with a distinct set of programs and personnel, the health services department at the Casper Re-Entry Center has one overarching goal: to preserve and promote the health of the incarcerated individual. The word “individual” is key: The NCCHC surveyor who nominated CRC for this award lauded its commitment to providing “customized, focused, personal attention and responsiveness” to each resident.

Accredited since 2007, CRC is a private, multipurpose drug and alcohol treatment facility for males operated by Community Education Centers, Inc., which provides reentry treatment and education services for adult correctional populations. A 100-bed unit houses state prisoners who have been court ordered to receive treatment before parole; this service is provided under contract with the Wyoming Department of Corrections. On a separate floor, a 50-bed unit houses Native Americans from across the country who have been ordered to participate in CRC’s residential treatment program. CRC has contracts with numerous tribes and the Bureau of Indian Affairs to provide these services. Both the WDOC inmates and the BIA inmates must meet strict criteria before they are accepted into the respective programs.

The common thread between the two groups is the comprehensive health services provided. Each individual receives thorough intake screening and primary and specialty care, including dental, psychiatric and optometry. (The federal Indian Health Service provides dental care to BIA inmates.) Some BIA inmates have a constellation of chronic and communicable diseases that have not been identified, so the screenings often detect significant health problems that can now be managed.

Preventive care and health education are essential to CRC’s mission, and to that end the health services administrator developed a robust wellness program that begins with the each new intake receiving a workbook. Participants receive a wellness physical and additional educational materials. Each day the program offers a variety of physical classes along with seminars; group and individual meetings occur weekly.

Clearly, the substance abuse treatment programming is a high priority, and to maximize effectiveness, the clinical staff uses a variety of treatment models within a therapeutic community environment. Sensitive to their unique cultural needs, the program for Native Americans incorporates traditional approaches such as a sweat lodge and a talking circle.

Together, these programs and services, along with dozens of others, cohere to form an individual-focused therapy designed to help the residents succeed in maintaining healthy, drug- and alcohol-free lifestyles upon reentry.

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

Berkshire County Jail and House of Correction, Pittsfield, Massachusetts
Long-Term Care and Discharge Planning Program
The day an arrestee is booked into the Berkshire County Jail and House of Correction is the day he or she has an opportunity for a better, healthier life. Taking a proactive approach to inmate care, the facility uses a team to coordinate assessment of needs and the planning to meet those needs, both during incarceration and after release.

The medium-security facility, which has an average daily population of more than 300, reports that the program has proven successful: The three-year recidivism rate has steadily declined from 44.1% in 2006 (three years after the program started) to 33.0% in 2012.

The team members represent six areas: mental health, substance abuse, case management, education, medical and security. Upon intake, inmates receive screenings by a mental health clinician, an LPN or RN, a booking officer and a shift supervisor. That information is used to create an initial care plan. Follow-up assessments include mental health, physical health and case management. The intent is to develop a profile of long-term care and discharge planning needs.

The care plan is not static. Weekly meetings ensure that information is shared, issues are identified and inmate needs continue to be met. Ninety days before release, case managers initiate reentry plans that may include job prospecting, housing and transportation. Medical planning includes appointments, health records and medications. The week before release, everything is reviewed with the inmate, who receives a discharge checklist and information about postrelease meetings with the reentry case manager.

The accreditation surveyor who nominated the jail for the award attended one of the team meetings. “It was clear,” he says, “that the program offers patients a tremendous opportunity to reenter their communities with the support of caring and dedicated Berkshire County staff!”
The 2014 editions of the Standards for Health Services for jails and prisons saw significant changes to many standards. For Standard C-08 Health Care Liaison, the changes were made to assist the field in understanding when a health care liaison is required and to clarify the role of this person in the overall health care delivery system.

Why Is a Health Care Liaison Required?
The intent of this standard is that health care service continues to be coordinated when health staff are not available for an extended period of time, normally 24 hours or more. Because an inmate’s right to access to care does not disappear in the absence of qualified health care professionals, facilities must have a plan so staff can continue to coordinate health care and maintain patients’ rights to see a clinician, be given professional clinical judgment and receive care that is ordered. The health care liaison is responsible for maintaining this continuity of services when health staff are not on site.

When Is a Health Care Liaison Required?
A health care liaison is most commonly seen in facilities with health staff on-site Monday through Friday but not on weekends. For facilities that have health staff on-site daily but less than 24 hours per day, a health care liaison is not required. However, there must still be a plan in place that tells custody staff what to do when a health situation arises when health staff are not present. This standard does not apply to facilities that have health staff 24 hours per day, seven days per week.

Who Should Serve as a Health Care Liaison?
The health care liaison is typically a correctional officer, a child care worker (in juvenile facilities) or other person without a health care license. This person must be instructed in his or her role and responsibilities by the responsible physician or designee and receive instruction in and maintain confidentiality of patient information. Often, custody shift supervisors are chosen to fill this role, although it may be filled by anyone capable of carrying out the duties assigned to the health care liaison post.

Duties and Limitations of a Health Care Liaison
The definition of this post clearly outlines the limited aspects of health care coordination assigned to the health care liaison. These duties include the following:

- Reviewing receiving screening forms for follow-up attention
- Reviewing nonemergency health care requests
- Carrying out clinicians’ orders regarding diet, housing and work assignments
- Maintaining patients’ rights to privacy

It is important to note that the health care liaison does not deliver health care. Duties such as taking orders for new medications, administering injections and setting up or beginning new prescriptions from pharmacy stock exceed the limits of this post and do not meet the intent of this standard.

If a health care liaison’s duties include contacting the on-call provider or nurse for guidance, the advice should (1) fall within the duties outlined above or (2) if the problem is nonemergent, the patient should be referred to the next regularly scheduled sick call or (3) if the problem is urgent or emergent in nature, the patient should be referred to an outside health care facility for an evaluation by a health care professional. All other necessary health care that does not fall within these three parameters should be delivered by qualified health care professionals.

An Important Role
The health care liaison is an important role in the health care delivery system. Understanding both the responsibilities and limitations of this post will help facilities utilize the health care liaison appropriately and allow inmates access to care in a timely manner.
Although they had the support of two prison doctors and an outside expert, five Massachusetts prisoners lost their challenge to the state’s modification of medication procedures to require all HIV prescriptions to be dispensed in person at a pharmacy window (the “HIV line”) in Nunes v. Massachusetts Department of Correction, 2014 WL 4494202 (1st Cir., Sept. 12, 2014). Plaintiff Richard Nunes and four anonymous co-plaintiffs—all identified as having HIV—sought injunctive relief only for all similarly situated, but there was no class certification.

The court’s description of the facts indicates that Massachusetts adopted a unit (or single) dose pharmacy window procedure for HIV medication “to save money” because HIV medication consumed about 40% of the pharmacy’s budget, and the keep-on-person (KOP) system, under which patients were issued monthly bottles of medicine to take at specified times, was perceived as creating waste when prisoners left the system or were noncompliant with instructions.

Unlike the KOP system, the patient’s ingestion of the medicine was directly observed at the pharmacy window for each dose, requiring standing in line sometimes two or more times daily. Certain types of non-HIV medication also required window dispensing, while KOP continued for most other types of medication.

The plaintiffs challenged the “HIV line” as cruel and unusual punishment under the Eighth Amendment, calling attention to their HIV status, promoting “disparate treatment” under the Americans with Disabilities and Rehabilitation acts and (as to Nunes) denying “reasonable accommodation” under the same statutes.

Two of the prisons’ doctors filed affidavits in support of the inmates, saying that patients would be “less compliant” if they have to go to a window twice a day at fixed times and had no ability to adapt their medication consumption to their daily activities. The prisoners’ expert, Dr. David Bangsberg, identified the practice as “substandard,” but (like the prison doctors) he did not allege any specific patient harm, and he did not examine the plaintiffs.

Pre- and Post- Assessment of the Change

Before making the change, corrections officials assessed its impact. They found that more than 90% of HIV+ patients already went to the daily med line for other medications and that almost half had issues of noncompliance regardless of method of administration. The court found this to be a “sincere effort to gauge the effects of the policy change.”

Following implementation, the department said that “patient outcomes have held steady or improved,” with a slight increase in the number of patients with undetectable viral load. Although the plaintiffs disputed the significance of the data, they did not contest it, and they offered “no alternative quantitative metric” and “relatively little evidence regarding their own situations.”

The court ruled that no Eighth Amendment claim existed because no reasonable finding of deliberate indifference to serious medical needs could be made within the meaning of Farmer v. Brennan, 511 U.S. 825, 846 (1994), on these facts. The risk of harm was not “objectively intolerable,” and defendants had not disregarded substantial risks. At most, the anonymous plaintiffs’ evidence showed temporary side effects (which were addressed) and “a handful of missed doses.”

Even if plaintiff Nunes’ medical profile did offer evidence of deterioration, the court found that he refused to take any HIV medication since the change, claiming that he could not stand in a line and demanding restoration of the KOP system for him alone. The department offered him a walker, a bench on which to sit while waiting without losing his place in line and admission to the medical unit if he were too ill to go to the dispensing window.

The court found that these “accommodations” were sufficient, noting that Nunes offered no medical evidence supporting his claimed inabilities and that the record indicated that he “regularly walks to and from the prison cafeteria and engages in exercise, and … had jobs walking with a blind prisoner and cleaning corridors.”

No Harm to Inmates

The court found that none of the evidence, including that from the objecting doctors, showed that plaintiffs’ individual treatment had fallen “below professional standards.” Rather, “the undisputed facts show that the department engaged in facially reasonable efforts, well before this
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William J. Rold, JD, CCHP-A, is a civil rights lawyer and former judge in New York City. He represented the American Bar Association on the NCCHC board of directors for six years.

This article first appeared in edited form in the October 2014 issue of Gay & Lesbian Law Notes. It is reprinted here in modified form with permission from the publisher, the LGBT Bar Association of Greater New York.
This two-part article details the effective management of a prison dental program. Part 1 discusses the burden of dental disease in the correctional environment, the varying populations of inmates and an effective system for tracking inmate dental needs. Part 2 will cover the scope of dental responsibilities, correctional dental practice settings, preventive dentistry, advanced dental treatment, management with data and statistics, dental activity reporting, security and infection control.

**The Burden of Dental Disease**

Dental disease is a significant health concern in a correctional system. Many inmates have largely neglected their dental health until becoming incarcerated. Conservatively, about half of all inmates are received with urgent dental problems, and 90% arrive with some level of dental disease. This significant level of disease affects inmates, prison dental providers and prison administrators responsible for ensuring access to dental care for the inmate population.

The revolving door of corrections impacts our ability to effectively deliver dentistry because the inmates who leave “take” their improved oral health with them and are subsequently replaced by incoming inmates with high levels of severe dental disease. Consequently, it is very difficult for the correctional dental staff to keep pace with the dental treatment needs of an ever-changing inmate population.

Correctional dental health care needs can vary depending on an inmate’s stage of incarceration. New and returning inmates often have urgent dental conditions requiring immediate treatment. General population inmates can be divided into the following groups:

- **Inmates serving short sentences**: These inmates can be persistent about having their dental care completed before they are released.
- **Longer term general population inmates**: They typically have better oral health but can find themselves waiting for long periods of time to see the dentist while “routine” dental problems progress to more serious conditions.
- **Inmates in segregation**: Access to care can be difficult due to behavioral and security concerns.

This mix of populations presents a daunting challenge that can be summarized with the question, “How do we handle the constant stream of inmates arriving with severe dental problems while maintaining an acceptable level of dental health for our general population inmates?”

A sound strategy and consistent approach are needed to develop and maintain a successful correctional dental program. The crucial ingredients are as follows:

- **Accurate tracking of every inmate and his/her dental needs**
- **Quantification of the workload**
- **Effective scheduling**
- **Completion of a sufficient quantity of quality treatment each day**
A Strategic Approach
The components of a solid correctional dental program are described below.

Initial Evaluations and Examinations
Upon reception into the correctional system, the best practice is for a licensed dentist to perform a complete dental exam on each inmate. This includes an inspection of oral hard and soft tissues using a light, dental mirror and explorer; radiographs; recording of findings; a diagnosis; and a treatment plan. The initial examination and treatment planning establish a baseline record of an inmate’s oral health status. (See sidebar for the NCCHC Standards’ requirements for oral screening and examination in prisons.)

Tracking and Scheduling
Develop and implement a program that accurately tracks each inmate’s dental treatment plan in a fair and organized manner. An effective program takes time to create and maintain, but it makes a dental office optimally organized and will help to maximize treatment output. Chances are that most correctional dental offices are already doing some form of tracking, so the time required to implement a bulletproof program will be negligible and the efficiency gained by doing so is invaluable.

In Pennsylvania, we use a Microsoft Excel spreadsheet and have found this method to be the best and fairest currently available to us. A dental waiting list, ordered chronologically and by acuity, is created through daily input of data gathered from new patient exams, chart reviews, emergency presentations and updates after routine/preventive appointments. Scheduling inmates from this program ensures that those who have the most severe problems, and have been waiting the longest, are treated each day.

Because correctional dental offices are such busy places, without an organized tracking and scheduling program it is easy to fall into a number of substandard practices. Most prominent is running a sick-call-based and/or request-driven dental program. These methods are initially the easiest to implement. They require no effort to track and schedule because one simply responds to those inmates who request care each day.

Dental sick call is supposed to provide immediate access to care for inmates experiencing an acute dental condition. However, if staff is not vigilant, a program can deteriorate to the point where it no longer serves its original purpose. Therefore, using the sick-call program to gain more frequent access to the dental office for nonurgent services should be discouraged. This can be done by levying co-payment fees (in the Pennsylvania system, a legislatively mandated fee is assessed for dental sick-call visits), restricting the daily time frame for dental sick call, ensuring that nonurgent presentations are tracked and providing treatment only for very serious conditions during the sick-call period. Treating all conditions during dental sick call or advising inmates to sign up for sick call when they want to be seen dilutes the program to the point of ineffectiveness.

A request-driven practice is similar to and often goes hand-in-hand with a sick-call-driven system. The difference is that inmate request forms are used to bring more routine conditions to the attention of the dental staff. These requests for routine care can be easily researched and the inmates can be responded to, in writing, if one has a thoroughly detailed database in place. If not in the database, the inmate can be examined and routine problems entered. The inmate is then advised and scheduled in turn.

Rescheduling the same inmates over and over until their treatment plans are complete is also not advisable. While this may sound good on the surface, it can lead to many other inmates waiting for very long periods of time to be seen. Due to these long treatment delays, pending routine dental problems progress to more serious conditions. When inmates wait a long time to be called, they are often compelled to sign up for dental sick call, thereby incurring co-payment fees. If widespread, these factors lead to inmate dissatisfaction with the dental program, administrative correspondences and more negative encounters with staff.

Repeatedly medicating dental patients instead of rendering definitive care is a by-product of disorganization and the feeling that there is not enough time to render appropriate treatment. In reality, by practicing in this manner, an already disorganized office falls further behind. If a dental office is functioning effectively, patients can be scheduled appropriately, definitive care can be rendered, inmates are not repeatedly requesting care for the same problems and the need for medications is reduced.

Differing Schools of Thought
Some correctional dentists make the argument that we should be operating like a private practice, where patients who want to be seen make contact with the dental office, are scheduled and are then treated accordingly. Such an approach sounds logical but does not translate well to the correctional setting. In prison, the dental office is part of the security algorithm and is required to maintain fair and equal access to dental services for all inmates. By using one of the flawed practices described above, many inmates wait for undesirable periods of time to receive dental services, disparities are created among inmates and security is compromised. These are a few of the possible negative outcomes:

- A few inmates receive extensive care while others receive little or no care. Inmates perceive this negatively as preferential treatment by staff.
- Inmates with greater financial means can afford the repeated sick-call co-payment fees while others go without needed care.
- If inmates are appointed and treated upon request (routine or sick call), they will continue to correspond. Word will get around the institution and the dental office will soon be inundated with more requests for treatment than can be managed. When the inevitable occurs and the dental staff cannot quickly handle the high volume, inmates

continued on page 12
will become upset. This leads to increased stress levels for dental office staff, the erroneous belief by dental staff that more dental staff needs to be hired, inmate correspon-
dences to administrators, inmate grievances, inmate litiga-
tion and security concerns.

- When inmates do not receive care and their oral health
deteriorates, providers become potentially liable through
deliberate indifference and/or negligence litigation.

A fair method of tracking, scheduling and treating
inmates for dental services is essential. It is a viable solution
to a variety of problems encountered in the effective deliv-
ery of dental services to a diverse population of inmates.

**Analysis of the Workload and Waiting Times**

Other advantages of the Excel tracking system are that it
quantifies the dental workload and analyzes waiting periods
in real time. At any given moment, dental providers can
know exactly how many extractions, restorations, prosthesis
and root canals are out there waiting to be completed.
The daily schedules can be planned to stay abreast of the
tide of urgent and pending dental treatment.

The program also tracks dental hygiene and periodic oral
exam frequencies. At any time, a list of all waiting inmates
and when they are due for these services is available.

An additional feature of this program is that it tracks
the last time an inmate may have been seen for a specific
service. This is helpful when answering inmate correspon-
dences or answers to administrative inquiries.

Finally, the tracking system is an asset to prison adminis-
trators who need to know the state of affairs of the dental
program. Whenever needed, an automatic, real-time wait-
ing list report is available for administrative review. A list of
all inmates who are waiting for all dental services is present-
ed in an easily interpreted table (see example below).

**Scheduling**

Once the workload and waiting times have been quanti-
fied, daily scheduling is completed by sorting the list for
the various dental disciplines and selecting those inmates
who come to the top. This enables the inmates with the
most serious conditions and/or who have been waiting the
longest to be scheduled. By having the workload quantified,
the staff knows how much treatment to schedule and com-
plete each day to avoid undesirable waiting times.

A good rule of thumb for daily scheduling is as follows:
- Six routine patients from the waiting list
- Four to five patients from sick call
- Hygiene exams
- Reception exams that may have been missed at intake
- Referrals from the medical department
- Other emergencies or urgent presentations, such as calls
  from corrections officers on the cell blocks

It may be possible to treat more patients each day (and
some days it is), but in a correctional setting many custodial
events can affect our ability to do so. These include lock-
downs and drills, inmate work schedules, inmate educa-
tion and rehabilitation programs, count, meals, inmate line
movements and inmates declining dental services or failing
to report for appointments.

The dental department must accomplish other essential
activities, such as administrative tasks, equipment main-
tenance and repair, meetings, reports and inventory and
tool control. As providers and auxiliary staff must complete
these tasks, we should allow time by scheduling proce-
dures that do not require constant assistance and leaving
brief periods of time each day to complete such tasks.

Avoid assigning too many nontreatment responsibilities to
licensed providers.

**Refusals and No-Shows**

A longer discussion regarding inmates refusing services
and/or failing to report for dental services could occur at
this point, but is perhaps subject matter for another time.
However, it can briefly be said that high rates of such occur-
rences impact our ability to deliver enough dental service.
These occurrences can be symptoms of other problems
with the dental program and should be investigated. We
have found that such patterns can be reversed and often
require support from facility administrators and actions to
change staff behaviors.

Dino R. Angelici, DMD, is chief of dental services for the
Pennsylvania Department of Corrections, Mechanicsburg, PA.

---

**Dental Backlog Tracking**

<table>
<thead>
<tr>
<th>Time (Months)</th>
<th>Routine Caries</th>
<th>Complex Caries</th>
<th>Endodontics (Root Canal)</th>
<th>Oral Surgery</th>
<th>Contract Oral Surgeon</th>
<th>Dentures</th>
<th>Cleanings</th>
<th>Exams</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>605</td>
<td>14</td>
<td>5</td>
<td>194</td>
<td>8</td>
<td>28</td>
<td></td>
<td></td>
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<tr>
<td>6-12</td>
<td>392</td>
<td>14</td>
<td>5</td>
<td>117</td>
<td>1</td>
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<td></td>
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<tr>
<td>12-18</td>
<td>87</td>
<td>14</td>
<td>5</td>
<td>4</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>1</td>
<td>14</td>
<td>5</td>
<td>1</td>
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<tr>
<td>24-30</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-36</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;36</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total on list</strong></td>
<td><strong>1085</strong></td>
<td><strong>14</strong></td>
<td><strong>5</strong></td>
<td><strong>317</strong></td>
<td><strong>8</strong></td>
<td><strong>29</strong></td>
<td><strong>2045</strong></td>
<td><strong>2045</strong></td>
</tr>
</tbody>
</table>

Backlogs that exceed the predefined time frames appear in pink font.
Not all correctional healthcare providers are the same.

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The Clinician’s Responsibility in Promoting Staff-Engaged Infection Control Programs

by Brenna Ferguson, MBA, BSN

As clinicians working in correctional health care, we are acutely aware of both behavioral and environmental risk factors that make inmates more susceptible to developing infectious diseases. Each year, millions of individuals enter the penal system with either a known infectious disease or they acquire an infectious disease through direct transmission.

Infectious diseases can cost lives. According to the Centers for Disease Control and Prevention, correctional mortality statistics for 2010-2011 show 18,514 deaths from hepatitis, 13,834 deaths from AIDS and 536 deaths from tuberculosis. The CDC also reported 47,989 active HIV cases, 9,884 active TB cases and 5,517 newly diagnosed hepatitis ABC cases in U.S. prisons in 2010-2011. On a national level in the community, the CDC reported that 722,000 cases of health-care-associated transmission of infectious disease, leading to 75,000 deaths.

As health care providers, we have formal training on disease prevention and modes of transmission. Unfortunately, there has not been sufficient expectations or emphasis placed on the training and development needs of nonmedical staff members who have frequent, if not daily, contact with inmates. These team members—officers, dietary staff, ward clerks, housekeeping personnel and others—are just as important in the prevention of infectious disease.

Without proper measures in place, untrained nonclinicians can inadvertently infect inmates, staff members, themselves and members of the community at large. Clinicians are in a unique position to share information that can ultimately save lives. To promote a culture of safety, all staff members must have a unified standard of practice and knowledge of infectious disease fundamentals. This objective is best served through developing, promoting and sustaining an effective infection control program.

Job-Specific Essentials

To maximize the effectiveness and relevance of an infection control program, evidence-based infection control practice standards from the CDC and Occupational Safety and Health Administration must be incorporated into job-specific learning objectives. The CDC recommends that all individuals working in health care environments who come into contact with inmates with known or potential infections are educated on basic infection control principles and practices. Nonhealth care professionals should have a basic understanding of disease transmission and precautionary measures to mitigate the spread of infection. All employees should have access to personal protective equipment and a clear understanding of when and how to use PPE to protect themselves and others against the spread of disease.

The CDC recommends that the following key principles be incorporated into the infectious disease prevention programs in correctional settings.

• Standard precautions: These precautionary measures should be taken when in contact with a known or potential infection (e.g., HIV, hepatitis B, hepatitis C).
• Hand hygiene: Evidenced-based initiatives have proven that hand hygiene, either through hand washing with soap and water for 15 to 30 seconds or using alcohol-based gels, is one of the most effective measures in preventing the spread of microorganisms. The World Health Organization recommends that individuals working in health care environments wash their hands:
  – Before touching a patient
  – Before clean/aseptic procedures
  – After body fluid exposures/risk
  – After touching a patient
  – After touching a patient’s surroundings
• Personal protective equipment: PPE includes gloves and gowns, which provide a protective barrier against blood, body fluids, vomit, feces and contaminated equipment, as well as face masks, which protect against respiratory secretions and aerosols containing blood or body secretions.
• Needles and sharps disposal: Inmates commonly share needles for intravenous drug use and tattoos. Sharps disposal containers should be readily accessible to nonhealth care personnel to discard contaminated used needles. The initial training of nonhealth care personnel should emphasize that injection needles must never be recapped due to high likelihood of puncturing oneself.
• Cleaning and disinfectants: Housekeeping personnel should receive education and orientation on how to dispose of infectious waste and handle soiled linen, as well as the proper use of disinfectants and sanitizing agents approved by the Environmental Protection Agency for use to prevent the spread of VRE, MRSA and Clostridium difficile. Housekeeping policy should mandate glove use by all housekeeping personnel and specify that all exam beds, door handles, light switches, windows, medical equipment, toilets, sinks, walls, floors and inmate transport vehicles be cleaned using proper approved techniques.
• Food preparation and storage: All dietary staff should be knowledgeable of proper cleaning, preparation and storage of food. Refrigerator temperature should be checked daily and maintained at 40 F. Dietary personnel should keep daily logs to assure that proper temperature is maintained as well as mandatory scheduled cleaning of refrigerator. Persons preparing meals should not have open sores, diarrhea or vomiting. All food and liquids should be checked for expiration dates; policy should state that expired items are to be discarded.

Transmission Precautions

Infection control measures differ according to the infectious agent of concern.
• Contact precautions: (MRSA, VRE and C. difficile): Patients with known or suspected infections should be housed in a private room or with another inmate who has the same active infection. The CDC recommends that when individuals enter the room or come in direct contact with the patient, they wear nonsterile gloves and gowns and immediately wash their hands with soap and water upon entering and exiting the room. Disposable stethoscopes and medical equipment should be available and reserved for single use only. Important: Medical equipment used for inmates who are in contact precautions must be cleaned and disinfected prior to using on other inmates.

• Droplet precautions: (Neisseria meningitidis, Bordetella pertussis, influenza, adenovirus, Haemophilus influenzae type b, Mycoplasma pneumoniae, rubella). All people who come in contact with the inmate should wear a face mask to protect against droplet-borne pathogens.

• Airborne precautions: Inmates with suspected or confirmed TB, measles, varicella, smallpox or SARS should be placed in airborne isolation in negative pressure rooms. Doors must remain closed, and all individuals entering the room must wear a respirator with a tight seal over the nose and mouth. If transporting inmates, they should wear a surgical mask that covers the mouth and nose.

Ongoing Training
Prevention of infectious disease is everyone’s responsibility. All employees should be trained during their initial orientation and receive ongoing education and observation to maintain compliance. This can be accomplished through infectious disease preparedness drills and developing job-specific quality teams designed to be peer mentors who monitor their own job-specific department infection rates. Peer mentors can provide ongoing direct communication to staff members regarding infection rates and staff members’ compliance. Such communication is critical to the ongoing continuous quality improvement that needs to be embedded within the organizational culture. Staff development regarding infectious disease needs to incorporate educational opportunities that are engaging and applicable to staff members’ daily job responsibilities. Creative methods to facilitate the educational process include self-directed Web-based applications and group learning such as role playing and simulations.

Clinicians Empowering Others
As health care leaders, it is our responsibility to design policy and procedures that promote effective infection control programs. As clinicians, we are in a position to empower and save lives through education. Leadership that proactively addresses the design of clinical areas facilitates the application of principles that promote infectious disease prevention—for example, accessible hand-washing stations and visual cues such as posters that reinforce proper standards, including appropriate personal protective equipment. The program must also provide resources, equipment, health screenings and health promotion. Activities such as employee and inmate vaccinations, screenings and timely detection of infection can reduce transmission.

Communicating and creating an awareness of ongoing challenges as well as successes is essential to an effective infection control program. Various communication channels that can be used include shift reports, staff meetings, employee newsletter, fliers and emails.

Ultimately, promoting a culture of safety is a multifaceted process that involves engagement, commitment and compliance at all levels of an organization.

Brenna Ferguson, MBA, BSN, is a patient care facilitator for UTMB-TDCJ Nursing Administration, Galveston, TX. Contact her at bgfergus@utmb.edu.
Patient Safety: More Than Risk Management or Quality Improvement

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the first in a series discussing the basics of patient safety. Subsequent articles will present a patient safety model for correctional practice, the principles of patient safety and causes of clinical errors.

A 50-year-old man, serving time for drunk driving, collapses in his jail cell and is pronounced dead of a pulmonary embolism after emergency transport to the nearby hospital. A lawsuit is settled by mediation and two staff members are disciplined for negligent behavior after an internal investigation.

Keeping patients safe is fundamental to our roles as correctional health care professionals. Most of us entered health care to help those who are ill, injured or suffering, yet our patient care systems can get in the way, leading to patient harm instead of the quality care we intend. Thus, patient safety is a growing field within traditional health care and an increasing emphasis in the correctional setting.

In the NCCHC 2014 Standards for Health Services, standard B-02 Patient Safety establishes the need to “proactively implement patient safety systems to prevent adverse and near miss clinical events.” Yet, most clinical sites already have quality improvement systems and risk management processes in place. How would a situation like the case above be handled differently from a patient safety perspective?

While risk management programs focus on reducing legal liability and quality improvement programs respond to clinical quality issues, patient safety systems seek to reduce clinical error. This is, then, a patient-centered approach to fulfill our professional ethical obligation to do no (or at least less) harm in the delivery of necessary health care. A comparison of the concepts of risk management, quality improvement and patient safety can clarify differences and support the proposition that a patient safety framework for organizing care delivery is superior.

Risk Management

The purpose of risk management is to reduce the chance for organizational loss. In the case above, organizational risk managers would view the care concerns from a perspective of reducing financial loss to the organization during litigation or poor press coverage. Although risk managers seek to prevent and reduce loss in other areas such as property, financial risk, employees and medical staff privileges, a prime focus is prevention of loss related to legal claims against the clinical program. Thus, a risk management program includes claims management, contract and policy review, and regulatory and accreditation compliance functions. Risk management, then, is a financial function. By its nature, risk management primarily focuses on reducing financial loss. Reducing clinical error is a welcome by-product of risk management activities but not the primary motivation.

Quality Improvement

The focus of quality improvement is to improve processes and outcomes of patient care. Quality improvement actions are often taken when a catastrophic clinical situation such as the case above occurs. The health care unit manager could perform a chart review to determine whether all policies and procedures were followed for this patient during his stay at the facility. Quality improvement activities seek to improve the efficiency and effectiveness of patient care and are often a part of a clinical administrator’s role. Quality improvement is, then, primarily a management function. Benchmarking and best practices are used to determine goals for improvement activities. As with risk management, a secondary benefit of quality improvement activities can be the reduction of clinical error.

Patient Safety

The primary focus of patient safety is preventing patient harm. Rather than a financial focus, as with risk management, or a management focus, as with quality improvement, a patient safety framework is patient-centered and seeks to reduce clinical error. Systems thinking, clinical process change and standardization to build in reliability of clinical processes lead to improved patient outcomes and decreased patient harm. From a patient safety perspective, clinicians would use an extreme situation like the case above to evaluate the clinical systems and processes to determine gaps that led to the diagnostic and treatment decisions. This model turns the current system upside down, making increased process effectiveness and decreased financial risk secondary benefits.

Patient safety can be a lens through which all correctional health care clinical processes are viewed and evaluated. A patient safety framework is patient-centered and focuses on reducing patient harm. This focus also reduces risk of litigation and improves care quality, enhancing both of these traditional functions.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation services to jails and prisons on projects to improve professional practice and patient safety. She also is the 2013 recipient of NCCHC’s B. Jaye Anno Award of Excellence in Communication. Her latest book, the Correctional Health Care Patient Safety Handbook, is available in print and Kindle versions from amazon.com.
Maximize Your Potential

Today it’s more important than ever to use your skills and resources most effectively. Here are some great reasons why you should attend Spring 2015.

- Discover the latest tools and techniques for making health services delivery more cost-effective
- Learn how other organizations have implemented successful programs for improving clinical efficiency
- Develop strategies for meeting national standards
- Network with colleagues, from top decision makers to in-the-trench staff, to learn how they are handling the programs that you face every day
- Explore problem-solving products in the exhibit hall
- View cutting-edge research with the poster presentations

Session Sampler

Here is a sample of the 55-plus presentations:

- Abdominal Pain: Causes and Clinical Significance
- Collaborating Between Corrections and Communities: A Public Health Concern
- Diabetes Primer for the Correctional Nurse
- Exploring Palliative Care in Corrections: Implications of a Scoping Review
- Important Techniques in Communicating With Legal Counsel
- Predicting Future Behavior: Performing More Accurate Risk Assessments
- Treating the Adolescent Male Psychopath
- Tuberculosis: Preventing the Next Outbreak
- Understanding Gender Dysphoria in a Correctional Setting

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Topical, informative seminars will help you stay up to date on critical issues facing the field. Maximize your education while you learn about NCCHC standards and other vital subjects.

Full-Day Seminars (Saturday, 9 a.m. to 5 p.m.)
- An In-Depth Look at NCCHC’s 2014 Standards for Health Services in Jails
- An In-Depth Look at NCCHC’s 2014 Standards for Health Services in Prisons
- An In-Depth Look at NCCHC’s 2015 Standards for Mental Health Services

Half-Day Seminars (Sunday, 9 a.m. to 12:30 pm and 1:30 p.m. to 5 p.m.)
- The Affordable Care Act and How It Will Affect Correctional Health Care
- Principles for a Viable Suicide Prevention Program
- Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care
- Nurses’ Scope of Practice and Delegation Authority

Conference Site

All conference activities will take place at the Hyatt Regency New Orleans, 601 Loyola Ave., New Orleans, LA 70113. Reserve a room at the Hyatt by March 20 to ensure availability and lock in the special NCCHC conference rate of $189 single/double + tax. Make your reservation online at www.ncchc.org/spring-conference or call 888-421-1442. Be sure to mention NCCHC to receive the discounted rate.

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- Nurses
- Physicians
- Psychologists
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The maximum hours that may be earned includes attendance at preconference seminars. See the conference website or final program for details.

Register Early, Save Money!

Early-bird registration is $345 for up to 12.75 hours of stellar continuing education designed specifically for correctional health professionals. That’s only $27 per credit hour, and the irreplaceable face-to-face networking is FREE! Add preconference sessions to your registration and take home 26.75 continuing education hours. Register by March 6 and take $50 off the regular rate. You also will be entered into a drawing to receive a two-night hotel stay at the Hyatt Regency New Orleans. After April 3, registration must be done on-site (a $25 fee will apply). For more details about the conference or to register, visit www.ncchc.org/spring-conference.
Evidence-Based Research Points to Cost-Effective Model for Juvenile Detention

by David W. Roush, PhD

Think Before You Act is a publication by researchers at the University of Chicago’s Crime Lab that details an evidence-based public policy proposal for a better way to achieve violence reduction for adolescent African-American males. Part of the paper describes positive life outcomes for youth of color involved in the juvenile justice system. These findings are from the U.S. District Court reform of unconstitutional conditions of confinement that existed at the Cook County Juvenile Temporary Detention Center. In August 2007, the American Civil Liberties Union convinced the court to intervene and to appoint Earl Dunlap as the transitional administrator with the necessary administrative and operational authority. Dunlap, who was the 2012 recipient of NCCHC’s Bernard P. Harrison Award of Merit, invited the Crime Lab to assist in the evaluation of this court-ordered reform.

The Crime Lab evaluation revealed powerful statistically significant improvements in life outcomes for those detainees who had been randomly assigned to Dunlap’s reformed living units. The data suggest that even the most challenging youth of color from the streets of Chicago experienced positive life outcomes through a brief intervention based on helpful detention. In the history of juvenile detention, this is the first evidence-based research comparing the effects of helpful detention in running a juvenile detention facility. Current national juvenile detention reforms, of which the Cook County Juvenile Probation Department is a model site, have consistently stressed the importance of data-driven and evidence-based decision making. However, juvenile detention professionals have had to extrapolate findings from related fields regarding how to improve conditions of confinement because of the absence of evidence-based research in juvenile detention. Now, the commitment to evidence-based research creates an imperative for us to act on the Crime Lab research findings.

Public Policy Implications

The public policy implications are equally impressive. The Crime Lab’s behavioral economists first used a cost–benefit analysis of the reforms, calculating a 1-to-30 cost–benefit ratio, or a $30 savings for every $1 of Cook County taxpayer investment in the new system. This cost–benefit ratio is four to five times better than other exemplary delinquency prevention programs identified by the Washington State studies on cost-effective interventions.

The all-too-frequent problems of dangerous conditions of confinement make a national policy shift that replicates the Cook County reforms appear to be a prudent use of public funds. More importantly, the power of the research provides the motivation to rethink, perhaps transform, the way we deliver programs and services to detained youth of color, especially African-American males. Recent detention reforms have successfully removed from secure detention those youth with the best chances to succeed in community-based alternatives. Still detained, however, is an increasingly disproportionate minority population with a noticeably greater prevalence of serious needs. New approaches, such as the PYD/CBT reforms, are needed to increase positive outcomes with these youth.

Conditions of Confinement

Changing the environmental context proved to be an effective strategy for improving conditions of confinement, and this approach should be used in other facilities. Juvenile
Reducing the Number of Mentally Ill People in Jails

The National Association of Counties has partnered with the Council of State Governments Justice Center to reduce the number of people with mental disorders in jails. The effort involves a bipartisan commitment in the 114th Congress. The national initiative emphasizes state-—local collaboration and targeted action on the ground. It aims to improve access to effective mental health and substance abuse treatment, strengthen criminal justice collaborations with behavioral health stakeholders and advance public safety goals. A “call to action” for county leaders will be launched in spring 2015.


Correctional Population Decline Continues, but Slows

An estimated 6,899,000 persons were under the supervision of adult correctional systems at year-end 2013, a decline of about 41,500 from year-end 2012, according to a Bureau of Justice Statistics report released in December. The decline during 2013 (0.6%) was less than 1% for the second consecutive year, down from 2.1% in 2010, when the fastest annual decline in the population was observed. All of the decline in the correctional population during 2013 resulted from decreases in the probation (down 32,100) and local jail (down 13,300) populations.

- www.bjs.gov/content/pub/pdf/cpus13.pdf

Juvenile (continued from page 18)

detention reforms have not enjoyed the same successes regarding how to improve problematic conditions of confinement, so here is where the Cook County reforms can be hugely instructive to the field.

Dunlap’s plan assumed that helpful detention could foster and sustain a positive environmental context or healthier conditions of confinement for youth with increasingly serious needs. The value of helpful detention in the improvement of conditions of confinement has been affirmed empirically.

Exemplary Evidence-Based Model

The U.S. District Court’s intervention improved the health, safety, well-being and positive life outcomes of many of Chicago’s most difficult juvenile offenders. As of today, we have (a) a new cost-effective model of improving conditions of confinement that can be disseminated and replicated nationally and (b) confidence in this model based on the first evidence-based research in juvenile detention.

Next Steps

There are logical next steps that need to be accomplished. More inquiry, investigation and research will be needed to explain fully the policy and practice implications of the Crime Lab research. But, for the time being, this research has justified a substantial rethinking of current strategies about how to improve conditions of confinement, invited an expansion of helpful programs for juvenile offenders of color and certified the positive outcomes of the U.S. District Court’s intervention at the Cook County Juvenile Temporary Detention Center.

David W. Roush, PhD, is the director of Juvenile Justice Associates, LLC, Albion, MI, a consulting firm that specializes in program and staff development and improved conditions of confinement. He is a longtime member of NCCHC’s board of directors, serving as liaison of the National Partnership for Juvenile Services, and NCCHC’s juvenile health committee.

Review Course Gives CCHP Candidates a Leg Up Before the Exam

Ninety-three CCHP candidates were the first to take part in a certification exam prep/review course that premiered at the 2014 National Conference on Correctional Health Care in Las Vegas. The 90-minute course was developed and delivered by Susan Laffan, RN, CCHP-RN, CCHP-A, principal of Specialized Medical Consultants and a member of the CCHP board of trustees. The course was designed to help participants better understand the content of the examination for basic CCHP certification, apply the knowledge and concepts they had learned while studying and improve their test-taking skills. Key points of the presentation are summarized here.

**Exam Content**

The proctored, written examination has 80 to 100 multiple-choice, objective questions. Candidates are allowed two hours to complete the exam and must answer 65% of the questions correctly to pass.

The exam tests knowledge, understanding and application of national standards. Items are based on NCCHC’s Standards for Health Services for jail and prison settings (candidates need study only one of these books), Standards for Health Services in Juvenile Detention and Confinement Facilities and Correctional Health Care: Guidelines for the Management of an Adequate Delivery System. The content outline covers eight general areas that parallel the major sections of the Standards. See the Candidate Handbook for specific topics within each area.

- Governance and administration (15% - 20%)
- Safety (5% - 10%)
- Personnel and training (8% - 14%)
- Health care services and support (8% - 14%)
- Inmate care and treatment (15% - 20%)
- Special needs and services (12% - 18%)
- Health records (5% - 10%)
- Medical-legal issues (8% - 14%)

Each question has only one best answer. Questions focus on ideal, not real, situations and are looking for conformity with standards rather than outside-of-the-box thinking. The review course presented several types of practice questions, including one each that tested for knowledge on a definition, an acronym, a compliance indicator, a work scenario, a statistical/numerical requirement and a description.

**Exam Performance**

Strong performance on the CCHP exam depends mostly on one’s knowledge base (60% - 70%), followed by test-taking skills (25% - 30%) and personal considerations (10% - 15%). To build knowledge, create a study plan based on the time until the exam date and then focus on weak areas. Learn principles and patterns for application. In other words, study to decide, not to tell. Concentrate on quality, not quantity, and focus on the most important facts.

Spaced repetition is key to learning. We all learn differently, but it helps to use those tips and tricks that we learned in school, such as flash cards and crib sheets. Form study groups and engage in group discussions. Practice recall during repetitive tasks. Use memory aids such as acronyms and rhymes. Take practice tests and focus on application.

**Test-Taking Skills**

Become an expert at multiple-choice questions. Read the entire question carefully and recognize its purpose. Identify the key word(s) and components of the question: the stem, the “distracter” responses and the key, or correct, response. Base your answers on national trends, national standards of care and the assumption you are the responsible health authority. Do not base your answers on local practice.

If you are confused or don’t know the answer, move on and come back to that question later. Finally, try to keep your nerves under control.

**CCHP Exam Dates**

<table>
<thead>
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<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 21</td>
<td>Regional sites</td>
</tr>
<tr>
<td>March 26</td>
<td>Hood River, OR</td>
</tr>
<tr>
<td>April 12</td>
<td>New Orleans, LA</td>
</tr>
<tr>
<td>June 6</td>
<td>Regional sites</td>
</tr>
<tr>
<td>July 11</td>
<td>Long Beach, CA</td>
</tr>
<tr>
<td>October 1</td>
<td>North Bend, OR</td>
</tr>
</tbody>
</table>

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.

**Welcome to New Trustees!**

- Juan R. Nunez, MD, CCHP, is the newest elected member of the board. He is the Florida regional medical director for Armor Correctional Health Services, Inc.
- Sharen Barboza, PhD, CCHP-MH, is a public appointee. She is vice president of clinical operations – mental health, for MHM Correctional Services, Inc.

In addition, NCCHC board member Pauline Marcussen, RHIA, CCHP, is serving her second term as an appointed trustee; she also is vice chair. She is project manager for the Rhode Island Department of Corrections.
SCP’s Armand Start Award Recipient
Joe Goldenson, MD, FSCP, the medical director for jail health services for the San Francisco Department of Public Health, was awarded the prestigious Armand Start Award for Excellence from the Society of Correctional Physicians. A long-time member of SCP, Goldenson was honored for the wisdom, ethics and knowledge he has brought to the field of correctional medicine. “He is a leader, activist, correctional health care expert witness, court-appointed monitor, scholar and teacher,” according to an SCP release. Goldenson also serves on NCCHC’s board of directors as liaison of the American Public Health Association. The award was presented at SCP’s annual conference in October.

Jan Lindsey, 1943-2014
Long-time NCCHC accreditation surveyor Jan Lindsey, MSN, RN, CCHP, passed away Oct. 23 at the age of 71. Lindsey, who lived in New Port Richey, FL, was a retired nurse from both San Mateo County and Santa Clara County and a nurse educator specializing in correctional nursing. She served as a surveyor for 20 years. She also was among the first group of Certified Correctional Health Professionals when the CCHP program was launched in 1991 and she maintained her certification until her death.

American Pharmacists Association
APhA has announced a partnership with MediMergent to develop and implement a national medication safety training program for pharmacists and their staff. The program will support the National Medication Safety Outcomes and Adherence Program established by MediMergent (a data collection, integration and analytics company) under a research collaboration agreement with the Center for Drug Evaluation Research at the U.S. Food and Drug Administration. NMSOAP is a partnership that aims to enhance medication safety through the direct pharmacy collection of data related to newly approved and marketed drugs, according to APhA.
• www.pharmacist.com/news

American Public Health Association
APHA Press has released the 20th edition of its Control of Communicable Diseases Manual, a leading global reference for identifying and controlling infectious disease. All 138 chapters have been updated with the latest information about the occurrence, transmission, resistance and control of infectious diseases, including SARS, MERS and other coronavirus infections, as well as West Nile virus and others. A preview chapter on Ebola is available for free download. The book is available for purchase at the online APHA store.
• http://secure.apha.org/imis/ItemDetail?iProductCode=978-087553-0185&CATEGORY=BK

Field Notes

This exciting multitrack event covers both the essential and advanced topics necessary to successfully lead a correctional health care program.

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www.NCCHC.org/leadership-institutes
Who Attended in 2014?
Nurse/nurse practitioner 48%
Physician/physician assistant 17%
Administrator 13%
Psychiatrist/psychologist 7%
Social worker, therapist, counselor 6%

Decision Makers With Authority
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Health services administrator 13%
Department manager/supervisor 6%
Health services, dental or mental health staff 40%

Who Do Attendees Represent?
Jail facility 44%
Prison facility 14%
Private corporation 9%
State DOC/agency 13%
Juvenile detention or confinement facility 6%
Federal agency 4%

Categories Attendees Recommend or Buy
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Looking for a job? 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.

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Qualified applicants must have a MD degree, be ABIM board certified/eligible, and eligible for licensure in South Carolina. Salary commensurate with experience. Interested applicants should submit a letter of interest and CV to: Shawn Chillag, MD, Professor and Chair, USC Dept. of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203 or email at shawn.chillag@uscmed.sc.edu. The University of South Carolina is an AA/EOE employer.

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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.

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www.ncchc.org Winter 2015 • CorrectCare 23
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Defining ‘Current’ ‘Opiate’ Use

Q In the 2014 editions of the Standards for Health Services, compliance indicator #4 of E-02 Receiving Screening says that “If a woman reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to fetus.” How is “current” defined? And how is “opiate” defined? Is it used as a broad term to include opioids or is it specific to natural opiates only?

A NCCHC does not have an official definition of “current,” but the intent is that if the woman has been using opioids recently, then the pregnancy test should be done. Your physician should help you define a time line. Regarding the definition of “opiate,” the glossary of the 2014 Standards defines it as follows: “any preparation or derivative of opium, as well as opioid, a synthetic narcotic that resembles an opiate in action but is not derived from opium.”

Determining Genital Status per PREA

Q Our administrators are having trouble deciding how to approach PREA Standard 115.15 Limits to Cross-Gender Viewing and Searches, in particular part (e), which addresses trying to determine an inmate’s genital status. The PREA standard states that it can be accomplished by conversing with the inmate, by reviewing medical records or as part of a broader medical examination. Our medical staff are stating that they are not to be involved in the process of determining genital status. Does NCCHC limit them in this way?

A Concerning PREA, in NCCHC’s 2014 Standards for Health Services, standard B-04 Federal Sexual Abuse Regulations only requires written policy and defined procedures for how the facility will comply with this federal law. The situation you describe extends to other areas of the standards, particularly involving a patient’s right to privacy and confidentiality of health records. Medical practitioners may learn of an inmate’s genital status through routine medical examinations for medical purposes, such as during the initial health assessment. Health staff should not do an exam for the sole purpose of determining genital status.

NCCHC standard A-09 Privacy of Care requires that discussions among staff regarding patient care occur in private, without being overheard by inmates and nonhealth staff, and that clinical encounters occur in private, without being observed or overheard. Standard H-02 Confidentiality of Health Records requires that health records are stored and maintained under secure conditions separate from correctional records, and that health staff receive instruction in maintaining patient confidentiality.

However, local, state or federal laws may allow certain exceptions to the obligations of health care professionals to maintain confidentiality. The responsible health authority should maintain a current file on the rules and regulations covering confidentiality and a list of the types of information that may or may not be shared. Health staff should inform inmates at the beginning of the health care encounter when these circumstances apply. Otherwise, releasing confidential medical information to nonhealth staff would require the written consent of the patient.

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

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s Spring Conference on Correctional Health Care, being held April 11-14 in New Orleans.
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