

# CorrectCare<sup>®</sup>

The magazine of the National Commission on Correctional Health Care



Minimize  
**COMPASSION FATIGUE,**  
Avoid **BURNOUT** and  
Reignite your **PASSION**

*Effective Management  
of the Prison Dental  
Program (Part 2)*

*Sovereign Citizens in  
Correctional Settings*

*A Patient Safety Model  
for Correctional Practice*

National Commission on Correctional Health Care  
1145 W. Diversey Parkway, Chicago, IL 60614



National Commission  
on Correctional Health Care

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## Training From NCCHC in High Demand

The National Commission is well known for its top-notch educational programs, starting with our flagship National Conference on Correctional Health Care and progressing through our most recent offering, leadership training for medical professionals and health administrators. (For the full array of NCCHC educational events, see [www.ncchc.org/education-conferences](http://www.ncchc.org/education-conferences).)

But did you know that correctional agencies across the country also turn to NCCHC for specialized training? These activities are tailored to the individual needs of the agency and can help with everything from compliance with national standards to updates on the latest developments in correctional health care.

### National Standards and Best Practices

Recently, the Florida Sheriffs Association enlisted NCCHC to conduct four trainings across the state. The purpose was to help the participants gain a better understanding and appreciation of best practices in clinical care and health services administrative operations. Each training had dozen of participants, including sheriffs, jail administrators, medical personnel and staff who are responsible for inmate health care.

At these daylong trainings, NCCHC representatives explained the legal context for NCCHC's standards for health services and its accreditation program, and discussed the importance of adhering to these nationally recognized standards in order to meet constitutional requirements for health services quality.

"Our jail has been accredited by NCCHC for more than 10 years. Without a doubt, this accreditation has been essential in defending the constitutionality of health care services," said participant Tara Wildes, who has worked for the

Jacksonville (FL) Sheriff's Office for more than 30 years and serves as director of the city's department of corrections.

### Implementing Mental Health Systems in Jails

Another training took place at a recent meeting of the Western States Sheriffs' Association, which sought NCCHC for its expertise in mental health care. NCCHC delivered a three-hour talk that drew from the curriculum on Planning and Implementing Effective Mental Health Services in Jails developed by NCCHC for the National Institute of Corrections. Nearly 100 sheriffs and other senior officials attended the training.

The session provided instruction on how to gauge the impact of the mentally ill on participants' facilities, as well as the impact of the facility on the mentally ill. It prepared participants to analyze administrative and legal requirements for planning and implementing mental health services and how they apply to their own jails. It also identified mental health treatment practices, components and the credentials necessary to provide effective services. Importantly, participants learned how custody and health care staff can improve their capacity to treat inmates with mental illness by using both in-house and community resources. Ultimately, participants improved their understanding of how to design a system of jail operations and mental health services that facilitate improved safety and better interactions between staff and inmates with mental illness.

### How May We Help?

If you are interested in having NCCHC develop training for your institution or agency, please contact us by email at [technicalassistance@ncchcresources.org](mailto:technicalassistance@ncchcresources.org) or call 773-880-1460.

## Calendar of events

<b>June 6</b>	CCHP exam, regional sites
<b>June 26</b>	Accreditation Committee Meeting
<b>July 10-11</b>	Correctional Health Care Leadership Institutes, Long Beach, CA
<b>July 11</b>	CCHP exam, Long Beach, CA
<b>July 12-13</b>	Correctional Mental Health Care Conference, Long Beach, CA
<b>August 28</b>	Accreditation Committee Meeting
<b>October 18</b>	CCHP exam, Dallas
<b>October 18</b>	Accreditation Committee Meeting

For the complete list of CCHP exams, including regional exam sites, see [www.ncchc.org/cchp](http://www.ncchc.org/cchp).

## New Mental Health Standards

The 2015 *Standards for Mental Health Services in Correctional Facilities* are hot off the presses. As with the first edition, the manual aligns with the jail and prison *Standards*, but makes more explicit the requirements for constitutionally acceptable delivery of mental health services. Ultimately, the mental health standards are a valuable tool to help correctional facilities determine proper levels of care, organize systems more effectively and efficiently, and demonstrate that constitutional requirements are being met. They also are the foundation of NCCHC's mental health services accreditation program. Purchase the standards at [www.ncchc.org](http://www.ncchc.org).

## NCCHC Position Statements

In October, the NCCHC board of trustees adopted five position statements, two of them new and three of them updated. The new statements are Optimizing Health Insurance for Incarcerated Persons and STD Testing for Adolescents and Adults Upon Admission. The revised statements are Administrative Management of HIV in Correctional Institutions, Health Care Funding for Incarcerated Youth and Women's Health Care in Correctional Settings. Find all of the statements in the Standards and Guidelines section at [www.ncchc.org](http://www.ncchc.org).

## What We Do Makes a Difference

by Patricia N. Reams, MD, MPH, CCHP

**A**n inmate who was the mother of five children expressed gratitude that the prison nurse had taken the time to teach her about aspects of child-rearing. She hoped that she would soon be released to care for her children and that she would do a better job in the future. A young man with diabetes was surprised that his blood sugars were so well controlled with consistent insulin use. He felt better and resolved to improve his self-care upon release. A middle-aged man was thankful that his hypertension had been diagnosed and treated. Chronic leg ulcers that had been present for years were starting to heal on an elderly patient who had no previous access to health care.



These are some of the stories I have collected from inmate interviews while conducting accreditation surveys for the National Commission on Correctional Health Care. Those of you who work with inmates have your own stories. In a recent issue of the *Journal of Correctional Health Care*, a study documented the perceived improvement in the health of soon-to-be-released prisoners. Almost all of the prisoners who had perceived poor health on intake felt that their health had improved in prison. The authors speculate that this perception will help motivate the newly released inmates to be receptive to the message about health maintenance in the future. If they had not perceived an improvement in health with routine medications and lifestyle changes, they would not be likely to maintain their health after release.

### Unique Opportunities and Challenges

This is why we do what we do. Most correctional health care workers whom I meet love their jobs. Corrections facilities are places where their expertise is needed and respected. They allow for independent thinking and application of skills. They provide a unique opportunity to change peoples' lives.

On the other hand, corrections facilities can be challenging places to work. Conflict can arise between correctional and health care staff over the inmates' access to care, autonomy in making medical judgments and budgets for staffing and equipment. Movement through locked doors and other security measures can be frustrating. Many inmates have difficult personalities. They have no choice in their selection of providers, yet providers are required to treat them. Friends and family may not understand the allure of working in a corrections facility.

The National Commission on Correctional Health Care exists to help overcome these challenges and promote the

professionalism of health care in corrections facilities. The standards spell out the means to resolve the inherent areas of conflict. Each revision of the *Standards for Health Services* gradually elevates the minimum requirements in order to enhance continuous improvements. Accreditation gives institutional and personal feedback. Educational programs provide networking and inspiration to busy professionals.

People who work in correctional facilities deserve commendation, especially when they convey an enthusiasm for what they do. We display with pride our Certified Correctional Health Professional credentials. This pride and enthusiasm must be conveyed to others to bring more excellent professionals into the field. In the meantime, we know that what we do makes a difference.

*Patricia N. Reams, MD, MPH, CCHP, is chair of the NCCHC board of directors and serves on the board as the liaison of the American Academy of Pediatrics. She also is a pediatrician at Cumberland Hospital, New Kent, VA.*

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## The Acid Bath of Cynicism

by Robert B. Greifinger, MD

There are a few ancient precepts that physicians learn in their medical education, in one form or another. At the start is “primum non nocere,” which is Latin for “first, do no harm.” This is a caution against actions that risk greater harm than good, called nonmaleficence in health care ethics. I am not waxing philosophical without purpose here. My aim is to remind correctional administrators and health care staff to think about minimizing the risk that they will cause harm, through their action or inaction, before they even begin to think about their complementary objective to do good (beneficence).



I write about this elemental precept of risk reduction in the context of my work, work that has been dedicated for 25 years to reducing harm and promoting health in incarcerated populations. One piece of this work has been addressing litigation on medical care, initially as a defendant (in my position as deputy commissioner/chief medical officer for the New York State Department of Correctional Services) and later as a consultant, federal court monitor and expert witness.

I recently reviewed for common themes the more than 60 cases in which I have testified, mostly as a plaintiff expert, and class action cases where I have monitored on behalf of judges. I tried to identify the actions and inactions that led to preventable harm. I found a series of common themes, mostly system deficiencies unrelated to insufficient resources. But there was one pervasive theme that appeared repeatedly in the great majority of cases and was linked to the most serious harm, those of death or serious disability.

### Cynicism

That predominant theme was cynicism, in the form of inappropriate distrust of prisoner patients. I am not talking about the appropriate caution or skepticism that all professionals should have in their minds when confronted with a clinical puzzle. I am talking about stereotyping attitudes (e.g., “They all lie.”), minimizing symptoms (e.g., “She is just drug-seeking.”), assigning motives with no basis (e.g., “He just wants to get out of the jail.”) and generally negative approaches to patients solely because they are prisoners (e.g., “What does he want, a Cadillac? My mother can’t get a doctor’s appointment for weeks, and she isn’t an offender.”).

These negative thoughts lead to one or more very high-risk inactions that in turn lead to harm: delay in timely access to an appropriate level of care, practice beyond the scope of a nursing license, failure to follow policies and clinical guidelines or failure to document and/or communicate

leading to lapses in continuity and coordination of care. As a consequence, people suffer and die. As examples, I have seen cynicism result in needless deaths from suicide, alcohol withdrawal, bowel perforation and asthma.

Then there is the litigation, leading to anger, defensiveness, blaming the victim, finger pointing, shame (for those less cynical) and cost. The cynicism in these cases was corrosive, for the patient, staff and families. While litigation, indeed, has promoted constructive changes in correctional health care, a better driving force is necessary for the next evolutionary steps.

In my professional field, I get to see some of the correctional facilities that are not working well. Cynicism is often the predominant attitude, especially among nurses, but there is more. These poorly performing prisons often have no mission or a mission that is not understood by the leadership and staff. These facilities lack enlightened leadership; there is a lack of accountability for health services; sometimes (but not always) underfunding or understaffing; practice outside the scope of professional licenses; barriers to timely access to care; poor continuity and coordination of care; and ignorance of evidence-based clinical guidelines for patient safety.

### Solutions

What, then, are the solutions to these challenges? The first is leadership. Health care staff in correctional facilities used to be considered “guests of custody.” This is no longer true, a lesson that was learned in the early 1990s when the spread of drug-resistant tuberculosis, especially among HIV-infected prisoners, demonstrated the nexus of public health with health behind bars. Health care staff members are part and parcel of the facility team. Or they should be. Correctional administrators and correctional health care staff have a common interest in promoting the institutional objectives of safety and security. To minimize the risk of harm is to promote safety in the institution.

Working collaboratively, correctional and health care staff need to emphasize their professional duty to treat prisoners with medical problems as patients, in a manner consistent with professional codes of conduct and ethics. Staff need to be trained and supervised to assure that they are familiar not only with the ethics of correctional health care, but also with the tools to address common problems among prisoners and appropriately seek care for those problems that are not so common.

Without leadership, I am pessimistic about the ability to reduce risk of harm and risk of litigation regarding that harm. Leadership is the primary challenge, in large part because of the differences in institutional culture between correctional facilities and health care facilities. The command-control culture of a prison has worked well in

*Without leadership, I am pessimistic about the ability to reduce risk of harm and risk of litigation regarding that harm*

most places for security, to minimize violence and escapes, as examples. Correctional administrators, however, would do well to understand that health care staff members are trained in institutions that promote different values.

Physicians need to be autonomous and are selected, in part, for their ability to think independently on behalf of their patients. Security is often a matter of certainty—for example, every door needs to be locked and checked in a certain way. Medicine is different. It is a field where there is broad uncertainty and a culture that teaches practitioners how to work with uncertainty. This is a major cultural difference, but it is not a divide. In making a diagnosis and formulating a treatment plan, a physician will consider a wide variety of options and will remain open to changing the course of treatment, depending on later findings. Prison health services will thrive (and reduce risk) only when correctional administrators understand the culture of medical decision making and health care staff members understand the imperatives of security.

After attending to leadership and what I call the “cultural diversity” of corrections and health care, the solution lies with attention to systems of care, performance measurement, problem intervention and training.

Typically, there is insufficient oversight of a facility’s health care. A common facility administrator refrain is “That’s ‘medical’s’ job, I’m not a doctor.” Let’s give that response a second thought. Wardens are not trained as nutritionists, plumbers, electricians, nor teachers, yet they do not shy from managing those aspects of facility operations. Managing the smooth operation of a facility’s health care is not so very different from managing other operations that rely on specially trained folks. Correctional administrators should assure that health care resources are sufficient for staffing, space, equipment, medication and outside services. In addition, they should monitor attitudes to minimize negative thinking. They should assure that systems are in place for timely access to an appropriate level of care and provide direct oversight, without “throwing it over the wall” to health care staff who may be ill-equipped to develop and monitor systems of care for which they have not been trained. Correctional administrators should stay in touch with their prisoner audience, who often can pinpoint system deficiencies well before these are recognized by health care staff.

Correctional health care staff is typically isolated from community colleagues. The consequences include little contact with specialists for education or consultation, scant continuing education, poor communication with emergency departments and hospitalists and precious little transfer of pertinent medical information, in either direction. To the extent possible, health care should be integrated with community resources for efficiency, continuity, coordination and professional development. There are some opportunities to drive change in this arena with the 2014 implementation of the Affordable Care Act.

The next affirmative step toward minimization of risk

is changing the model of health care behind bars from an episodic care model (“Band-aid medicine”) to a primary care model. There is ample scientific evidence that focusing on a patient as a person, as opposed to focusing on an ailment, is effective at reducing morbidity, mortality and cost. Further, patient-centered care is effective in reducing not only harm, but also the risk of litigation, even when there is an adverse outcome to medical care.

Staff members who do not communicate well as a team typically perform care for prisoner patients with chronic disease, mental illness and/or drug addiction. This is another “throwing the problem over the wall” situation that would benefit from some real teamwork.

Teamwork includes improvements in transfer of medical information, within the facility and to and from the community. True primary care involves continuity and coordination of care. This cannot be accomplished without communication and the transfer of medical information that is pertinent to a patient’s health.

Well-functioning correctional health care systems have clinical performance measurement systems as part of their quality management programs. This should not be a rote exercise to demonstrate how well staff functions; it should be a program to help identify barriers to timely access to an appropriate level of care. Clinical performance measurement is not just a list of how many visits, or even for how long. It involves regular measurement of timeliness and clinical quality—for example, does the care for chronic illness follow evidence-based guidelines that are nationally accepted? Performance measurement should always include self-critical analysis of morbidity, mortality and sentinel events and should always include substance analysis of grievances.

Attention to reentry is increasingly understood to be important for individual health and for public health, and to reduce rates of return to prison. Correctional systems are increasingly reaching out to community providers and letting community health care organizations reach in to prisons and jails, so as to improve continuity of care on release. In Europe, they use the term “throughcare,” to ease transitions in both directions.

### **Prescription to Reduce Risk**

If I could write one single prescription to reduce risk of harm and reduce costly litigation regarding health care behind bars, it would be a prescription for an anticynicism remedy. This involves serious self-critical analysis to find the source of the cynicism that can be insidious in any institution. It involves leadership, training, supervision and reinforcement on the mission of the facility, for staff to attend to safety and security, with the understanding that timely access to an appropriate level of medical care is a concern for both safety and security.

Then, I would look to assurance of proper staffing and other resources, practice within the scope of licenses and systems of care to assure continuity and coordination of



*continued on page 18*

# Spotlight on the standards

by Tracey Titus, RN, CCHP-RN, and Jeffrey Alvarez, MD, CCHP

## E-12 Continuity and Coordination of Care During Incarceration (essential)

All aspects of care are coordinated and monitored from admission to discharge.

— 2014 *Standards for Health Services* for jails and prisons

In the 2014 revision of the *Standards for Health Services* for jails and prisons, significant changes were made to standard E-12 Continuity and Coordination of Care During Incarceration. This essential standard has compliance indicators that cover all aspects of care from the time an inmate enters the facility until the inmate leaves. It requires that all aspects of care are coordinated and monitored from admission to discharge.

Coordinated care means integration of medical, mental health, dental and nursing services—along with specialty consultations as needed—to improve clinical outcomes. However, ensuring that a sound system is in place presents many challenges, which we will address throughout this article.

### Examples of the Standard's Requirements

Clinician orders must be evidence based. It is important for the facility's responsible physician to base his or her clinical guidelines on accepted medical practice. This helps guide facility providers toward evidence-based treatment orders. National clinical practice guidelines for chronic care disease processes (and others) are updated continuously by organizations such as the Federal Bureau of Prisons and NCCHC supporting organizations.

Orders must be implemented in a timely manner. The responsible health authority should look at the process for order transcription. Are there any delays due to shortage of staff, knowledge of staff, pharmacy restrictions, transport availability, health record availability and so forth?

Documentation requirements are also specified in this standard. The health record should reflect the following occurrences:

- There are clinically justified deviations from the standard of practice
- Diagnostic tests are reviewed by the treating clinician
- Treatment plans are modified as clinically indicated by diagnostic tests and treatment results
- Patients returning from outside appointments (hospital, specialty consult) are seen by qualified health care professionals
- Discharge orders and follow-up care are implemented
- Specialty consultations are reviewed and acted upon
- Deviations from recommendations by consultants are clinically justified

A notable change to the standard is its strong focus on engaging patients in the development of their treatment plans. This allows a degree of ownership on the part of the patient and supports better compliance with treatment plans and better outcomes. Therefore, the health record must confirm that information is shared and discussed with the patient when treatment plans are developed or changed and when test results are received. The standard is clear that all test results must be shared and discussed

with the patient; it does not matter if the testing was done for screening or diagnostic purposes. This may be accomplished by scheduling follow-up appointments for the patient with the most appropriate qualified health care professional. Form letters for screening tests indicating normal results can also be used as long as the letter does not indicate specific disease processes or contain positive results.

The responsible physician should determine the frequency and content of periodic health assessments based

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The standard is clear that all test results must be shared and discussed with the patient; it does not matter if the testing was done for screening or diagnostic purposes.

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on protocols promulgated by nationally recognized professional organizations. For example, a yearly physical exam in a young healthy male is not a community standard of care. However, a yearly TB screen for all detainees in a correctional facility is a recommended standard.

### Checking the System

This standard has many areas that could be studied in the continuous quality improvement program of the facility. Data collection could begin by conducting the chart reviews that are required by this standard and identifying areas of deficiency. The chart reviews should be completed by members of a multidisciplinary team as well as by clinicians during clinical encounters to ensure true integration of all aspects of care. Multidisciplinary team meetings are also of great value to discuss complex patients.

While other standards address elements of the patients' total care, this standard focuses directly on the health staff's ability to integrate all of these individual compliance standards while ensuring a continuum of care from admission to discharge.

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*Tracey Titus, RN, CCHP-RN, is NCCHC's manager of accreditation services. Jeffrey Alvarez, MD, CCHP, is the medical director of Maricopa County Correctional Health Services, Phoenix, AZ. He is also a physician surveyor and trainer for NCCHC.*

*If you have a question about the NCCHC standards, write to [accreditation@ncchc.org](mailto:accreditation@ncchc.org). Find the complete Spotlight series at [www.ncchc.org/standards-explained](http://www.ncchc.org/standards-explained).*



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- Utilization Management as Quality Improvement
- A New Generation of Telemedicine
- Mock Trial: Medical Necessity vs. Community Standard
- Correctional Health Care Leadership: Doing the Best You Can
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**Conference Venue:** All events will take place at the Hyatt Regency Long Beach, just south of downtown Los Angeles. Reserve your room online or call 800-233-1234.

**Registration:** Several options are available, including a package that includes the Correctional Mental Health Care Conference and discounts for members of the Academy of Correctional Health Professionals or the Society of Correctional Physicians.

**Visit [www.ncchc.org](http://www.ncchc.org) for complete details.**



## Correctional Mental Health Care Conference

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The Bureau of Justice Statistics estimates that more than 50% of all jail and prison inmates suffer from a mental health problem. As a correctional health care professional, you have firsthand experience with that large and growing population. You understand the stresses and threats that mental illness presents to correctional health care professionals, other staff members and community health and safety.

The Correctional Mental Health Care Conference is a unique opportunity for mental health professionals like you to gather with others facing similar challenges, exchange ideas and learn about solutions. At this two-day exchange of thought leadership, you will learn about best practices, emerging legal issues and practical solutions to care delivery — and come away with actionable insights and tools.

The conference will feature two full days of focused mental health discussions, 30 sessions in three educational tracks and special networking events to help you make lifelong connections. Program faculty have been selected based on their expertise, knowledge and experience in correctional mental health care.

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- Chronic Pain Management: The Mental Health Provider's Role
- DSM-5: An Overview and Its Impact on Behavioral Health
- Innovative Practices in Correctional Behavioral Health: A Panel Presentation
- Involuntary Treatment at a Maximum Security Prison
- Jail Diversion Options for Rural Areas
- Latest Developments in Hepatitis C and Depression
- Legal Challenges: Handling Imminently Dangerous Patients
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# New Position Statement Addresses STD Testing Upon Admission

*Editor's note: This position statement was adopted by the National Commission on Correctional Health Care board of directors in October 2014. All NCCHC position statements, along with white papers and other resources, can be viewed online at [www.ncchc.org/standards-guidelines](http://www.ncchc.org/standards-guidelines).*

## Introduction

For many years, studies and surveillance projects have shown a very high prevalence of sexually transmitted diseases (STDs) in persons entering jails and juvenile facilities. These projects have identified stratified risk factors for individual diseases based on geographical location, age, and gender. Local health departments are an important resource for information on prevalence and treatment of these diseases in a specific area. Identification and treatment of STDs in jails and juvenile facilities offers a cost-effective opportunity to prevent complications of the diseases and reduce transmission of STDs in jails, juvenile facilities, prisons, and the community.

## Background

*Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) are STDs that can lead to acute pelvic inflammatory disease, chronic pelvic pain, infertility, and ectopic pregnancy in women. These infections may be asymptomatic in women and men, and they can also cause symptoms of discharge and urethral pain; women may experience irregular vaginal bleeding with these STDs. Among infected pregnant women, GC and CT are associated with miscarriage, premature rupture of membranes, and preterm birth. Newborns born to infected mothers are at risk for conjunctivitis and, from chlamydial infection, pneumonia.

Both STDs have a high prevalence rate in correctional settings, especially among young people, with CT being more common. Women are more likely to be positive than men in any age group, with 7.4% positivity among adult females entering correctional facilities and 15.7% among females entering juvenile facilities; in correctional settings, the male positivity rate is 7.1% for both adults and juveniles. Gonorrhea rates are lower (less than 5% in all age groups), but are still higher among females entering correctional facilities than males. The GC and CT positivity rate among young women (under age 20 to 25) in correctional facilities throughout the country often exceeds the rate acknowledged as cost-effective for testing by five or six times. With increasing age, the likelihood of a positive test decreases so that by age 35, testing is generally less cost-effective. Among men, although the rate of positivity is lower, there is still greater likelihood for positivity under age 20 to 25, with decreasing rates up to age 35. Screening and treating people in correctional settings has an impact on community prevalence of these infections when people are released from correctional facilities.

Syphilis, which causes a constellation of symptoms from

rashes to neurologic disease, differs in regional epidemiology. It can be especially serious in newborns, and for that reason prenatal care includes syphilis screening for all pregnant women. In 2011, correctional facilities accounted for up to 6% of reported syphilis cases in the United States. In at least one location, treatment of syphilis in a jail had a substantial impact on the prevalence in the local community.

Since most STDs may be asymptomatic, it is impossible to determine infection without direct laboratory testing. Those with symptoms or with risk factors for infection benefit from laboratory testing for these infections. Most laboratory testing for GC and CT is done together with one specimen collection test. Assays testing urine for these infections have high accuracy and are easy samples to collect.

## Position Statement

NCCHC recognizes the ongoing constraints associated with providing additional STD screening and testing services to persons entering correctional facilities. NCCHC also recognizes that those services should prioritize men and women under age 25. NCCHC also acknowledges the availability of noninvasive laboratory test methods for ease in screening. Therefore, NCCHC recommends the following:

1. Local institutional administrators and medical staff are encouraged to develop and/or enhance their working relationships with their local health departments' communicable disease managers in an effort to determine the best use of resources available for the provision of STD laboratory testing and treatment.
2. Facilities should conduct CT/GC laboratory testing on women up to age 25, and when possible 35, and among pregnant women regardless of age, at receiving or as soon as possible unless the inmate is transferred from a facility where the testing was done.
3. Laboratory testing for CT/GC should be performed on all sexually active men up to age 25 unless being transferred from a facility where the testing was done.
4. Facilities should review the yield of active syphilis screening within their institutions to determine whether laboratory testing is appropriate.
5. Facilities should consider additional STD testing (i.e., HIV, *Trichomonas vaginalis*) for persons testing positive and newly diagnosed for CT/GC or syphilis.

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# Minimize Compassion Fatigue, Avoid Burnout and Reignite Your Passion

by Sonya Khilnani, PhD, CCHP

*All too often, those of us in the helping professions put ourselves at the bottom of our own lists*

**E**ngaging in correctional health care can be a fulfilling career choice. However, burnout and compassion fatigue have become pressing issues in corrections. In general, correctional professionals experience higher levels of job stress compared to their community counterparts. If not guarded against, the cumulative challenges of the correctional work environment may affect staff negatively and produce poor outcomes, such as premature death, health problems, mental health concerns, social issues and decreased job performance.

Correctional officers tend to die sooner than average and have higher rates of stress-related illnesses. The likely culprit is overall lack of job satisfaction, which may lead to increased absenteeism and staff turnover. Low levels of job satisfaction have also been linked to burnout, and this may eventually lead to what is commonly referred to as compassion fatigue.

While there is some literature on CF and burnout among correctional officers, there is scant information on how these phenomena affect correctional health care staff. This article discusses ways that CF may adversely impact the well-being of qualified mental health professionals who work in jail and prison settings. When left untreated, CF may result in serious and detrimental personal costs to the individual and organization. These costs can be mitigated by positive self-care, which also will be addressed in this article.

## What Is Compassion Fatigue?

CF is a general term applied to anyone who suffers as a result of serving in a helping capacity. CF has been seen in professions such as nursing, fire rescue and emergency care and in the general medical community. This phenomenon occurs as a consequence of knowing about a traumatizing event experienced by another.

Victims of CF may experience trauma indirectly through the retelling of traumatic events, as within a therapeutic encounter. A noteworthy percentage of offenders have experienced some form of trauma, particularly during childhood. In trauma-informed care, a best practices approach, processing horrific events may be a routine component of the counseling session. Working with inmates with trauma histories creates an environment where the QMHP may also experience that trauma to some degree. This places those who care for inmates at risk for CF. Regularly hearing detailed information about assaults, murders and robberies can traumatize the psyche of correctional staff and leave them vulnerable to CF.

Ironically, a reduced ability to be empathic about a traumatizing event may occur and potentially lead to desensitization. Common symptoms of CF include working excessive hours, isolating oneself, overeating and drinking or drug use to cope with what you have been indirectly exposed to. QMHPs may even behave antitherapeutically and withdraw from the patient, become less active in session or rely solely on a supportive versus a problem-focused approach. Other signs are increased irritability, procrastinating, not returning

calls or being routinely late for sessions or meetings.

It is important to clarify how CF differs from burnout and corrections fatigue. The concept of burnout first became widely known in the field of nursing. Those in the helping professions who neglect to satisfy human needs for companionship, reasonable working hours, free time, vacation and so on can eventually succumb to burnout. But nursing is not the only health care profession prone to this kind of strain. QMHPs have undergone a dramatic increase in stress levels due to greater professional demands in caring for severely physically, emotionally and mentally ill patients, accompanied by limited resources. Burnout is insidious and its effects become progressively worse over time. While burnout is not specifically related to trauma, it can engender feelings of powerlessness and frustration.

Similarly, corrections fatigue is considered a gradual deterioration of the spirit, mind and body of the corrections officer. Although akin to compassion fatigue, corrections fatigue is not necessarily associated with exposure to secondary trauma, whereas the hallmark of CF is the repeated vicarious exposure to traumatic events.

Compassion fatigue is not the same as post-traumatic stress disorder in that the latter is personally/directly experienced. Moreover, CF reflects prolonged vicarious exposure to trauma as opposed to transient, work-related stress that may result in temporary feelings of anxiety or short-term memory or concentration problems. In contrast, CF involves significant impairment.

## The Role of Trauma

The role of trauma has largely been overlooked until recently. Today, we are more aware of the effects of secondary traumatic stress on health care professionals. Traumatic stress differs from "ordinary stress" in that neural-chemical imprinting of traumatic stress often results in a memory of the event that can be evoked without conscious awareness of the person experiencing it. Secondary trauma can profoundly alter our physiologic reactivity and stress hormone secretion. To compensate for this ongoing hyperarousal, traumatized people, including clinicians, may withdraw, shut down or become emotionally numb, attempting to avoid the chronic noxious stimuli.

Helpers who have experienced trauma in their own lives may be more vulnerable to absorbing and internalizing the emotions of their patients. CF can be triggered suddenly, gradually or cumulatively—secondary to being presented with traumatizing material. After (re)telling of the event(s), changes in individual thinking and response transpire. These changes include responses such as sadness, avoidance, detachment or withdrawal. Depletion of emotional resources, somatic complaints, negative thinking and decreased intimacy may occur. Other symptoms of CF may include exhaustion, lack of appetite, disturbing dreams, emotional numbing, irritability, agitation, lack of attention to detail and distancing.

CF may produce unintended consequences in the workplace, such as diminishing staff morale or impeding team accomplishments. CF costs the organization and reduces

productivity via absenteeism, poorly functioning teams, conflicts, incomplete assignments, negativism and inflexibility. These issues are magnified in correctional settings, where CF and burnout are so common.

## Why Do We Neglect Ourselves?

All too often, those of us in the helping professions put ourselves at the bottom of our own lists. While we may take great care of others, we aren't as diligent about taking care of ourselves. We may also deny our own challenges and, thus, avoid dealing with them. How can we encourage our patients to seek balance and look after themselves when dealing with stressful situations, yet we don't heed our own advice when we ourselves are struggling? A few reasons and cognitive errors are offered below:

- You may not recognize the severity of your own level of distress, and you don't make adequate time for self-reflection.
  - Your distress may mask itself in physical symptoms (e.g., headaches), which lead to a search for more of a physical/medical explanation instead of a psychological one.
  - You may think you just need a vacation rather than looking at the bigger picture of what needs to change.
  - Even though you recognize the need for self-care, you may decide that it's not feasible due to the many demands on your time.
  - You do not give yourself permission to find help.
  - You may feel that since you are a helper, you should be able to help yourself. In other words, you feel embarrassed or humiliated because you think therapists should be able to solve their own problems.
  - You have doubts regarding the efficacy of therapy.
  - You have feelings of superiority that hinder your ability to identify your own need for help.
  - You may know many of the mental health professionals in your area and that may prevent you from seeking help.
- When a QMHP fails to take care of him- or herself, it can lead to incapacitating personal distress, dysfunctional relationships, moral and spiritual issues, and impaired professional behavior such as ethical violations.

Those who work in correctional settings are encouraged to pay close attention to their personal and professional needs, including obtaining regular clinical consultation.

## The Importance of Prevention

There are many effective strategies that can minimize the negative effects of burnout and compassion fatigue. These include establishing strong social support in both personal and work life, balancing work and home life, finding satisfaction and purpose in your work, modulating exposure to trauma when possible, practicing optimal self-care, using supervision, obtaining training and education about work-related stress and being appropriately self-aware.

Managing empathy is also important. Although emotional contagion is an inevitable consequence of human interaction, as clinicians we can choose whether or not

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we are infected by another's feelings by developing the appropriate skills. It is common to react to another's pain, but this may bode unfavorably for the unaware therapist over time. Clinicians are especially prone to the chameleon effect—a tendency to copy mannerisms, facial expressions and breathing patterns of those we serve. Learn to identify whether your feelings and body sensations are the result of overempathizing.

### Compassion Satisfaction

The flip side to CF is compassion satisfaction. This is the upside to the work we do and is based on the notion that there are intrinsic rewards that arise out of helping. You may feel positive about your collegial relationships, your ability

to contribute to the work setting, contributing to a safer society and helping others through our work. Experiencing a "helper's high" is when you feel that you are in the right place at the right time, and that what you are doing is making a difference. Healthy levels of compassion satisfaction allow you to feel reenergized by the act of helping, satisfaction with the progress of your patients and optimistic about your ability to make a difference. It is essential to work on building your own resilience and not take it for granted as a fixed human trait.

### Calendar It!

Although it may sound paradoxical, structuring and planning ahead when it comes to adequate self-care ensures greater calm and clearer thinking on your part. Both you and your patients will benefit from this. Ask yourself about the following as they relate to self-care: regular exercise, problematic drinking or drug use, participation in leisure activities, social life, sleeping, relaxing, eating, productivity and maintaining healthy professional boundaries. Remember, you are responsible for your self-care.

### Organizational Considerations

On a broader scale, organizations can provide ways to offset CF and burnout, such as providing regular breaks for employees and offering alternate posts (e.g., inpatient, outpatient, reception/intake, segregation) in which a QMHP works. These rotations may minimize upsetting exposure and promote cross-training. CF can be mitigated by openly discussing it during staff meetings, encouraging peer support, increasing awareness through education and trainings, holding debriefing sessions and providing access to employee assistance program services and supportive groups. Team meetings and case supervision are also excellent forms of organizational or peer support. Sending individuals to training sessions and bringing in speakers to provide on-site, staffwide training may also help with employee morale and worker satisfaction.

These cost-effective strategies could lead to improved patient outcomes and enhanced feelings of appreciation among health care providers. Such supportive activities may reduce feelings of isolation and distress in staff. When a climate of appreciation, support and attention to professional development is created, individuals will experience fewer of the negative reactions of burnout and CF.

### Take Care of Yourself!

I hope that after reading this article, you will take steps to engage in self-care and guard against CF and burnout. Were you able to recognize any unhealthy patterns so that they may be addressed in a constructive manner? Taking a proactive approach to ward off burnout and CF will help you sustain a long, productive career as a correctional health care professional.

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*Sonya Khilnani, PhD, CCHP, is a behavioral health manager for Corizon, Brentwood, TN.*

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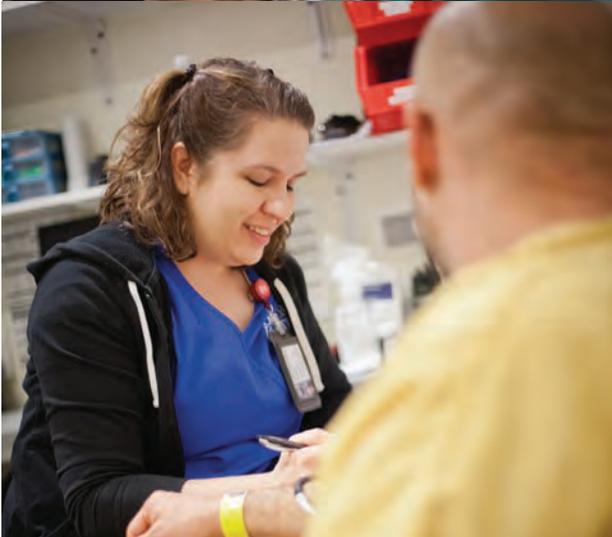


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# Effective Management of the Prison Dental Program (Part 2)

by Dino R. Angelici, DMD

*Part 1 of this article discussed the burden of dental disease in corrections, variations within the inmate population and an effective system for tracking dental needs. Part 2 continues our discussion of the infrastructural components for successful management of the correctional dental program.*

## Treatment Settings

### Reception Centers

A correctional system's reception center is usually a large facility with a high population of new and returning inmates in addition to its more stable general population. The areas in which the reception center dentists work may vary on any given day, depending on the demands of reception exams, sick call and permanent general population workload. Typically, a dentist and a dental assistant will be needed for the complete examination and treatment planning component. One to two dentists will be needed for the routine treatment needs of general population inmates. Sick call can be significant due to the large volume of incoming inmates presenting with urgent conditions. Assign one or two dentists to handle sick call to maximize efficiency and minimize the time required.

### Field Institutions

Most inmates are assigned to field Institutions after completing the reception and classification process. Dentistry at these facilities usually differs from reception facilities by one or more of the following factors:

- Short sentences: Today, the trend is toward minimizing prison time for significant numbers of specific types of offenders whose rehabilitative needs have been determined to be amenable to community-based therapies. Inmates in this category usually spend six months to two years in a state institution before transfer into a secure community-based program. Often, these inmates have not had much treatment by the dental staff. They frequently request dental services because they know they are leaving prison soon.

- Lifers and longer sentenced inmates: These inmates make up the bulk of our dental patients. It behooves us to ensure that these patients adopt better oral hygiene habits and healthier nutritional choices. They should receive the most comprehensive care since they will be with us for the long haul, and it is in our best interest to try to stabilize their oral health. Failing to adequately care for these patients is a poorly defensible position because they cannot seek dental care elsewhere.

- Segregation status can present barriers to dental care due to inmate behaviors or availability of security staff. To improve access for this population, develop a schedule with administrators and supervising security staff, calling on

the assistance of the health care administrator. If space and resources permit, it is helpful to have a satellite dental office in the restricted housing unit in facilities with large populations of inmates in segregation.

- By being disorganized and/or falling into one or more of the substandard practices discussed in Part 1 of this article, we run the risk of neglecting our general population inmates.

## Dental Hygiene Treatment

Hygiene is an important element of the correctional dental program as it not only improves oral health but also can help to slow or arrest some conditions. When a facility operates an effective oral hygiene program, inmates express greater satisfaction with the dental office and wait more patiently for other services. The patient tracking system discussed in Part 1 also tracks the aspects of preventive dentistry for which inmates are periodically called and enables timely recalls.

## Advanced Dental Treatment

For advanced treatment needs, the facility's dental program may need to call on a network of prison dentists and off-site specialists. To keep inmates in-house as much as possible, it helps to identify colleagues who excel in various disciplines of dentistry. To avoid indecision that leads to procrastination of care and to reduce transports into the community, inmates can be temporarily transferred to different facilities within the department of corrections for advanced care not available at the home facility. Of course, reliable and competent off-site community-based specialists will always be needed for some conditions. However, these can be kept to an appropriate level by establishing the intrasystem network.

## After Hours Dental Care

Invariably, inmates will experience dental conditions that arise after the staff has gone for the day. Protocols for these conditions must be in place so medical staff has informational resources to which they may refer. On-duty medical staff can then ensure that patients receive necessary care.

For example, an inmate presents to medical with traumatic injury to his jaw. This patient must be evaluated, diagnosed and treated right away. The protocol will entail taking a history, evaluating clinical appearance, taking and evaluating an X-ray of the fracture, consulting with a physician or dentist by telephone, notifying security and transporting the patient to the hospital as soon as possible.

## Managing With Data and Statistics

During my 22 years in corrections, information technology has emerged as an adjunct to our clinical and managerial repertoire. Many correctional managers still rely heavily on the "sixth sense" of a seasoned administrator. There is validity to this approach: Many administrators began their

**A manager can get a good feel for the quality of service from the dental office by observing the staff and the clinic's appearance**

careers by working on the cellblocks, where they learned to trust their intuition and to recognize potential signs of trouble. But sometimes these individuals do not give credence to statistical data that may differ from their perceptions of institutional states of affairs. As correctional managers who rely on information technology as well as our “sixth sense,” it can be a challenge to bring the old-timers around to accepting our assessments of some dental office situations.

As a correctional dental manager, I have seen dental offices that functioned very poorly. Statistical analyses showed disturbing trends, but when speaking with an administrator I was told, “Yes, but the inmates are not complaining!” There may be other signs, of which prison administrators may not be fully aware, such as the following:

- High numbers of inmates declining dental services
- Low numbers of requests for dental service
- Directing requests for dental services to the medical department instead of to the dental office
- Statements by the dental office staff that “The inmates here don’t want dental services”
- Failing to report for scheduled dental appointments
- Frequent down time for the dental staff

In such scenarios, one must be very diplomatic but firm in presenting “the rest of the story” to administrators.

The statistical data can enhance our managerial skills that have been honed by experience. As discussed in Part 1, having good data is a tremendous advantage that will enable managers and dental providers to operate an efficient and effective dental program. Important data to track are no shows, refusals, late arrivals, dental requests directed to the medical staff and rescheduled inmates.

A dental activity report will enable a manager to know how much treatment each dental provider is rendering on a monthly basis. For each dentist, oral surgeon, hygienist and dental assistant, the report should indicate hours worked, number of inmates seen, number of hygiene hours, number of “definitive” dental procedures (i.e., those of a permanent, problem-solving nature), definite procedures per hour worked, number of encounters requiring local anesthesia and number of other procedures.

Using this activity report, in conjunction with the workload report from the tracking program, enables a manager to assess whether the dental office is completing enough treatment to meet the demand. Strong and weak points of the dental program can be evaluated and action plans developed to improve practices and eliminate deficiencies.

### **Dentistry in a Secure Environment**

*“The longer I am in corrections, I think less like a dentist and more like a security captain.”*

As a reaction to the high volume of treatment demand, some correctional dental offices attempt to minimize their responsibilities with respect to inventory and tool control. Good security practices not only increase safety but also are a sign of effective organizational skills, thorough understanding of policies and attention to detail. “Cutting corners” can lead to complacency and negative consequences for the dental program and potentially the entire facility.

Contraband is an ongoing concern. Prisons are spartan environments for staff as well as inmates. The lack of access to snacks and other comforts can tempt some staff to bring items into the facility that are not permitted. As space is usually limited, storage can become compromised. The end results can range from diminished work performance to compromised staff to contraband or dangerous items falling into the hands of inmates.

I have seen prison dental offices that could have been fodder for the popular television show “Hoarders.” Some of those offices had so much contraband and clutter that infection control was compromised and potentially hazardous items could not be properly secured or inventoried. Fortunately, there were no serious incidents and the deficiencies were corrected, but the potential for disaster was real.

These types of occurrences start small, with ideas such as:

- “We really do not have to count these items”
- “I need some of this available to me,” even though it is not supposed to be inside the secure perimeter
- Taking advantage of administrative memoranda that permit small amounts of food and beverage to be brought in for camaraderie and short-term consumption

Over time, such small beginnings mushroom into serious lapses in security. I have found that these lapses often extend into the clinical realm, as well. Dental office organization is vital, security is paramount and it is everyone’s responsibility. We may have differing opinions on specific policies and practices, and should share any concerns we may have, but once policy is established, we must follow it closely. As correctional managers, we should pay close attention to the conditions of our dental offices with an eye toward potential lapses in security and clinical effectiveness.

Security includes maintaining accurate inventories and secure storage of equipment, supplies and medications. Inventory should be conducted at least three times per day on a standardized form, with two people counting independently. Items required to be inventoried should be organized such that nondental staff can conduct the inventories. It helps to provide pictures of dental items with descriptions. The usual suspects are needles and syringes, scalpels, dental instruments, small equipment items and hazardous substances. But don’t overlook lab burs, blister packs of medications, anesthesia carpules, endodontic irrigating syringes and suture needles.

Most of the time, we are not required to count dental burs. However, there are some sticklers on our security forces. If you are being ordered to count these items, the following strategies will help with efficiency of the process:

- Keep only enough on hand to maintain uninterrupted service.
- Keep bulk amounts in a separate storage area where they only need to be counted periodically and/or when accessed.
- Use bur blocks in the clinical area and keep a minimal number of burs in the block. For example, a bur block with six or eight burs can easily be counted at a glance.



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# The Sovereign Citizen Movement: What Mental Health Professionals Need to Know

by Alexandra Pajak, LMSW, CCHP

Within the past 40 years, the sovereign citizen movement has become more prominent throughout the United States both in numbers of followers and notoriety. By some estimates, as many as 300,000 people are involved with sovereign citizen extremism, with perhaps 100,000 people forming a core of the movement, according to Mark Potok, a senior fellow at the Southern Poverty Law Center. Potok was quoted in a CNN story on a Department of Homeland Security intelligence assessment, released in February, of the domestic terror threat.

Although generally nonviolent, sovereign citizens often enter the criminal justice system as a result of actions based on antigovernment beliefs.

Because of the violent actions of some sovereign citizens against law enforcement, the belief that the U.S. government has no jurisdiction over them and a pattern of harassment toward government employees, the FBI identifies the sovereign citizen movement as a domestic terrorist group.

Interestingly, sovereign citizens often present with unique patterns of speech, vocabulary and paranoid beliefs. These characteristics may resemble psychosis and present challenges to mental health clinicians in discerning mental illness versus norms of sovereign citizens' culture.

## Shared Characteristics

Although not highly structured or organized, sovereign citizens share similar characteristics. Sovereign citizens are generally middle-aged White males in their 60s or 70s, although some White women are also members and even leaders within the group. Recently, Black Americans have joined the movement in increasing numbers and identify themselves as "Moors," "Moorish" or "Mu'urish." Sovereign citizens often spell their names with the prefix "Noble" or the suffixes "El Bey" or "Bey." When writing their names, sovereign citizens may incorporate unusual punctuation including hyphens, semicolons, colons, commas or even a copyright symbol ©.

Individuals attracted to the movement are often artists, people angry at the government and people experiencing financial hardship. Sovereign citizens often refer to themselves as "state citizens" and "constitutionalists." They often refuse to use zip codes, paper money, hunting licenses, license plates and driver's licenses. Some reject a judge's legal authority if a gold fringe-trimmed American flag stands inside the courtroom. Many file false liens against judges and other government officials.

## Beliefs

Antigovernment sentiment and conspiracy theories regarding the United States government are the central tenets of the movement. Sovereign citizens often insist that there exists a "missing" 13th Amendment that would have

prevented citizenship for lawyers, and that a new class of citizens was formed by passage of the 14th Amendment. Many defend criminal actions by citing various laws and legal precedents that never actually occurred.

## Common Charges

Common charges that lead to incarceration of sovereign citizens include driving without a driver's license or presenting law enforcement with a counterfeit driver's license, proof of registration and proof of insurance at traffic stops. Other charges include impersonating a police officer, tax evasion, threatening judges, investment schemes and possession of illegal weapons. In the past decade, numerous members of this group have been arrested for "squatting" in foreclosed homes and seizing the homes as their own when foreclosed upon. Extremists within the movement have made threats and committed acts of violence against law enforcement and government officials.

## Behavior in Correctional Settings

As increasing numbers of sovereign citizens enter the criminal justice system, they continue to spread their ideology and recruit members while incarcerated. This includes teaching inmates "paper terrorism" tactics to harass security staff, including asking relatives in the community to file various documents against correctional staff as a form of harassment.

## Implications for Mental Health Professionals

Sovereign citizens display beliefs and language that may present similar to psychosis. They tend to exhibit odd behavior and speech and hold a paranoid and bizarre belief system. Although some sovereign citizens may suffer from mental illness, possessing the beliefs and behaviors of a sovereign citizen alone does not meet criteria for mental incompetency. In a study published in the September 2014 issue of the *Journal of the American Academy of Psychiatry and the Law*, researchers examined nine competency evaluations conducted on sovereign citizens between 2003 and 2012. The authors conclude that "sovereign citizens typically have the capacity to understand criminal proceedings and assist an attorney."

As the sovereign citizen movement increases in membership and likely encounters with the criminal justice system, mental health professions would be wise to educate themselves on the presentation and beliefs of this unique ideology. Early identification and accurate assessment of incarcerated sovereign citizens are imperative to preventing unnecessary treatment and hospitalizations, thereby aiding efficiency and accuracy for both the mental health and legal processes.

*Alexandra Pajak, LMSW, CCHP, is a mental health counselor with more than four years of experience working in a jail.*



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# A Patient Safety Model for Correctional Practice

by Lorry Schoenly, PhD, RN, CCHP-RN

*This article is the second in a series discussing the basics of patient safety. Subsequent articles will present the principles of patient safety and causes of clinical errors.*

**P**atient safety is a growing field in health care and an increasing emphasis in the correctional setting. In the NCCCHC *Standards for Health Services*, B-02 establishes the need for patient safety systems to prevent adverse and near-miss clinical events, voluntary reporting of adverse and near-miss events in a nonpunitive environment and methods for the organization to evaluate and learn from clinical errors that take place. A model for understanding and applying patient safety principles can help speed implementation of a patient safety program.

A four-component model for correctional health care patient safety was created based on organizing principles from the work that physician Linda Emanuel and colleagues developed for traditional health care settings. Emanuel's model included the interacting elements of health care workers, patients and systems of therapeutic intervention. The highly volatile component of the environment of care delivery was added for application of the framework in the corrections specialty. What are the key elements of each area of patient safety?

## Environment of Care

The environment in which health care is provided affects the interaction of the patient, the health care workers and the systems used to deliver care. The environment is primarily the organizational culture of the workplace but can also include the physical environment, such as the design of the care delivery setting and the available equipment and supplies. The secure environment of the criminal justice system adds intensity to the environment of care by imparting a unique set of values and cultural norms. A patient safety framework seeks to advance the organization to a "just culture" that is continually learning and improving.

The environment of care is of particular concern in a correctional setting. Unlike traditional health care, most correctional care delivery takes place in an environment managed by others. Correctional professionals have a worldview nurtured by their values and beliefs, which can compete or conflict with the role of health care and lead to patient safety challenges. Organizational culture must support mutual goals of health care and custody so that the environment promotes safety.

## Systems for Therapeutic Action

Patient care is delivered through a complex system of intertwined processes. The patient and health care workers interact with these systems of therapeutic action within the environment of care. These interacting components have

weaknesses that lead to clinical errors. Vulnerabilities within the system of care delivery, including the potential for miscommunication among staff and patients, create an ongoing need for attention to improve patient safety. This can be especially concerning in correctional health care, where practitioners must effectively practice within the criminal justice system among many disciplines. This increases the number of interacting components for standard processes and adds barriers to care delivery.

Systems of care, then, are an important component of a patient safety environment. Therapeutic systems, based on principles of high reliability systems design and human factors engineering, reduce the potential for patient harm. Communication and teamwork based on transdisciplinary collaboration can stabilize communication patterns to improve patient safety within this system. Patient safety principles can increase the reliability of care systems, reducing error and improving outcomes.

## Patient-Recipient of Care

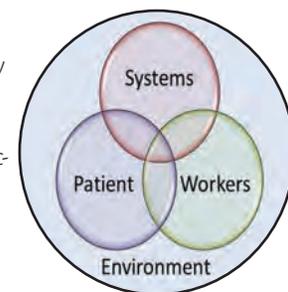
The patient, as recipient of care, is also a vital part of a safety framework. Interacting with health care workers and the systems of therapeutic action within the environment of care, patients have opportunity to actively participate in and monitor care delivery. However, there are many barriers to engaging patients in the criminal justice system that must be considered and overcome.

The role of patients in the correctional health care patient safety program may, at first, seem minimal. Applying principles of patient-centered care and educating the patient population about their role can, however, increase meaningful participation. Patients can be valuable members of their health care team when they understand their role, are health literate and are motivated. Health professionals have an obligation to encourage patient participation to improve safety and reduce clinical error.

## Health Care Workers

The competence and judgment of health care staff are major factors in patient safety. Staff interact with the patient and take therapeutic actions to deliver health care. Throughout the continuum of practice, health care workers have an opportunity to improve patient safety by developing and maintaining clinical competence.

Internal and external factors such as fatigue, work stress, impairment and shift rotation affect workers' abilities to deliver safe care. Health care workers must be aware of their own biopsychosocial well-being and take steps to reduce physical and compassion fatigue or work stress when possible. This includes actively monitoring general health and well-being to determine if disease or medical treatment may be impairing clear thinking and dexterity. Individual workers and their teammates also have a responsibility to be aware of potential substance use issues. Organizations,



*Correctional Health Care Patient Safety Model*

*continued on page 18*

## Medical Problems of Prisoners and Jail Inmates

An estimated 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition in the 2011–12 National Inmate Survey, according to the Bureau of Justice Statistics. Half reported a history of a chronic medical condition. High blood pressure was the most common condition reported by prisoners (30%) and jail inmates (26%), followed by asthma and arthritis. About 66% of prisoners and 40% of jail inmates with a current chronic condition reported taking prescription medication. Among those who did not, the most common reason given by prisoners was that a doctor did not think medication was necessary or that the facility would not provide it.

Overall, 21% of prisoners and 14% of jail inmates reported ever having an infectious disease such as tuberculosis, hepatitis B or C, or other STDs (excluding HIV or AIDS). About 1% of prisoners and jail inmates who had been tested for HIV reported being HIV positive.

More than 8 in 10 prisoners (85%) and jail inmates (82%) reported being questioned at admission about their health or medical history. Eighty percent of prisoners and 47% of jail inmates reported seeing a doctor, nurse or other health care professional since admission. More than half of prison-

ers (56%) and jail inmates (51%) were either very satisfied or somewhat satisfied with the health services received.

• Highlights: [www.bjs.gov/index.cfm?ty=pbdetail&iid=5219](http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5219)

## Improving Inmate Health Leads to Better Public Health

A new review study concludes that offering treatment to prisoners or linking them to community-based physicians and psychiatrists after release leads to less substance abuse, mental health problems, chronic diseases and health service utilization, as well as a reduced spread of infectious diseases. Titled “A Systematic Review of Randomized Controlled Trials of Interventions to Improve the Health of Persons During Imprisonment and in the Year After Release,” the study was published in the Feb. 25 issue of the *American Journal of Public Health*. The researchers reviewed 95 international studies about inmates receiving health care treatments in prison or after release. In 59 studies, interventions led to improved health. A summary of the study’s significance was release by St. Michael’s Hospital, Toronto, where the lead author, Fiona Kouyoumdjian, MD, is a postdoctoral fellow with the Centre for Research on Inner City Health.

• Summary: [www.stmichaelshospital.com/media/detail.php?source=hospital\\_news/2015/20150225\\_hn](http://www.stmichaelshospital.com/media/detail.php?source=hospital_news/2015/20150225_hn)

## Cynicism *(continued from page 5)*

care for patients with serious medical needs. (A serious medical need is a valid health condition that, without timely medical intervention, will cause (1) unnecessary pain, (2) measurable deterioration in function [including organ function], (3) death or (4) substantial risk to the public health.)

Third, I would prescribe oversight, either internal or external; integration with community health care resources; abandoning the episodic care model for a primary care model; assuring teamwork among in-house medical, mental health, dental and addiction treatment staff; improved transfer of medical information, within and outside the facility; development of clinical performance measurement systems; and attention to continuity of care on release.

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*Robert B. Greifinger, MD, is a consultant on correctional health care. He is co-editor of the International Journal of Prisoner Health and the editor of Public Health Behind Bars: From Prisons to Communities. He credits an observation by Justice Oliver Wendell Holmes, Jr., for the title of this commentary.*

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## Patient Safety Model *(continued from page 17)*

however, have a primary responsibility for attending to external factors such as staffing ratios, staffing mixes and shift work—all factors that affect an employee’s ability to deliver safe patient care.

Diagnostic error is a new area of patient safety investigation, with up to 15% of medical diagnoses found to be incorrect. How diagnosticians process data to make clinical decisions and the factors affecting decision making are currently under investigation. Although research is sparse at present, clinicians and organizations can apply cognitive skill education and decision-making tools to assist diagnosticians in making accurate medical diagnoses.

### Summary

Implementing a patient safety program can seem overwhelming. Using a framework such as the Correctional Health Care Patient Safety Model can speed implementation and understanding of the various components of patient safety in our specialty.

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*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.*

# 'Change Team' Study Improves HIV Reentry Services in Delaware

As part of a national research project to improve HIV care in correctional facilities, the University of Delaware's Center for Drug and Alcohol Studies and the Delaware Department of Correction conducted a study aimed at strengthening components of the HIV services continuum of care for DE DOC inmates and those being released to the community.

The effort used a "change team" model that led to (a) improvements in communication between DOC medical staff and community HIV provider staff, (b) new patient forms and planning processes that improved linkages to care, (c) statewide adoption of these new forms and processes as DOC policy and (d) changes to other components of the HIV services continuum, including testing and education.

The project, along with lessons learned from the experience, is described in the April issue of the *Journal of Correctional Health Care*. This special issue features seven articles focused on HIV/AIDS research, care and prevention among populations in correctional settings. The Delaware article was written by Holly Swan, PhD, and colleagues.

## Walk-Throughs Reveal Path to Improvement

This study was part of the HIV Services and Treatment Implementation in Corrections (HIV-STIC) research program that was borne of the National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies. In Delaware, the study partners agreed to focus on linkage to HIV care in the community upon reentry in order to reduce harmful disruption in HIV treatment. The project involved experimental sites, which followed the change team protocol, and control sites, which received a directive from correctional administrators to improve HIV services but were not instructed on how to do so.

The change team consisted of a DOC administrator, a facility administrator at the prison involved in the study, the head nurse for the DOC's contracted medical provider, an external process improvement coach, substance abuse treatment providers, a representative from the HIV community provider and others. The head nurse best met the criteria for change team leader and was assigned to that role.

Key to the success of this project was a "walk-through" of the service that the team sought to improve. In this case, it meant that several of the change team members simulated the experience of HIV-positive individuals in two scenarios: (a) undergoing medical intake and discharge processes in the correctional facility and (b) upon release, finding the community HIV program and going through intake there.

This exercise helped team members to understand what the client experiences when trying to access and participate in particular services, what steps are involved in obtaining services, how long it takes to receive services and so forth.

The findings informed the goals and strategies that the team undertook to improve HIV treatment linkages. The team then used a "plan-do-study-act" approach to rapidly make changes based on specific, short-term process goals.

Monthly meetings ensured that the work stayed on track. Overall, the project took about one year.

Although the initial, primary goal was to improve linkage to care upon reentry, the project also led to improvements in the entire HIV services continuum, including HIV education and HIV testing. The authors conclude that the use of a change team model is a viable method for making organizational change in correctional settings.

## JCHC Volume 21, Issue 2

HIV/AIDS Research in Correctional Settings: A Difficult Task Made Even Harder? — Mark E. Johnson, PhD, Karli K. Kondo, PhD, Christiane Brems, PhD, ABPP, and Gloria D. Eldridge, PhD

HIV Knowledge Among a Longitudinal Cohort of Juvenile Detainees in an Urban Setting — Charbel El Bcheraoui, PhD, MSc, Xinjian Zhang, PhD, Leah J. Welty, PhD, Karen M. Abram PhD, Linda A. Teplin PhD, and Madeline Y. Sutton, MD, MPH

Prevalence and Predictors of Mental/Emotional Distress Among HIV+ Jail Detainees at Enrollment in an Observational Study — Thomas Lincoln, MD, CCHP, Dominique Simon-Levine, PhD, Julianna Smith, PhD, Geri R. Donenberg, PhD, Sandra A. Springer, MD, Nickolas Zaller, PhD, Frederick L. Altice, MD, Kevin Moore, PsyD, Alison O. Jordan, LCSW, Jeffrey Draine, PhD, and Maureen Desabrais, MEd, LSW, LADC-1, CCDP-D

After the Fact: A Brief Educational Program on HIV Postexposure Prophylaxis for Female Detainees in a Local Jail — Neha Gupta, MD, Heidi Schmidt, MD, Timothy Buisker, Mi-Suk Kang Dufour, Joe Goldenson, MD, Janet Myers, PhD, and Jacqueline Tulsky, MD

Epidemiological Criminology: Contextualization of HIV/AIDS Health Care for Female Inmates — Mark M. Lanier, PhD, Barbara H. Zaitzow, PhD, and C. Thomas Farrell, PhD, MPH

Improvements in Correctional HIV Services: A Case Study in Delaware — Holly Swan, PhD, Daniel J. O'Connell, PhD, Christy A. Visher, PhD, Steven S. Martin, MA, Karen R. Swanson, BSN, CCRC, ACRN, and Kristin Hernandez, BSN, RN

HIV Subspecialty Care in Correctional Facilities Using Telemedicine — Jeremy D. Young, MD, MPH, and Mahesh Patel, MD

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## CCHPs Share their Expertise and Commitment at Spring Conference

The commitment of Certified Correctional Health Professionals to the field of correctional health care, and to sharing their expertise and educating others, was very much in evidence at the Spring Conference on Correctional Health Care, held in New Orleans in April.

More than 45 CCHPs presented educational sessions, representing almost 50% of all conference speakers. Among the presenters were CCHPs with the nursing and mental health specialty certifications, CCHP-RN and CCHP-MH, as well as those with the advanced designation, CCHP-A. The wide variety of issues they discussed—medical, nursing, mental health, administrative, legal and dental—represent the diversity of expertise in the field.

“CCHPs demonstrate exceptional dedication and leadership in their work every day,” says director of certification Matissa Sammons, CCHP. “Lending their expertise at NCCHC conferences is just one more way they give back to the correctional health care community.”

### Dementia, EKGs and Pandemics

Among the presenters was John Wilson, PhD, CCHP-MH, senior clinical operations specialist with MHM Correctional Services, Inc., who addressed the growing prevalence of dementia among the aging inmate population. “There is no question that inmates with dementia represent a high-risk, high-need population that is challenging to manage and treat in our facilities,” he told his audience. Based on outcome data, he outlined a multidisciplinary approach to treating, managing and monitoring inmates with dementia.

Eileen Couture, DO, RN, CCHP, reviewed critical skills for interpreting EKGs, a diagnostic tool that, while routine, often causes confusion for providers. “Although many EKGs are now read by the machine, results must be reviewed by providers,” she said. Participants left her session with more confidence and a better understanding of how to systematically approach reviewing EKGs. Couture serves on

the NCCHC board of directors as liaison of the American College of Emergency Physicians.

Sue Lane, RN, CCHP, and Sue Smith, MSN, RN, CCHP-RN, discussed disaster planning for an infectious disease outbreak. “The best way to prevent panic during an outbreak is to be educated,” said Lane. Their talk explored historic and current epidemics and pandemics, lessons learned through those events and ways to stay prepared for the next outbreak, including having correct information, resources, equipment and training.

### Unique Set of Traits

What compels these CCHPs, and so many others, to share their expertise at professional conferences? Their answers speak to the unique combination of professionalism, intelligence and altruism required to work in correctional health care.

“We need to be the voice for people who can’t be heard,” says Lane. “We are doing a disservice if we send sick people back out into the community. We are an extension of public health and have an important public health message to share.”

“I’m committed to improving care in correctional facilities,” says Couture. “Plus, presenting is enjoyable! Everyone is eager to learn and eager to talk. They ask great questions, and we have wonderful discussions.”

“I love to learn, and presenting is a wonderful opportunity to learn,” says Wilson. “Studying in detail a topic that is slightly outside my area of expertise is stimulating to me. It’s also a chance to take the long view, to look at what is on the horizon and help systems prepare, for the good of the inmates.”

CCHPs also earn credit toward recertification by presenting at professional conferences. Credit awarded is based on the number of hours spent preparing for and delivering the talk.

### CCHP Board Welcomes Newest Certificants!

The CCHP exams held in the fourth quarter of 2014 yielded 114 newly minted Certified Correctional Health Professionals. In addition, 16 existing CCHPs earned specialty certification: 15 registered nurses earned the CCHP-RN credential and 1 mental health professional is now a CCHP-MH. These certifications became official on Jan. 1. The CCHP board of trustees congratulates and welcomes them!

To download lists of these individuals, visit the Recent News section at [www.ncchc.org/recent-news](http://www.ncchc.org/recent-news).

### CCHP Exam Dates

<b>June 6</b>	Regional sites
<b>July 11</b>	Long Beach, CA
<b>August 22</b>	Regional sites
<b>October 1</b>	North Bend, OR
<b>October 18</b>	Dallas, TX

We are seeking sites for regional exams as well as CCHPs to proctor the exams. To participate, contact the certification assistant at 773-880-1460 or [cchp@ncchc.org](mailto:cchp@ncchc.org). See the complete calendar at [www.ncchc.org/cchp/calendar](http://www.ncchc.org/cchp/calendar).

Custody of inmates while they are under our care is another responsibility that is vital to security. The following protocol should be observed when inmates are in our care or are performing maintenance or janitorial services on behalf of the dental office:

- Do not leave inmates alone in any area of the dental office. If we must leave a room for any reason and no other staff members are present, we must direct the inmate to come with us.
- Do not tempt inmates by leaving instruments, equipment, materials or supplies unsupervised or otherwise unsecured. If using over-the-patient delivery treatment units, pull the instrument tray away from the inmate's reach or remove the tray and place it in a secure area.
- Do not allow inmate maintenance or janitorial workers to be alone in dental office areas where security items are present or where female staff members can be compromised.

### Infection Control

The concept of maintaining good infection control is similar to that of maintaining good security: organization, understanding and appreciating protocols and attention to detail will yield excellent results. To enable good housekeeping, remove everything from the countertops and work surfaces and eliminate clutter, personal items and contraband. Supervised inmate janitorial services should include floors, walls, door knobs and switches. Annual infection control training should be required of all staff in the dental office.

### Effective Management Summary

A manager can get a good feel for the quality of service from the dental office by observing the staff and the clinic's appearance. Warning signs of potentially poor quality include schedules that never seem to come off as planned, frequent down time, disorganization and lax security and infection control.

Back up those "sixth sense" subjective impressions with objective observations and statistical data to reach conclusions about the dental program. When negative trends are identified, discuss this with appropriate staff and administrators and come to a consensus. The next steps are to develop solutions, implement protocols, communicate goals to staff, direct staff to follow protocols and measure the results.

Management tools to monitor and maintain quality include quarterly internal audits and monthly staff meetings. It is important to monitor quality measures and processes as necessary. If quality fails to improve despite these measures, progressive discipline may be required. Finally, good data are essential to justify staffing levels as well as equipment and space needs.

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*Dino R. Angelici, DMD, is chief of dental services for the Pennsylvania Department of Corrections, Mechanicsburg. He expresses his appreciation to Gary C. Mangieri, DMD, regional dental supervisor, PA DOC, for his efforts and expertise in corrections dentistry.*



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State/facility medical director, director of nursing, other directors	16%
Health services administrator	9%
Department manager/supervisor	11%
Health services, dental or mental health staff	26%

### Who Do Attendees Represent?

Jail facility	44%
Prison facility	21%
State DOC/agency	11%
Private corporation	9%
Juvenile detention or confinement facility	4%
Federal agency	1%

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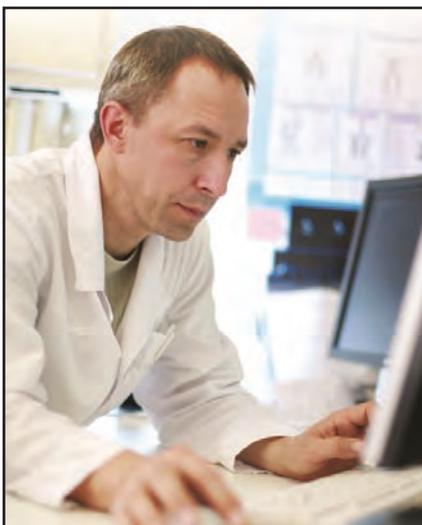
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## Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

### Sharing Psychological Autopsy Results

**Q** Standard A-10 Procedure in the Event of an Inmate Death requires that the results of the clinical mortality review and administrative review are to be shared with treating staff. In the event of a suicide, a psychological autopsy must also be completed. Is it necessary to share results of the psychological autopsy with treating staff in such cases?

**A** You are correct that the results of the administrative and clinical mortality review should be shared with treating staff. In the case of suicide, the psychological autopsy should be considered part of the clinical mortality review and should also be shared with treating staff.

### Clinical Performance Review for Hygienists

**Q** Since registered dental hygienists are licensed practitioners, do they require the clinical performance enhancement reviews discussed in standard C-02? If so, would the supervisor within the same discipline be a dentist or a dental hygienist? Most dental hygienists do not have

supervisors who are also registered dental hygienists. Also, the standard does not specify whether midlevel providers are reviewed by the physician or whether another supervisory midlevel provider would conduct those reviews.

**A** While clinical performance review of dental hygienists is good practice, technically it is not required by the NCCHC standards. If you opt to conduct the reviews, a dentist could do that since, as you noted, hygienists do not normally have a peer supervisor. Concerning the reviews of midlevel providers, which are required by the standard, those can be completed by the physician.

### Nonemergency Health Care Requests

**Q** Our jail is developing a continuous quality improvement rubric to be used by our contract monitor with regard to nonemergency health care requests and services (standard E-07). We are measuring the time between receipt of the sick-call slip and when someone actually is seen. Compliance indicator #1 states that inmates who describe clinical symptoms should be seen face to face by a professional within 48 hours (72 on weekends). If the slip is triaged within 24 hours, does that time count toward the 48 hours, requiring the person to be seen the next day? Or does the "clock" start over again and we have an additional 48 hours after it is triaged to have the patient seen by a provider? Our contract monitor is using the interpretation of 48 hours from receipt of the slip, which has generated the debate that it is unreasonable to expect a face-to-face encounter within 24 hours of assigning it to a provider.

**A** Upon receipt of a written request for health care, it must be triaged within 24 hours and if the request describes a clinical symptom, a face-to-face encounter with a qualified health care professional must occur within 48 hours from receipt of the written request. The "clock" does not start over again after triage. Your question also refers to the need for the patient to be seen by a "provider," which is normally a physician or midlevel provider. The standard says that the encounter must be with a "qualified health care professional," which also includes nurses. Please see the glossary for a definition of who is considered qualified health care professionals.

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](mailto: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](http://www.ncchc.org).

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC's National Conference on Correctional Health Care, being held October 17-21 in Dallas.



UNIVERSITY OF  
**SOUTH CAROLINA**  
School of Medicine

### Infectious Disease Medical Director –SC Department of Corrections/USC Internal Medicine

USC School of Medicine seeks an Infectious Disease physician to serve as ID Medical Director for the SC Department of Corrections (SCDC) Broad River Correctional Institution/Kirkland facility with a clinical faculty appointment as Assistant/Associate Professor of Medicine. This is a clinical position responsible for directing inmate infectious disease health care delivery services for SCDC and coordinate ID education and training of medical providers serving in the SCDC correctional facilities in the state of South Carolina. This position reports to the SCDC Medical Director and the Asst. Deputy Dir. of Health Services for the SCDC. As a USC Dept. of Medicine faculty member, this position joins our innovative educational, clinical, and research programs in the infectious disease division.

#### SC Department of Corrections:

- Infectious Disease Medical Director – SCDC Broad River/Kirkland complex
- Provides the coordination of health care, medical treatment, and services for HIV-infected inmates.
- Supervises mid-level and clinical staff, medical students, residents and infectious disease fellows.
- Provides ID/HIV education and training of SCDC personnel and medical providers serving in the SCDC facilities across South Carolina.
- Provides inmate inpatient infectious disease consultation at the Broad River/Kirkland facility.
- Develop and implement infectious disease programs such as Antimicrobial Stewardship, Infection Control, Epidemiology, Telemedicine, and infectious disease treatment protocols.

#### USC School of Medicine:

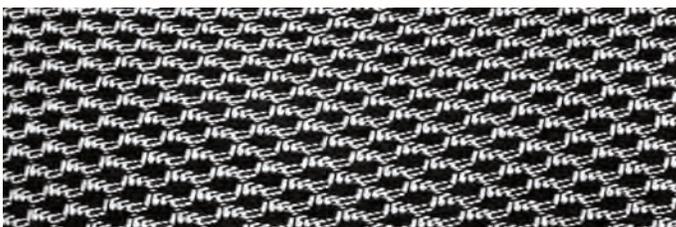
- Assistant/Associate Professor of Clinical Internal Medicine- Division of Infectious Disease
- Provide ID patient care including attending on inpatient teaching services at Palmetto Health Richland and outpatient clinic at USC Immunology Center, focusing on released inmates.
- Participate in research projects impacting quality and delivery of patient care, such as infection control, antimicrobial stewardship, HIV, and Hepatitis C.

Qualified applicants must have a MD degree, successful completion of accredited Internal Medicine Residency program and Infectious Disease Fellowship program, Board Certification in Internal Medicine and Board Certification or Board Eligibility in Infectious Disease, and be 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 Department of Medicine, 2 Medical Park, Suite 502, Columbia, SC 29203** or email at [shawn.chillag@uscmcd.sc.edu](mailto:shawn.chillag@uscmcd.sc.edu). The University of South Carolina is an AA/EOE employer.

**BECKY LUETHY, RN, MSN, CCHP**  
DIRECTOR OF OPERATIONS DEVELOPMENT  
28 YEARS OF EXPERIENCE



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