HINDSIGHT IS BITTERSWEET

Quality Improvement Studies as Evidence in Inmate Litigation

How to Recognize and Manage Neurological Diseases of the Aging

The Medical Risks of Chronic Alcohol Use

National Conference Preview
His opioid dependence got him here.

VIVITROL® (naltrexone for extended-release injectable suspension) is a nonnarcotic, nonaddictive, once-monthly medication indicated for:

- Prevention of relapse to opioid dependence, following opioid detoxification
- Treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with VIVITROL. Patients should not be actively drinking at the time of initial VIVITROL administration
- VIVITROL should be part of a comprehensive management program that includes psychosocial support

For additional Important Safety Information, please see Brief Summary of Prescribing Information on adjacent pages.
Now help him get on a path to treatment.

Learn more about the only once-monthly FDA-approved medication that when added to counseling may help him prevent relapse to opioid dependence after detoxification.1

Call: 1-617-852-7356
E-mail: GovernmentAffairs@Alkermes.com

Important Safety Information

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

Prior to the initiation of VIVITROL, patients should be opioid-free for a minimum of 7-10 days to avoid precipitation of opioid withdrawal that may be severe enough to require hospitalization.


Visit vivitrol.com to learn more about how VIVITROL can help.

INDICATIONS AND USAGE: VIVITROL is an opioid antagonist. VIVITROL should be part of a comprehensive management program that includes psychosocial support. Opioid-dependent patients, including those being treated for alcohol dependence, must be opioid-free at the time of initial VIVITROL administration. VIVITROL is indicated for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with VIVITROL. Patients should not be actively drinking at the time of initial VIVITROL administration. In addition, VIVITROL is indicated for the prevention of relapse to opioid dependence, following opioid detoxification.

CONTRAINDICATIONS: VIVITROL is contraindicated in: patients receiving opioid analgesics, patients with current physiologic opioid dependence, patients in acute opioid withdrawal, any individual who has failed the naloxone challenge test or has a positive urine screen for opioids, and patients who have previously exhibited hypersensitivity to naltrexone, polylactic-co-glycolide (PLG), carboxymethylcellulose, or any other components of the diluent.

WARNINGS AND PRECAUTIONS: Vulnerability to Opioid Overdose: After opioid detoxification, patients are likely to have reduced tolerance to opioids. VIVITROL blocks the effects of exogenous opioids for approximately 28 days after administration. However, as the blockade wanes and eventually dissipates completely, patients who have been treated with VIVITROL may respond to lower doses of opioids than previously used, just as they would have shortly after completing detoxification. This could result in potentially life threatening opioid intoxication (respiratory compromise or arrest, circulatory collapse, etc.) if the patient uses previously tolerated doses of opioids. Cases of opioid overdose with fatal outcomes have been reported in patients who used opioids at the end of a dosing interval, after missing a scheduled dose, or after discontinuing treatment. Patients should be alerted that they may be more sensitive to opioids, even at lower doses, after an episode of opioid discontinuation, especially at the end of a dosing interval (i.e., near the end of the month that VIVITROL was administered), or after a dose of VIVITROL is missed. It is important that patients inform family members and the people closest to the patient of this increased sensitivity to opioids and the risk of overdose. There is also the possibility that a patient who is treated with VIVITROL could overcome the opioid blockade effect of VIVITROL. Although VIVITROL is a potent antagonist with a prolonged pharmacological effect, the blockade produced by VIVITROL is surmountable. The plasma concentration of exogenous opioids attained immediately following their acute administration may be sufficient to overcome the competitive receptor blockade. This poses a potential risk to individuals who attempt, on their own, to overcome the blockade by administering large amounts of exogenous opioids. Any attempt by a patient to overcome the antagonism by taking opioids is especially dangerous and may lead to life-threatening opioid intoxication or fatal overdose. Patients should be told of the serious consequences of trying to overcome the opioid blockade. Injection Site Reactions: VIVITROL injections may be followed by pain, tenderness, induration, swelling, erythema, bruising, or pruritus; however, in some cases injection site reactions may be very severe. In the clinical trials, one patient developed an area of induration that continued to enlarge after 4 weeks, with subsequent development of necrotic tissue that required surgical excision. In the postmarketing period, additional cases of injection site reaction with features including induration, cellulitis, hematoma, abscess, sterile abscess, and necrosis, have been reported. Some cases required surgical intervention, including debridement of necrotic tissue. Some cases resulted in significant scarring. The reported cases occurred primarily in female patients. VIVITROL is administered as an intramuscular gluteal injection, and inadvertent subcutaneous injection of VIVITROL may increase the likelihood of severe injection site reactions. The needles provided in the carton are customized needles. VIVITROL must not be injected using any other needle. The needle lengths (either 1.5 inches or 2 inches) may not be adequate in every patient because of body habitus. Body habitus should be assessed prior to each injection for each patient to assure that the proper needle is selected and that the needle length is adequate for intramuscular administration. Healthcare professionals should ensure that the VIVITROL injection is given correctly, and should consider alternate treatment for those patients whose body habitus precludes an intramuscular gluteal injection with any of the provided needles. Patients should be informed that any concerning injection site reactions should be brought to the attention of the healthcare professional. Patients exhibiting signs of abscess, cellulitis, necrosis, or excessive swelling should be evaluated by a physician to determine if referral to a surgeon is warranted. Precipitation of Opioid Withdrawal: The symptoms of spontaneous opioid withdrawal (which are associated with the discontinuation of opioid in a dependent individual) are uncomfortable, but they are not life-threatening and can be managed safely. However, when withdrawal is precipitated abruptly by the administration of an opioid antagonist to an opioid-dependent patient, the resulting withdrawal syndrome can be severe enough to require hospitalization. Review of postmarketing cases of precipitated opioid withdrawal in association with naltrexone treatment has identified cases with symptoms of withdrawal severe enough to require hospital admission, and in some cases, management in the intensive care unit. To prevent occurrence of precipitated withdrawal in patients dependent on opioids, or exacerbation of a pre-existing subclinical withdrawal syndrome, opioid-dependent patients, including those being treated for alcohol dependence, should be opioid-free (including tramadol) before starting VIVITROL treatment. An opioid-free interval of a minimum of 7–10 days is recommended for patients previously dependent on short-acting opioids. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as two weeks. If a more rapid transition from agonist to antagonist therapy is deemed necessary and appropriate by the healthcare provider, monitor the patient closely in an appropriate medical setting where precipitated withdrawal can be managed. In every case, healthcare providers should always be prepared to manage withdrawal symptomatically with non-opioid medications and time. It is important to determine whether a patient has had an adequate opioid-free period. A naloxone challenge test may be helpful; however, a few case reports have indicated that patients may experience precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically recognized as a manifestation of opioid withdrawal, opioid withdrawal that is precipitated abruptly may lead to systemic sequelae including acute liver injury. Patients should be warned of the risk of hepatic injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of VIVITROL should be discontinued in the event of symptoms and/or signs of acute hepatitis. Patients should be monitored closely for evidence of liver injury, and if symptoms of hepatitis occur, VIVITROL should be discontinued. Any individual who has failed the naloxone challenge test or has a positive urine screen for opioids should be monitored for the development of depression or suicidal thinking. Providers should be aware of the potential for precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids. VIVITROL® (naltrexone for extended-release injectable suspension) 380 mg/vial Intramuscular
Patients taking VIVITROL may not benefit from naloxone or VIVITROL in pregnant women. VIVITROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Category C: Reproduction and developmental studies have not been conducted for VIVITROL. Studies with naltrexone administered via the oral route have been conducted in pregnant rats and rabbits. Teratogenic Effects: Naltrexone has been shown to increase the incidence of early fetal loss when given to rats at doses ≥30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). Labor and Delivery: The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. Nursing Mothers: Transfer of naltrexone and 6β-naltrexol into human milk has been reported with oral naltrexone. Because of the potential for tumorigenicity shown for naltrexone in animal studies, and because of the potential for serious adverse reactions in nursing infants from VIVITROL, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

ADVERSE REACTIONS: Serious adverse reactions that may be associated with VIVITROL therapy in clinical use include: severe injection site reactions, eosinophilic pneumonia, serious allergic reactions, unintended precipitation of opioid withdrawal, accidental opioid overdose and depression and suicidality. The adverse events seen most frequently in association with VIVITROL therapy for alcohol dependence (ie, those occurring in ≥5% and at least twice as frequently with VIVITROL than placebo) include nausea, vomiting, injection site reactions (including induration, pruritus, nodules and swelling), muscle cramps, dizziness or syncope, somnolence or sedation, decreased appetite or other appetite disorders. The adverse events seen most frequently in association with VIVITROL therapy in opioid dependent patients (ie, those occurring in ≥2% and at least twice as frequently with VIVITROL than placebo) were hepatic enzyme abnormalities, injection site pain, nasopharyngitis, insomnia, and toothache. Clinical Studies Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In all controlled and uncontrolled trials during the premarketing development of VIVITROL, more than 1100 patients with alcohol and/or opioid dependence have been treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. Adverse Events Leading to Discontinuation of Treatment: Alcohol Dependence: In controlled trials of 6 months or less in alcohol-dependent patients, 9% of alcohol-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 7% of the alcohol-dependent patients treated with placebo. Adverse events in the VIVITROL 380-mg group that led to more dropouts than in the placebo-treated group were injection site reactions (3%), nausea (1%), vomiting (1%), headache (1%), and suicidal behaviors (0.5%). In the placebo group, 1% of patients withdrew due to injection site reactions, and 0% of patients withdrew due to the other adverse events. Opioid Dependence: In a controlled trial of 6 months, 2% of opioid-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 2% of the opioid-dependent patients treated with placebo.

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

USE IN SPECIFIC POPULATIONS:

Pregnancy: There are no adequate and well-controlled studies of either naltrexone or VIVITROL in pregnant women. VIVITROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Category C: Reproduction and developmental studies have not been conducted for VIVITROL. Studies with naltrexone administered via the oral route have been conducted in pregnant rats and rabbits. Teratogenic Effects: Naltrexone has been shown to increase the incidence of early fetal loss when given to rats at doses ≥30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). Labor and Delivery: The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. Nursing Mothers: Transfer of naltrexone and 6β-naltrexol into human milk has been reported with oral naltrexone. Because of the potential for tumorigenicity shown for naltrexone in animal studies, and because of the potential for serious adverse reactions in nursing infants from VIVITROL, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and efficacy of VIVITROL have not been established in the pediatric population. The pharmacokinetics of VIVITROL have not been evaluated in a pediatric population. Geriatric Use: In trials of alcohol-dependent subjects, 2.6% (n=26) of subjects were >65 years of age, and one patient was >75 years of age. Clinical studies of VIVITROL did not include sufficient numbers of subjects age 65 and over to determine whether they respond differently from younger subjects. No subjects over age 65 were included in studies of opioid-dependent subjects. The pharmacokinetics of VIVITROL have not been evaluated in the geriatric population. Renal Impairment: Pharmacokinetics of VIVITROL are not altered in subjects with mild renal insufficiency (creatinine clearance of 50-80 mL/min). Dose adjustment is not required in patients with mild renal impairment. VIVITROL pharmacokinetics have not been evaluated in subjects with moderate and severe renal insufficiency. Because naltrexone and its primary metabolite are excreted primarily in the urine, caution is recommended in administering VIVITROL to patients with moderate to severe renal impairment. Hepatic Impairment: The pharmacokinetics of VIVITROL are not altered in subjects with mild to moderate hepatic impairment (Groups A and B of the Child-Pugh classification). Dose adjustment is not required in subjects with mild or moderate hepatic impairment. VIVITROL pharmacokinetics were not evaluated in subjects with severe hepatic impairment.

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

This brief summary is based on VIVITROL Full Prescribing Information (rev. July 2013).
The National Conference features the most comprehensive and highest quality educational programming in our field, designed to help correctional health professionals stay informed about important trends and manage the challenges they face. This year’s meeting offers a broad range of timely topics, engaging sessions and myriad opportunities to connect with colleagues.

October 17-21, 2015
Anatole Hotel, Texas

www.ncchc.org/national-conference
whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities.

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

Contents

Features

8 National Conference Preview
10 Position Statement: Optimizing Insurance Coverage Postrelease
13 Legal Affairs: Failure to Early Diagnose Inmate’s Broken Jaw: A Basis for Deliberate Indifference
16 Hindsight Is Bittersweet: Quality Improvement Studies as Evidence in Inmate Litigation
20 How to Recognize and Manage Neurological Diseases of the Aging
22 The Medical Risks of Chronic Alcohol Use
23 Five Principles of Patient Safety

Departments

6 NCCHC News: Introducing NCCHC Resources, Inc.
7 Chair Notes: Medical Autonomy
12 Spotlight on the Standards: Clinical Performance Enhancement
25 Journal Preview: Immunization Coverage Among Juveniles
26 Society of Correctional Physicians Adopts New Identity
27 Academy of Correctional Health Professionals Celebrates 15 Years
28 CCHP Page: Specialty Certification for Physicians
32 Standards Q&A

Our Independence Matters

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

The National Commission is pleased to announce the formation and launch of its nonprofit affiliate, NCCHC Resources, Inc. Leveraging NCCHC’s expertise in correctional health care, NRI provides customized education and training, preparation for accreditation and professional certification, performance improvement initiatives and technical assistance to correctional facilities interested in health care quality improvement.

“I am convinced that the decision to reach out to you for technical assistance is undoubtedly one of the best that I have made since my arrival.”
—Medical Director, Department of Youth Rehabilitation Services, Washington, DC

Why create a separate entity? Accredited and non-accredited facilities alike have long called upon the National Commission for help with evaluation, implementation or training on various aspects of correctional health care. Because these requests have increased significantly, the NCCHC board of directors realized that it would be best to remove this function from the accreditation department. This approach also mirrors that of other accrediting bodies.

Furthermore, as a separate organization focused solely on its mission of helping facilities achieve quality improvement, NRI can better serve its clients. NRI will put together a team of experts—clinicians, educators, administrators or other thought leaders—to address any sized project or challenge.

CHORDS Strikes a New Note
Given its emphasis on performance improvement, the Correctional Health Outcomes Resource Data Set is now a project of NRI. The project’s newest effort is CHORDS-QI, a collaborative effort that will enable correctional health care systems to participate in structured improvement programs on topics critical to meeting NCCHC standards and, in the future, disease-specific improvement.

A pilot program will inform the content for a full-scale collaborative that will kick off at NCCHC’s National Conference on Correctional Health Care. Facilities that enroll in CHORDS-QI will use a model for testing change to identify actions they can take toward improvement. As they achieve measurable change, participants will share tips, protocols and tools.

For more information on how NRI can help your facility, contact info@ncchcresources.org or 773-880-1460.

NCCHC Board Welcomes New AJA Liaison, Oscar Aviles
The National Commission on Correctional Health Care welcomes Oscar Aviles, CPM, CJM, CCE, CCHP, to its board of directors. Aviles serves as liaison of the American Jail Association. He replaces Peter Perroncello, MS, CJM, who retired from the board after 11 years of service.

Aviles is the director of the Hudson County (NJ) Department of Corrections, where he oversees all aspects of the Hudson County Correctional Center and Juvenile Detention Center.

“NCCHC is a major proponent of the need to monitor and improve the quality of inmate health care,” says Aviles. “Provision of quality care has been a vital component of the services we provide in Hudson County, and our commitment in this area is clear. As administrator of a major NCCHC-accredited jail, as well as a member of the boards of directors of both the AJA and the New Jersey County Jail Wardens Association, I feel that I bring a wealth of experience that I can further broaden while serving the NCCHC board in its crucial mission.”

Aviles’ appointment took effect April 12 during the NCCHC board meeting.

In Other News...
NCCHC has adopted position statements on two timely topics. A new statement on use of naloxone in correctional facilities is designed to save lives that otherwise might be lost to opioid overdose. A revised statement on transgender health care calls for correctional facilities to adopt policies that assure appropriate and responsible provision of care to this high-risk population. All position statements are available online at www.ncchc.org/position-statements.

Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 10-11</td>
<td>Correctional Health Care Leadership Institutes, Long Beach, CA</td>
</tr>
<tr>
<td>July 11</td>
<td>CCHP exam, Long Beach, CA</td>
</tr>
<tr>
<td>July 12-13</td>
<td>Correctional Mental Health Care Conference, Long Beach, CA</td>
</tr>
<tr>
<td>August 28</td>
<td>Accreditation Committee meeting</td>
</tr>
<tr>
<td>October 17</td>
<td>National Conference on Correctional Health Care, Dallas</td>
</tr>
<tr>
<td>October 18</td>
<td>CCHP exam, Dallas</td>
</tr>
<tr>
<td>October 18</td>
<td>Accreditation Committee meeting</td>
</tr>
</tbody>
</table>

For the complete list of CCHP exams, including regional exam sites, see www.ncchc.org/cchp.
The Importance of Medical Autonomy

by Patricia N. Reams, MD, MPH, CCHP

In April, I proudly participated in my daughter’s graduation from medical school. There was a bit of nostalgia as I remembered 40 years ago when her dad and I did the same thing. That led to some thinking about what has changed in medicine in the past 40 years. It occurs to me that practice in the free world has come to resemble correctional medicine of the 1970s in many ways.

An example of this is the practice of medical autonomy, which in the parlance of the National Commission means the freedom of a health care provider to act in a patient’s interest without interference from another authority. This is related to the physician–patient relationship, where two people and perhaps some family members make health care decisions. In corrections, interference can come from administrators, courts, etc. In the free world, we now see it from third-party payers and government regulators.

Early in my career as a corrections physician I was told by a facility superintendent to stop sending so many teens for X-rays after injuries. He said it was too expensive and he did not have the staff to accompany them. I was surprised. It was the first time my authority had been questioned so it never occurred to me to take it as an order. I went back to the superintendent for a discussion. This led to some discoveries that improved the system and the safety of the youth. We discovered that most injuries happened during basketball games with staff who were playing too competitively for the uncoordinated teens. The superintendent agreed to stop that practice and the injuries decreased significantly. We also contracted to have X-rays done in-house, saving the costs of hospital outpatient studies and staff time.

The Value of Discussion

The discussion was valuable. The result was that everyone involved was served, including the juveniles, the individual patients, the physicians, the administration and the taxpayers. It is my perception that in the free world this discussion is happening less frequently now. Insurance companies have become more aggressive with denial of care. Health care providers are too likely to acquiesce to the demands of the payers without argument.

I have seen this happening in corrections facilities, even those that are accredited. Examples include a physician who has been told that it is too expensive to do chlamydia testing on intake for people recommended for testing by the CDC guidelines; a nurse who is told that she cannot see an inmate in administrative segregation; a physician’s assistant who is told that he must participate in punitive measures for an unruly inmate. There are many instances where health care providers are asked to cross professional ethical boundaries. If they do it without question, they are not serving themselves, their patients or their profession.

NCCHC standards require administrative meetings to bring these issues to the forefront. I think the free world would be better served if such discussions were also required. I have found that when an insurance company medical director tries to interfere with care of my hospital patients, I can better serve the patient by bringing the medical director into treatment decisions.

It is certainly not wrong for administrators or insurance companies to question practices that interfere with their mission, such as controlling a budget. However, I submit that it is wrong for them to have the authority to dictate medical practices. There needs to be some balance to the power. Health care providers must align themselves with patients to serve their needs and desires.

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.
**Why Attend?**

- Targeted education and excellent networking with peers and experts from every segment of the correctional health care field: clinicians, administrators, staff and management
- Up to 32 hours of continuing education credit with 100 sessions and preconference seminars to choose from
- Comprehensive coverage of all aspects of correctional health care: chronic care, mental health, suicide prevention, oral health, crisis intervention, liability challenges, risk management and more
- NCCHC is the nation’s leader in correctional health care education, certification and accreditation. Learn from respected authorities with years of experience in health care delivery in jails, prisons and juvenile confinement facilities.

**Preconference Seminars**

Topical, informative seminars will help you stay up-to-date on critical issues facing the field. Maximize your education while you learn about NCCHC standards and other vital subjects. Earn up to 14 hours of additional continuing education. Registration to the conference is not required to attend these seminars.

**Saturday, October 17**
- 9 am - 5 pm
  - In-Depth Look at NCCHC’s 2014 Standards for Health Services in Jails
  - In-Depth Look at NCCHC’s 2014 Standards for Health Services in Prisons
  - In-Depth Look at NCCHC’s 2015 Standards for Mental Health Services
  - In-Depth Look at NCCHC’s 2015 Standards for Health Services in Juvenile Facilities

**Sunday, October 18**
- 9 am - 12:30 pm
- 1:30 pm - 5 pm
  - The Affordable Care Act and How It Will Affect Correctional Health Care
  - Principles for a Viable Suicide Prevention Program
  - Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care
  - Pain Management: Pharmacological and Clinical Considerations

**Registration Information**

Save up to $75 when you register by Sept. 9! Visit www.ncchc.org to register online or to download a form, or call at 773-880-1460.

- Regular: early-bird $445; Sept. 10-Oct. 9 $495
- One Day: early-bird $235; Sept. 10-Oct. 9 $275
- Preconference Seminars: $195 full-day, $99 half-day
- Guest Registration: $75 (exhibit hall events only)

To be considered preregistered, your registration with full payment must be received by Oct. 9. After this date, please register on-site. An on-site fee of $25 may apply.

Members of the Academy of Correctional Health Professionals receive a $45 discount on early, regular and on-site rates.

**Full Registration Includes the Following**

- A choice of 100 concurrent sessions – create a curriculum that meets your needs
- Opening ceremony and keynote address
- Educational luncheons
- Roundtable breakfast discussions
- Informative exhibits
- Exhibit hall reception
- Poster displays
- Breaks and refreshments in the exhibit hall
- Final program and session abstracts
- Online conference proceedings for download before and after the event
- Up to 32 hours of continuing education credit (includes preconference seminars)

**Continuing Education**

Up to 32 hours of CE credit may be earned in each category below. This maximum number includes credits offered at preconference seminars. See the Preliminary Program or conference website for details.

- CCHP
- Nurse
- Physician
- Psychologist
- Social Worker
- General

**A Prestigious, Landmark Hotel**

Set in the heart of Downtown Dallas, the Hilton Anatole boasts a stellar reputation for its first-class accommodations. And its location can’t be beat: The hotel is just minutes from the arts and entertainment districts of the West End and Deep Ellum.

A special conference rate of $174 is available through Sept. 24. To reserve online, see the Hotel tab at the national conference website, or call 214-748-1200; use Group Code NCH.

**KEY DEADLINES**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 9</td>
<td>Early-bird discount</td>
</tr>
<tr>
<td>Sept. 24</td>
<td>Hotel group rate</td>
</tr>
<tr>
<td>Oct. 9</td>
<td>Preregistration</td>
</tr>
</tbody>
</table>

**LEARN MORE**

www.ncchc.org/national-conference
They say everything is BIGGER in Texas!

And the 2015 National Conference on Correctional Health Care promises to be bigger and better than ever, with more than 100 concurrent sessions, 100 exhibitors, close to 2,000 colleagues and five days jam-packed with education and networking. Whether you’re a seasoned leader or a newcomer to the field, you’ll find valuable guidance, inspiration and new ideas at the National Conference. With sessions geared toward basic, intermediate and advanced levels of experience and knowledge, the National Conference delivers unparalleled education and professional development opportunities.

Not-to-be-missed educational sessions include:

- Clinical Challenges of Treating Juveniles and Young Adults in Adult Correctional Settings
- Contraception for Females in Custody
- Diagnostic Maneuvers You May Have Missed in Nursing School
- Diet, Diabetes and Dementia: What the Connections Tell Us About Treatment
- Escaping the Glass Ceiling:
- A Woman’s Role as a Leader in Corrections
- Jail Suicide Prevention: A Risk Management and Clinical Response
- Lateral Violence in Nursing: How to Prevent Bullying and Create a Healthy Work Environment
- Medicaid Enrollment: A Quality Improvement Approach to Improving Transitions for High-Risk Inmates
- Medication Misadventures: Managing the Slippery Slope
- Preventive Dentistry: A New Paradigm for Correctional Dentistry
- Rights of the Transgender Inmate
- Seeing Stars: Updates on Post-Concussion Syndrome
- Turning Sick Call Upside Down
- Understanding the Ties Between Cultural Literacy, Understanding and Patient Safety

Valuable Networking and Idea Sharing

The National Conference is the perfect place for networking. Scheduled coffee breaks, lunches and exhibit hall breaks are among the built-in networking opportunities conference attendees enjoy. Take advantage of these opportunities to learn how others are handling the challenges you face every day.

And be sure to take part in special gatherings such as the roundtable breakfast discussions on Wednesday morning, where colleagues will meet to talk about hot topics and emerging issues, seek advice and share insights. Open to all attendees, these special gatherings are a great way to start the day.

Discover Dallas — Where Big Things Happen

Dallas is the glitz and glamour of the South, equal parts humble and endearingly ostentatious. No matter where your home is, you can bet your boots it ain’t bigger than Dallas. The Big D combines the humble roots of a Wild West town with the stainless and glass shine of a major city. It’s always moving, bustling and whirring, but it also enjoys taking it slow.

Mix in a fascinating history, the best shopping in the South, a bustling art and music scene and moderate weather, add famous steakhouses, BBQ joints and Tex-Mex cuisine, and you’ve got a city not to be missed. Check out www.visitdallas.com for great ideas on what to do and see while you’re there.
Position Statement Calls for Optimizing Insurance Coverage Postrelease

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 can be viewed at www.ncchc.org/standards-resources.

Introduction
Most prison inmates and a large proportion of jail detainees and jail inmates lack health insurance, yielding worse health care access postrelease, disruptions in continuity of care for serious conditions, and worse health outcomes. Lack of insurance coverage postrelease, particularly for mental health and substance abuse services, increases the risk of re-arrest, resulting in a vicious, costly cycle of recidivism.

The Affordable Care Act creates unprecedented opportunities for improving health care coverage for correctional populations postrelease. Many inmates are eligible for coverage through Medicaid. Among states with expanded Medicaid, persons are eligible with household incomes at 138% of the federal poverty level. Expansion of Medicaid provides an historic opportunity to improve health insurance coverage for correctional populations postrelease, to improve access to needed medical and behavioral treatment, and potentially to reduce costly recidivism.

Many states continue to terminate Medicaid coverage for persons following arrest rather than suspending Medicaid coverage. Termination of coverage results in unnecessary delays in Medicaid reinstatement postrelease, hindering health care access. Termination also precludes jail detainees being counted under federal “meaningful use” incentives for health information technology. These incentive programs offer financial payments to providers who optimize their use of health information technology, including use of electronic health records. However, to qualify for these payments, at least 30% of patients in the population under care must be Medicaid eligible. Inmates whose Medicaid has been suspended rather than terminated may be counted as Medicaid eligible. Thus, suspending Medicaid rather than terminating coverage not only offers opportunities for improving care continuity for detainees but also offers a means to support electronic health records in jails and detention facilities.

Under provisions of the Affordable Care Act that took effect January 1, 2014, inmates with household incomes between 138% and 400% of the federal poverty level are eligible for subsidized private insurance through health insurance exchanges following release.

In contrast to Medicaid, private insurance coverage extends to pretrial detainees, meaning that health care provided during pretrial detention is potentially covered by the detainee’s insurance, providing another source of needed revenue for health care within these facilities.

Position Statement
NCCHC believes that optimizing health insurance coverage and continuity represents a vital means for improving health care for correctional populations.

Suspension vs. Termination of Medicaid Coverage
States should adopt policies that minimize termination of Medicaid coverage for jail detainees. Suspending rather than terminating coverage significantly expedites activation of Medicaid for the detainee upon release, thus improving continuity of care. Suspending rather than terminating Medicaid also allows the detainee to be counted for “meaningful use” requirements, allowing more jail health care facilities to qualify for payments for electronic health record systems.

Enrollment and Coverage in Private Insurance
When feasible, jails should assist potentially eligible jail detainees with enrollment in health insurance exchanges and develop systems for billing private insurance when possible, providing an additional revenue source for health care services in jails.

Discharge Planning
As part of early discharge planning, prisons should assist inmates with insurance application prior to release. Prisons should take advantage of federal funding for insurance navigators to facilitate this process. As part of early discharge planning for longer-term detainees and inmates, jails should assist them with insurance application prior to release. Discharge planning is often enhanced with partnerships with community organizations, including insurance navigators that provide in-reach into jails.
Think of our quality management program as 24-hour surveillance on risks, costs and compliance.

In this business, there’s no such thing as the “end of the day.” Wexford Health can help ease your workload with a Quality Management and Contract Compliance team that constantly focuses on ways to improve health care outcomes, increase efficiencies, and lower costs. So when you go home, you can feel good that we’re still hard at work for you. To learn more, visit wexfordhealth.com.
A clinical performance enhancement process is an important component of a correctional health care personnel development and training program. The 2014 editions of NCCHC’s Standards for Health Services for jails and prisons provide guidance for the successful incorporation of a clinical performance enhancement process into the correctional health care system.

**Annual Performance Evaluation vs. Clinical Performance Enhancement**

Before going any further, it is important to explain the difference between an annual performance review and a clinical performance review.

An annual performance review typically evaluates employees on areas such as punctuality, teamwork, attitudes, goals and so forth. These types of reviews may be conducted by an employee’s supervisor regardless of the credentials or profession of either the employee or the supervisor. For example, in some facilities, the health services administrator may be supervised and evaluated by a facility commander on these aspects of performance.

In contrast, a clinical performance enhancement review focuses only on the quality of the clinical care that is provided. This type of review should be conducted only by another professional of at least equal training in the same general discipline. For example, an RN should evaluate other RNs and LPNs, a physician should review the work of a physician and a dentist should review the work of a dentist.

Typically the reviews are done by the health care professionals who are also in administrative or supervisory roles, such as the director of nurses reviewing the nursing staff, or responsible physician reviewing other physicians and mid-level providers. If the supervisors also provide clinical care, they should be reviewed in this process, as well. This can be accomplished by a memorandum of agreement with an outside practitioner, by an outside group such as a medical school or hospital, or through the regional or corporate system.

If at any time in a review there is a serious concern with an individual’s competence, an independent review is initiated by the responsible health authority (RHA) and procedures are implemented to improve the individual’s competence.

**Who and When?**

The standard requires that the facility’s direct patient care clinicians and RNs and LPNs are reviewed annually. Direct patient care clinicians are all licensed practitioners who provide medical, dental and mental health care in the facility. This includes physicians, dentists, midlevel practitioners and qualified mental health professionals (psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for mental health needs of patients).

NCCHC recognizes that there are many other professions that have licensed practitioners (e.g., dental hygienists) who may be considered direct patient care clinicians. While it is good practice to include these professionals in the clinical performance enhancement process, technically it is not required by the standard.

**Components of a Review**

The standard requires that the clinical performance reviews incorporate at least the following elements:

- Name of the individual being reviewed
- Date of the review
- Name of the reviewer
- Credentials of the reviewer
- Summary of the findings and corrective action, if any
- Confirmation that the review was shared with the individual being reviewed (normally accomplished through signature of individual)

The standard is less specific on what other components should be included. Although a standardized review form is recommended, these forms may vary in content. When developing a form, keep in mind the intent of the standard, which is to enhance patient care through a peer review of the individual’s clinical practice. Therefore, reviews should look at areas most vital to patient care (e.g., sick call response, chronic care management, continuity of care, clinical skills, appropriate use of nursing assessment protocols, mental health care, dental care and other clinical areas as appropriate).

Finally, the standard requires the RHA to maintain a log or other written record listing the names of the individuals being reviewed and the date of their most recent review.

**Designed to Enhance Competence**

In summary, a clinical performance enhancement review process is neither an annual performance review nor a clinical case conference. It is a professional practice review focused on clinical skills and is designed to enhance competence and to address areas in need of improvement.

Tracey Titus, RN, CCHP-RN, is NCCHC’s manager of accreditation services. If you have a question about the NCCHC standards, write to accreditation@ncchc.org. Find the complete Spotlight series at www.ncchc.org/standards-explained. For in-depth instruction on all of the standards, attend one of the preconference seminars at the National Conference on Correctional Health Care (see page 8).
Failure to Early Diagnose Inmate’s Broken Jaw: A Basis for Deliberate Indifference

by Fred Cohen, LLM

There are some correctional health care decisions that not only are interesting in some fashion but also are wonderful for didactic purposes. Perry v. Roy, ___ F.3d___ (1st Cir. 2015), is one such decision.

The defendants prevailed in the district court on their motion for summary judgment. The district court judge, in a word, found that the complaint did not allege facts that amounted to deliberate indifference. On review, the First Circuit strenuously disagreed, reversed and remanded for further proceedings.

Facts

On Saturday, June 9, 2007, at approximately 1:10 a.m., while Perry was being booked into the Bristol County, Massachusetts, facility following transfer from another correctional center, a fight broke out between him and several correctional officers. During the course of this incident, the officers caused serious injuries to Perry.

Within five minutes of this altercation, according to the complaint, Perry was evaluated by Nurse Roy, who asked him about his injuries. Perry swears that his mouth was “pouring blood” from a long gash, his jaw was “clenched” and he had a lump on his head. Although he could barely talk, Perry was able to tell Nurse Roy that he was in pain and that his jaw was broken. He claims further that Nurse Roy did not “thoroughly examine” him, nor did she ever “come to focus on his jaw.” Nurse Roy did, however, observe and diagnose a cracked tooth, clean the open wound, provide Perry with gauze, rinse his mouth with saline water and advise Perry to obtain a sick slip for the tooth to enable him to see a dentist, who would be available the following Tuesday, June 12. He was not given ice or aspirin for his pain, although he had on occasion released patients with broken jaws back to a stable home environment, he did not release Perry back to the Bristol County House of Correction in part because “[w]ith an injury this significant, with the amount of force required to fracture the mandible and have a laceration in the base of his mouth, waiting 20 hours to bring him in for medical attention, I didn’t know that he would receive appropriate attention.” Instead, Perry underwent surgery at MGH to repair the mandibular fracture. Dr. Fuerman also testified that Perry’s injuries as “critical injuries” caused by the use of a “tremendous amount of force.”

At around 4:10 a.m., he complained to a second attending nurse, Nurse Rocha, that he had been beaten by correctional officers and had an untreated broken jaw. Perry renewed his requested to be taken to a hospital. Nurse Rocha examined Perry through a glass window for less than a minute and noted that Perry had an “egg” on his forehead. Although Rocha initially said she would help him, her willingness to help ended after she spoke to Lt. Shubert, who had been involved in the incident where Perry was hurt. Perry claims that the officer asked her to let Perry “sleep it off.” Thereafter, Nurse Rocha denied all further care.

Perry does concede that Nurse Rocha told Lt. Shubert that she did not believe he had a broken jaw. Nurse Rocha claims that, despite Perry telling her that he had a broken jaw, he denied having any pain at that time. Finally, Nurse Rocha entered a note for someone to notify the medical unit if Perry began to suffer from nausea/vomiting or vertigo.

At approximately 5:30 p.m. to 6 p.m. that same day—17 hours after the beating—Perry was examined again, this time by a third nurse, due to his complaint of jaw pain and shortness of breath. Perry had developed swelling of the jaw and also some wheezing. This resulted in his immediate transfer to St. Luke’s Hospital, where, within two hours of his arrival, he was diagnosed with an acute bilateral mandibular fracture. The attending physician, Dr. Fuerman, also noted tenderness and swelling on Perry’s forehead, jaw, neck and cervical spine as well as bilateral shallow breath and bilateral rib pain. He classified Perry’s injuries as “critical injuries” caused by the use of a “tremendous amount of force.”

Perry was transferred to Massachusetts General Hospital because neither the attending physician nor any member of the St. Luke’s medical staff was qualified to treat Perry’s severe mandibular fractures. Dr. Fuerman testified that, although he had on occasion released patients with broken jaws back to a stable home environment, he did not release Perry back to the Bristol County House of Correction in part because “[w]ith an injury this significant, with the amount of force required to fracture the mandible and have a laceration in the base of his mouth, waiting 20 hours to bring him in for medical attention, I didn’t know that he would receive appropriate attention.” Instead, Perry underwent surgery at MGH to repair the mandibular fracture. Dr. Fuerman also testified that Perry required “critical care” when he arrived at the hospital and that he spent 60 minutes caring for Perry.

continued on page 14
Broken Jaw  (continued from page 13)

The District Court
The district court found that the plaintiff did receive some treatment and that obtaining hospital-level care within 17 hours seems reasonable. Further, the defendants provided the care they believed to be appropriate and that, he ruled, negates any claim of culpability.

The First Circuit
As for the initial constitutional requirement of a “serious condition,” the court finds that given the force involved in the altercation, and accepting Perry’s version of his symptoms as presented to the nurses (a clenched jaw that would not open fully and was causing pain sufficient for him to announce that he thought it was broken), a layperson could find it obvious that the nurses should at least have examined the jaw.

That simple finding—should have examined the jaw—actually speaks volumes. That is, deliberate indifference requires actual acknowledge of the risk that either was ignored or improperly dealt with. Here, the defendants appear to claim that based on what they saw and came to believe, there was no broken jaw that called for a response. There were injuries, yes, but nothing that appeared to be serious.

The reviewing court, in effect, finds that the inmate’s claims are credible at least to support the need for further medical evaluation. Indeed, to hold otherwise simply invites custodial staff to curtail their investigations of need (or diagnoses). This is not some invisible condition or disorder that goes under the obviousness radar. It is a claim, soon to be verified, of a serious injury consistent with an earlier physical confrontation.

Deliberate Indifference
The court notes that there are a number of factual issues in dispute that could lead to a supportable finding of deliberate indifference. Those disputed facts include whether Perry was barely able to speak or open his mouth since his first evaluation by Nurse Roy; whether Perry stated that he had a broken jaw and requested to go to the hospital; whether these facts, together with the gash, pain and bleeding, amounted on their own to a serious medical need; whether, if such complaints were in fact made, mere cursory inspection of Perry’s tooth—without any inspection of his jaw—was sufficient to justify postponing any treatment of the broken jaw given the other injuries to Perry’s mouth and face that were clearly present; whether Perry asked again to go to the hospital when Nurse Roy woke him up with smelling salts after passing out; whether Nurse Rocha said she would help him but then denied further treatment after talking to Lt. Shubert, who asked her to let Perry “sleep it off”; whether, despite having a broken jaw, Perry denied having any pain at all times as claimed by appellants; and whether the medical need may have been one that was so obvious “that even a layperson would easily recognize the necessity for a doctor’s attention.”

That the condition worsened over time does not mean it was not serious at the earlier time when a medical evaluation should have been done. The detriment caused by delay certainly is an open question. The wait-and-see approach taken by staff appears to be based on no thorough examination and the litigation deserves to go forward.

Comment
The really crucial takeaway here relates to the absence (or delay, if you will) of a thorough examination. Not every set of facts will support this as deliberate indifference, but given the altercation and plaintiff’s complaints and physical appearance, the need to do some sort of visual/manipulation exam seems clear.

The ultimate seriousness of the medical condition is demonstrated by the MGH diagnosis. The deliberate indifference relates to the delay in diagnosis and care.

Fred Cohen, LLM, is the executive editor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2015 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.
For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528, 609-683-4450; www.civicresearchinstitute.com.
Not all correctional healthcare providers are the same.

As the correctional healthcare pioneer and leader for 35+ years, Corizon Health provides client partners with high quality healthcare at an affordable cost. We are a company built on innovation and expertise. Our people, practices and commitment to constant improvement enable us to meet and exceed client expectations.

Hindsight Is Bittersweet: Quality Improvement Studies as Evidence in Inmate Litigation

by Jana Brady, JD, Theresa Powell, JD, and Keith Hill, JD

There is inherent value in continuing quality improvement studies (QIS) insofar as they shed light on what affects health outcomes and, consequently, allow providers to improve on health care efficacy and efficient use of resources. Critical to the success of QIS is fostering an environment where providers are able to speak candidly about what occurred and in assessing their own conduct as well as the conduct of their peers. To encourage the use of QIS, all of the states except for New Jersey have enacted legislation that makes QIS, also referred to as peer review, material privileged so long as the statutory provisions are strictly complied with.

These laws benefit health care providers as defined therein by protecting both the process and documents generated by peer review from being admitted or even discovered in subsequent litigation. This protection may be limited to state court proceedings. Claims against correctional health care providers, however, are often litigated in federal court. Consequently, claims filed pursuant to Section 1983—the statute that provides for the private enforcement of federal constitutional rights—may not be privileged, that is relevant to the claim or defense of any party ...” Evidence is relevant if it has the tendency to make a fact more or less probable than it would be without the evidence, and the fact is of consequence in determining the action. “Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence.” Plaintiffs’ attorneys will likely argue that discovery of peer review documents should be permitted, absent a privilege, because they are vital to uncovering facts necessary to prove their case.

Assertions of evidentiary privilege in federal court are governed by Federal Rule of Evidence 501, which requires application of federal privilege law to each element of a claim except those where state law “supplies the rule of decision.” Put another way, federal privileges apply to federal law claims (e.g., violations of civil rights) and state privileges apply to claims arising under state law (e.g., medical malpractice). When there are federal law claims in a case also presenting state law claims, the federal rule favoring admissibility, rather than the state law privilege, is the controlling rule.
**Ninth Circuit**

In *Leon v. County of San Diego*, 202 F.R.D. 631 (S.D.Cal. 2001), the plaintiff sued the county, the sheriff’s department and the sheriff for alleged medical malpractice and violations of the civil rights of an inmate who died while in custody. The discovery dispute involved the plaintiff’s request for two binders contained in the nurses’ station at the detention facility entitled “peer review” and “weekly unit meetings.” The defendants responded that the requested documents were irrelevant and privileged under California’s peer review law, California Evidence Code §1157.

California’s peer review law says, in relevant part, “Neither the proceedings nor the records of organized committees of medical ... staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code ... shall be subject to discovery.”

In making the threshold determination of whether the requested documents are relevant, the court noted that to prove municipal liability under Section 1983, the plaintiff must show that the unconstitutional deprivation of rights arose from a governmental custom, policy or practice. In concluding that the plaintiff’s discovery request was relevant, the court found that the nurses’ review of the level of care they provide to inmates may reveal a custom, policy or practice of the municipality as well as levels of training provided to the nurses.

Although the court recognized that the California peer review law represents an important policy objective, the court declined to recognize it in the case before it. The court reasoned that it made no sense to permit state law to determine what evidence is discoverable in a case brought against state actors for abuse of power.

**Eleventh Circuit**

In *Jenkins v. DeKalb County*, 242 F.R.D. 652 (N.D.Ga. 2007), the plaintiffs brought an action under Section 1983 against a county and jail officials, alleging violations of civil rights surrounding the death of an inmate. The discovery dispute arose from a postdeath “mortality and morbidity” report prepared by an employee of a correctional health care company. The defendants argued that the report was privileged under Georgia’s peer review law, which says, in relevant part, “The proceedings and records of a review organization shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action ...” (Ga. Code Ann. §31-7-133(a)).

In declining to apply Georgia’s peer review law, the court found that the inherent difficulty of discovering evidence of a jail’s practice and customs in a civil rights case rooted in a death of an inmate dramatically weakens the case for recognizing the privilege. According to the court, a review of a deceased inmate is not the straightforward evaluation of medical care that occurs in the civilian context. The generation of postdeath reports may include details such as when jail officials notified medical officials of a particular problem and whether there was a reason for nonmedical officials to have monitored the situation more closely. The court stated that not only is this type of information “nonmedical,” but it also may shed light, or at least raise an inference, on jail customs or policies.

**Seventh Circuit**

In *Belbachir v. County of McHenry*, 2007 U.S. Dist. LEXIS 53727 (N.D.II. 2007), after the suicide death of an inmate, the plaintiff sued, among others, the company that provided health care services to the jail for violations of civil rights. After the inmate died, the correctional health care company conducted a “core team meeting” where attendees discussed the chronology of events leading up to the inmate’s death and the policies and procedures that were employed by the company and the jail. Subsequently, the company conducted a “root cause analysis” meeting where attendees looked into the circumstances of the inmate’s death and formulated various proposals to prevent this type of event from recurring. The plaintiff requested documents from the defendant, and the defendant claimed that certain documents were privileged under Illinois’ peer review law.

Illinois’ peer review law says, in relevant part: “All information, interviews, reports, statements, memoranda ... or other data of ... committees of licensed or accredited hospitals or their medical staffs ... used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care ... shall be privileged ...”

In deciding whether to apply Illinois’ peer review privilege, the court balanced the need for truth against the policy underlying the peer review privilege. On the need for truth side of the scale, the court noted that information related to the defendant’s policies and practices was critical to the plaintiff’s claim, and difficult to expose. On the other side of the scale, the court recognized the important policy considerations of the peer review privilege, including the free flow of information between health care professionals resulting in higher quality of care. Ultimately, however, the court was convinced that, in the context of a federal civil rights action brought about by the death of an inmate, the need for truth in rooting out unconstitutional state action outweighed any concern over a chill placed on the peer review process.

**Practice Tips**

The seemingly inconsistent manner in which the courts have applied QIS privilege laws will likely continue until Congress and the state legislatures enact legislation that is unique to correctional settings. Until then, you can build effective health care systems through the use of QIS without creating, or at least minimizing, evidence that might be used against you in inmate litigation by adopting the following practices:

- When documenting areas of concern, use generic factual descriptions such as “there were two medication errors this month” rather than “Nurse Sally committed malpractice at least twice again this month.” [continued on page 18]
Litigation (continued from page 17)

• Peer review efforts should be led by medical providers who are knowledgeable about the areas of medicine under review and would be qualified to testify in court about the case—if it gets that far. Otherwise, you may be left with unsupported speculation that may be admissible as evidence even if unfounded. Also, consider an external reviewer for an unbiased consult who might have something different to add or suggest.
  • If a minority opinion is asserted, document that it was considered and why the medical literature, policies and procedures or facts favor a different conclusion.
  • Consider limiting those involved in QIS efforts and limiting recipients of QIS materials because you may be waiving a privilege by disclosing QIS materials to someone who is not covered under your state’s QIS law.
  • Remove protected health information—that is, any information that can be linked to a specific individual—from the case being reviewed.
  • QIS policies should be written so that they mirror your state’s QIS laws to the extent possible and those policies should be consistently followed and enforced. Floodgates open the moment you treat one patient’s case differently.
  • Establish a document retention policy concerning personnel and disciplinary records that is consistent with the employment laws in your state and consistently apply that policy. Employers often maintain disciplinary records even though they are not legally obligated to, and those records might come in as evidence against them.
  • However, be careful not to destroy evidence about a case that you know or reasonably should know might lead to litigation as you may then be sued for spoliation of evidence.
  • Do something educational and productive with your QIS findings, such as making recommendations regarding policies and procedures that might avoid a similar result, as opposed to merely gathering statistics or using it as a confrontational tool to vent frustrations.
  • To ensure continuity and quality of care, arbitrarily pull charts to review instead of reviewing only the cases with bad outcomes.

Jana Brady, JD, Theresa Powell, JD, and Keith Hill, JD, work for Heyl Royster, based in Illinois.

Brady is a partner in the Rockford office and defends correctional health care professionals, sheriffs, correctional officers and police officers who are sued by inmates.

Powell is the managing partner of the Springfield office and defends civil rights claims filed by inmates in the Illinois Department of Corrections and the clinical psychology facilitators at the State of Illinois sex offender treatment facility.

Hill is of counsel in the Edwardsville office and advises governmental entity clients on state and federal civil rights law and litigates claims brought under state and federal constitutions and other civil rights statutes.

Exceptional Careers in an UNEXPECTED PLACE

California Correctional Health Care Services has great opportunities for you at multiple locations throughout California. We are seeking dedicated and compassionate individuals to provide efficient, quality care to our diverse inmate-patient population.

You will enjoy a rewarding career in correctional medicine. We offer work-life balance with generous paid time off, a 40-hour work week, and paid insurance/license/DEA. Our competitive compensation package includes great salary, fantastic benefits, and retirement that vests in just five years.

Nurse Practitioner
$110,940* starting annual

Physician Assistant
$110,400* starting annual

Physician & Surgeon (IM/FP)
$240,456* starting annual (Lifetime Board Certified)
$253,140* starting annual (Time-Limited Board Certified)

Staff Psychiatrist
$233,196* starting annual

*A salary increase for FY 15/16 is anticipated for these classifications.

For more information or to apply online, please visit www.ChangingPrisonHealthCare.org
MedCareers@cdcr.ca.gov or 1.877.793.HIRE (4473)
Beyond a reasonable doubt...

Medi-Dose® and TampAlerT®

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They’re tamper-evident, ultraviolet inhibitant and minimize errors and pilferage. **Plus Medi-Dose contains no metal or glass!**

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitant polyethylene, with either regular or child-resistant screw caps. **Each cap contains a tamper-evident seal. And TampAlerT contains no metal or glass!**

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

**There’s no doubt about Medi-Dose and TampAlerT, proven in correctional facilities for over 30 years.**

**Medi-Dose, Inc.**

EPS®, Inc.

Responding to pharmacy packaging needs around the world

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.medidose.com
E-mail: info@medidose.com
How to Recognize and Manage Neurological Diseases of the Aging

by Kori Novak, PhD, MBA

Charles had never been a difficult inmate. Always collegial, rarely loud and never in scuffles with other men. But lately, he was different. Constantly complaining that his “thumb doesn’t work right” and it was “lazy.” Security staff first thought he was joking but soon became annoyed with the constant complaint. As the weeks went by, Charles became more vocal and aggressive about his complaint; at one point, he was yelling, causing a scene and demanding a visit to the infirmary.

Instead of the infirmary visit, however, Charles got a write-up and a visit by a mental health professional. During an interdisciplinary team meeting, the mental health professional made a few remarks about the case. The nurse in attendance suggested that Charles indeed be sent to the infirmary, just to be sure. She had a hunch.

The astute nurse was correct. After several tests, including an expensive lumbar puncture, Charles was diagnosed with amyotrophic lateral sclerosis, or ALS. The “laziness,” as Charles called it, or lack of strength in the extremities, can be an early sign of motor neuron disease. However, in our population, the complaint of a “lazy” hand or “floppy” feet is often viewed with skepticism.

As the population grays, however, it is important that administrators and staff understand that these complaints may not be attention-seeking games or ploys to get out of general population. In fact, it is essential that as a correctional health care community we begin talking about and preparing staff to identify early signs of aging diseases so that we can provide appropriate care and sometimes protection for these individuals. Moreover, training staff to understand the differences between aberrant behaviors and aging diseases is essential to the correct diagnosis and treatment of these often debilitating diseases.

With the deinstitutionalization of mental health patients in the 1980s, the United States essentially turned prisons into inpatient mental hospitals. Currently, with stricter sentencing laws in place and trends seeing offenders coming into the system at older ages, the United States is turning correctional facilities into nursing homes. Through trial and error over the years, correctional professionals have learned to “spot diagnose” mental illness. In other words, security staff and administrators often recognize the signs of mental illness, which leads directly to proper evaluations by mental health professionals. However, many facilities find themselves unprepared to deal with the special issues, both physical and psychological, that often accompany geriatric and aging inmates.

Dementia Behind Bars

When the discussions turn to neurological age-related disease, most people think of dementia and Alzheimer’s disease. In 2010, 41,470 inmates were documented as having some form of dementia, and this omits the unknown cases. The numbers are projected to rise to the 130,000-plus range by 2050. That, of course, assumes that there is predictable annual growth of inmates in the system. We know that the growth of the inmate population is anything but regular and predictable; thus, these number skew to the very conservative side. This being the case, one can understand the need to gain a basic understanding of these diseases.

Many individuals think that dementia is the early stage of Alzheimer’s disease and that all neurological diseases that encompass memory loss lead to Alzheimer’s. However, the diagnosis of “dementia” is much like the diagnosis of “cancer” in that the disease has a single name, but many different manifestations. Alzheimer’s is one manifestation of dementia. While there are many unique forms of dementia, we will examine the five most common types that are seen in the incarceration setting.

Lewy body dementia is often mistaken for aberrant behaviors in incarceration facilities. Much of this is due to an earlier onset of symptoms, which can include insomnia, hallucinations, movement disorders, difficulty regulating body function, confusion and disorganized speech. In a prison setting these symptoms can manifest in individuals as young as 35. At this age, rarely do even medical personnel consider degenerative neurological diseases as an initial cause of behavioral changes. However, if staff notice two or more of these symptoms, particularly hallucinations if the inmate has never had these before, the inmate should be checked for Lewy body dementia.

Korsakoff syndrome or amnestic-confabulatory syndrome can manifest at any age and is typically tied to severe alcoholism/alcohol abuse or severe malnourishment. There are multiple factors that may increase an individual’s risk for development of Korsakoff syndrome. These include extreme dieting, dialysis and chemotherapy, as with many neurodegenerative diseases, age and genetic factors are also considered common factors. The disease manifests in ways that mimic general aberrant behaviors, such as minimal content in conversations, invention of memories to cover gaps in memories (which is often seen as simple lying), severe loss of memories prior to the onset of the condition and, most closely tied to this form of dementia, apathy (losing interests or being indifferent to changes surrounding or including them). It can be difficult to determine whether the inmate is being difficult or has the condition. Knowing your population and noticing unusual changes in behaviors.
is the best red flag for this syndrome.

Vascular or multi-infarct dementia occurs when the inmate has small strokes that kill brain tissue. This dementia can manifest at any age, but tends to be in the 50+ range for incarcerated individuals. While these small strokes can occur for multiple reasons, they are often caused by hypertension. The onset is typically quite rapid. Symptoms can include severe headache (during onset), memory loss or "cloudiness," apathy, lack of attention, urinary incontinence and difficulty with spatial orientation.

Senile dementia is most associated with aging and primarily manifests after age 65. It has a gradual onset and is hallmarked by a decline in spatial or temporal orientations. There is also a decline of basic skills, such as dressing and feeding oneself. Senile dementia is often to "blame" by laypeople for forgetfulness or lack of basic abilities. However, it is important to keep in mind other symptoms, particularly in the incarcerated population. Senile dementia is not often confused with aberrant behaviors, but often blamed as the cause for them. Unfortunately, many people think this is part of normal aging, and thus proper medical attention and therapies are not introduced.

Alzheimer’s disease is the number one disease associated with dementia and dementia-related deaths. It typically manifests in older ages, but early onset is becoming increasingly diagnosed. For the incarcerated population this can come as early as 40 years old. Alzheimer’s disease manifests in the initial loss of short-term memory and ultimately the loss of all memory; this includes muscle memory, which ultimately leads to death. Plaque in the brain causes tangles that interfere with receptors that tell the body how to function. Often Alzheimer’s weakens the body to the point where other illnesses, such as pneumonia, set in and become the cause of death.

Beyond dementias, there are other equally devastating and costly diseases that affect the inmate population. These include Parkinson’s disease, which manifests with speech impediments, tremors in appendages and stiffness in joints. Parkinson’s disease typically leads to a loss of all motor control, which leaves the inmate wheelchair bound and needing care for all daily needs such as toileting and feeding.

Differentiating Behaviors

There are a number of red flags that can help nonmedical staff and administrators to quickly differentiate between aberrant behavior and aging diseases. (See box at right.) But many of these red flags can look the same as general difficult behaviors or mental illness. So how can the average security staff member or administrative professional who is not medically trained understand the differences between these telltale symptoms and inmates who are just difficult?

1. Know your inmate population. Trusting your gut is key to making the right decisions in the incarceration environment. It is also true when making snap behavioral analyses. If your security staff knows an inmate, and his personality suddenly changes or there is a distinct change in habits, something neurological may be awry.

2. Exercise patience and flexibility. Good judgment is also necessary when working with this population. If an inmate is struggling with something she has never struggled with in the past, exhibiting patience and watching her demeanor will help you judge if she is having an off day, or if she is struggling with a medical issue.

3. Administrators: Listen to your security staff. They often see the inmates on a daily basis and know them the best. If your staff bring up a potential issue in a meeting or to your offices, don’t dismiss it. Remember: Your security professionals have the benefit of daily contact and knowing daily habits and when there might be unusual changes.

Once a potential issue is identified, there are several easy ways to put your theory to the test. By using these means of identification, an individual can determine if there is need to further address the issue. Of course, these are not the totality of definitive tests and should be used only as helpful additional indicators.

• Look for specific traits of neurological distress such as putting shoes or clothes on backward or forgetting how to do basic tasks such as tying shoelaces, zipping zippers or using eating utensils.

• Ask the inmate to look at an analog clock and tell you the time. This is often a good indicator as most neurological diseases have some manifestation of numerical or spatial disorientation.

• Ask questions about the inmate’s day, morning or occurrences within the last two days. Then ask about occurrences from five or 10 years ago. If the inmate has significant trouble with these memories, or lies about them, he may have a neurological disorder.

Supportive Care

Once inmates have been identified with degenerative neurological diseases, there are a number of positive responses that can be taken to help with their care. It is important that they are closely watched as the disease progresses so that they are not victimized by others due to their diminishing capacity.

• Good lighting. Putting diagnosed inmates in cells with access to good lighting or sunlight may drastically reduce the incidence of sundown syndrome as well as help them adjust as the disease progresses. While for some it can be a frightening time, for others the consistency of dawn and dusk can be a comfort.

• Access to outdoor facilities. Often when individuals are diagnosed with degenerative neurocognitive disease, our first reaction is to keep them inside to decrease wandering or outside dangers. However, in a controlled setting, being outdoors helps to stimulate brain function.

• Purposeful programming with memory skills. Providing group settings with activities that include memory games or memory skills is important for determining decreasing

continued on page 27
The Medical Risks of Chronic Alcohol Use

by Susan Laffan, RN, CCHP-RN, CCHP-A

The many harms that result from alcohol abuse have been well documented. The Centers for Disease Control and Prevention reports “88,000 deaths and 2.5 million years of potential life lost each year in the United States from 2006 to 2010, shortening the lives of those who died by an average of 30 years.”

Furthermore, a 2010 report by CASAColumbia states that “America’s prisons and jails are rife with addiction and substance abuse.” As correctional health care providers, we need to be on the lookout for those individuals who may experience not only withdrawal symptoms shortly after arrival to a correctional facility, but also the other medical and mental health conditions that may be present. The key to preventing progression of chronic conditions is to recognize that the condition is present and to provide early treatment and reevaluations. This article describes common conditions related to alcohol use as well as the chronic physical effects that should be evaluated.

Conditions of Concern

Chronic alcohol use may cause anemia affecting the hematologic system made of blood, spleen, bone marrow and liver, causing low red blood cell counts. Symptoms include fatigue, shortness of breath and lightheadedness.

Alcohol can increase the risk for developing cancer. The body converts the alcohol into acetaldehyde, a known carcinogen. The most common areas for cancer development include the mouth, throat, liver and colon.

Cardiovascular disease may develop if the alcohol raises the levels of triglycerides, causing heart disease or stroke.

Alcohol causes inflammation of the liver and can cause scarring of liver tissue that can lead to cirrhosis. The risk increases with longer duration of use. It seems to run in families and women get it more often than men.

Alcohol affects the brain and can lead to memory loss and symptoms of dementia. Heavy alcohol use over a long period of time may cause Korsakoff syndrome, where people suffer short-term memory loss.

Alcohol abuse is often linked to depression. In some cases people are depressed and use alcohol to self-medicate.

Heavy or binge drinking, along with alcohol withdrawal, can lead to status epilepticus, a prolonged epileptic seizure and a life-threatening condition.

Gout is caused by the formation of uric acid crystals in the joints. Alcohol intake may increase the risk of developing gout, particularly in men. Beer seems to cause the condition more than other types of alcohol.

High blood pressure can become chronic and can lead to other medical conditions, including heart disease, stroke, kidney disease and acute hypertensive episodes.

Alcohol use can weaken the immune system and make it more susceptible to infections such as tuberculosis, pneumonia, HIV/AIDS and sexually transmitted diseases.

Alcoholic neuropathy is nerve damage caused by the combination of alcohol being toxic to nerve cells and poor nutrition. Symptoms include numbness, tingling, pain, muscle weakness and loss of bladder and bowel control.

Alcohol may cause inflammation of the pancreas, with symptoms such as acute abdominal pain, nausea and vomiting, and may lead to poor absorption of nutrients and changes in insulin production, leading to diabetes.

Body System Signs and Symptoms

Alcohol acts as an irritant to the body and may cause serious physical harm to any or all of the body systems. If signs and symptoms are recognized, evaluated and diagnosed early, many people can avoid more serious medical complications and conditions. The signs and symptoms to look for can be broken down into body system categories.

First is the person’s general appearance; the signs to look for include hand tremors, excitability, irritability, nervousness, rosacea, swelling of the parotid gland, finger clubbing and rhinophyma (“drinker’s nose”). Jaundice is a late sign, seen when there is already liver damage.

Signs and symptoms related to the gastrointestinal tract may include dyspepsia (a general feeling of discomfort after eating), nausea and vomiting, recurrent diarrhea, recurrent abdominal pain, acute and chronic episodes of pancreatitis, hypoglycemia or hyperglycemia, GI bleeding and liver diseases such as alcoholic hepatitis, cirrhosis and ascites.

In the cardiovascular system, signs and symptoms can include palpitations, cardiomyopathy, anemia, dilatation of blood vessels and body temperature regulation.

The respiratory system can be affected by chronic obstructive airway disease, by killing the alveoli and by recurrent chest infections such as bronchitis and pneumonia.

In the central nervous system, the impact is on neurons, with signs and symptoms including short-term memory impairment, blackouts, seizures, peripheral neuropathy, ataxia, insomnia or nightmares, hallucinations and, in the late stage of alcohol withdrawal, delirium tremens. Wernicke syndrome, which is injury to the brain stem and areas near the third and fourth ventricles of the brain, may result in diplopia, hyperactivity and delirium. Korsakoff psychosis is caused by chronic brain damage caused by thiamine deficiency; where the sludging of dead red blood cell components in small capillaries results in cell and tissue destruction due to hypoxia, causing symptoms of disorientation, delirium, memory loss and confabulation (a hallmark sign where the person makes up elaborate stories to cover memory loss or to fill in holes in the memory).

When addressing the musculoskeletal and genitourinary systems, the signs and symptoms to be aware of include muscle atrophy, alcoholic myopathy, nephritis, amenorrhea, impotence, polyuria and electrolyte imbalances, specifically sodium, chloride, magnesium, BUN and creatinine.

Laboratory tests that may help to identify these physical effects of alcohol include uric acid, triglycerides, mean corpuscular volume, alkaline phosphates and chemistry profiles.

Susan Laffan, RN, CCHP-RN, CCHP-A, is a co-owner of Specialized Medical Consultants, Toms River, NJ. She may be reached at njjailnurse@aol.com.
Five Principles of Patient Safety

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the third in a series discussing the basics of patient safety. The next article will address the causes of clinical errors.

Keeping patients safe from clinical error and unintended harm is a responsibility of every health care professional, system and organization. While community health care settings have been instituting patient safety concepts since the 1990s, correctional health care is just beginning to transfer these concepts to the unique setting and patient population of the criminal justice system.

Safety experts in traditional health care settings have established key principles that underlie a patient safety program. These principles are foundational to a safe patient care environment and can be organized within the four domains of the correctional health care patient safety model (see table and see article in the Spring 2015 issue).

A Just Culture in a Learning Organization

An organization's culture is the shared beliefs and meaning of actions that are pervasive among the individuals working within the environment. This culture can be determined by the common attitudes and meanings given to staff actions and the outcomes of those actions. A culture of safety, then, involves shared beliefs among the members that enhance patient safety. Elements of organizational culture found to enhance patient safety include the following:

- Respect and civility
- A regard for safety as a top priority
- Enhanced teamwork and collaboration among all disciplines and levels in the organization
- Openness and transparency about clinical errors when they take place

The willingness to report clinical error is based on an organizational understanding of the causes of error, as well as the interplay of the environment, clinical systems, health care workers and care recipients. A safety culture seeks to discover and correct flaws in the system. A “just culture” adds individual practitioner accountability to the concept of safety in an organization’s culture.

In a just culture, system design issues are balanced with individual accountability in evaluating a clinical error. It shifts the focus from that of errors and outcomes to one of system design and behavioral choices. This can be a huge culture change from that of blame and punishment that is sometimes found in a correctional setting. When health care staff have a real fear of being escorted out of the building for a clinical error, reporting near-miss and clinical mistakes is severely hampered.

A just culture is enhanced by a management philosophy that emphasizes ongoing staff development and system changes based on continuous learning about how the organization operates. Engaging in organizational learning requires openness, honesty and trust among peers throughout all levels of the organization. Punitive, blaming cultures are unwilling to learn from failure. They are unable to uncover and communicate about the causes of clinical error, thus missing the lessons to be learned. Organizational learning is movement toward a common goal—such as safer patient care—by adapting and changing the organization based on the collective experience. As it relates to clinical errors, a learning organization extracts meaningful lessons from adverse or near-miss events and converts these lessons into improvements in structures and processes.

High Reliability System Design

High reliability is critical in any system with a greater likelihood of catastrophic events. High reliability system design first emerged in the nuclear power and air traffic control industries, where error can result in significant loss of life. Since the emergence of data on the high number of deaths in health care related to clinical error, these design principles are increasingly applied in the clinical setting with positive result.

High reliability design establishes system defenses to avoid human error. Safeguards and barriers within the care delivery system are a primary means of error prevention. Reengineering clinical processes using high reliability principles involves seeking system changes that reduce human error. Concepts of high reliability design include the following:

- Mindfulness of potential error
- Formal structures and procedures that incorporate redundancy checks
- Informal culture open to safety accountability at all levels of the organization

Common tools used in high reliability systems include the following:

- Buffers to detect error before it reaches the patient
- Reminders to help avoid reliance on memory
- Forced functions such as requiring specific actions before allowing movement to a next process step
- Process constraints that prevent a clinician from taking a risky action

Decentralized decision-making authority for safety processes is a key component of high reliability system design. Correctional settings, however, typically rely on a centralized command-and-control structure that may not value frontline innovation. Even in these situations, staff must be encouraged to suggest system changes to improve patient safety, as they have a unique perspective on successful day-to-day health care operations.

Health care systems are complex adaptive systems where the communication among the parts is as important as the

continued on page 24
Patient Safety Principles (continued from page 23)

parts themselves. This is particularly true in a correctional setting, where there is an added layer of communication with security officers, custody administration and, in jail settings, the police. The interaction of multiple decision makers increases the need for a high reliability system design.

Communication and Teamwork
Communication is identified as a top reason for clinical error. In fact, according to the Joint Commission, 80% of hospital clinical errors can be traced to miscommunication. The safe delivery of patient care requires the following:

• A written and oral communication structure
• Solid processes for handoff of patient care
• Open communication of patient care concerns among the team members

Patient care is not accomplished in isolation, although many of the health care disciplines are trained in educational systems emphasizing individual practice. Without effective systems of communication or the appropriate use of them, patient information can be lost, care can be diminished or treatments can be inappropriately applied.

Effective communication and teamwork in the correctional setting must overcome barriers imposed by security requirements. Here are some examples of additional communication efforts needed in this setting:

• Health care staff may need to negotiate timing or location of care delivery with security officers, adding an additional layer of collaborative work.

• When the goals of health care and security conflict, tension builds, resulting in communication breakdown.

• Organizational structure can create communication silos that hinder safe patient care. Staff on off-shifts may need to communicate about patients with covering providers who are not familiar with the patient or the correctional environment.

• Many diagnostics and treatments must be accomplished outside the security perimeter. Communication with laboratories, diagnostic centers and specialty services can falter without well-established communication systems and astute, accountable practitioners.

For many reasons, often financial, correctional settings have been slower than their counterparts in other health care settings to adopt electronic medical records. Unfortunately, written documentation in medical records increases the chances of miscommunication through poor handwriting, missing reports or inaccessible records at the point of care delivery. EMRs are not without their safety issues, however, as human error can still lead to missing or incorrect data and technical failures. EMRs created for traditional health care settings are often difficult to adapt to the unique clinical processes of corrections.

Patient-Centered Care
A patient-centered approach to care can reduce the effect of the fragmented care delivery system inherent in the correctional environment. A patient focus—rather than an organizational or caregiver focus—shifts care delivery priorities toward decreasing patient harm. The Institutes of Medicine defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.” This is a tall order in the correctional environment, where individualized attention may conflict with a system that values anonymity and no one is allowed to receive specialized service or care. Yet, the patient is a key component of safety in the complex health care system: An active and informed patient provides additional safeguards and redundancy in care delivery. For example, patients can help with the prevention and early detection of potential error.

Competent Care Providers
Recruiting, selecting and hiring competent care providers are important components of safe health care delivery. This requires time and expertise, which can be lacking in a correctional health system. Although the last few decades have ushered in major improvements in this regard, the correctional setting can still be viewed as a refuge for poor practitioners. In order to continue improvements, unsafe practitioners must be eliminated from the system.

Correctional health systems are challenged to provide the time and finances to adequately orient newly hired staff and maintain the competence of incumbent staff. Staff development activities are rarely handled by dedicated staff educators and more likely considered a part of a unit manager’s responsibilities along with financial, staffing and clinical responsibilities.

New staff may be unfamiliar with the unique nature of the secure environment and the inmate population. They must quickly learn to negotiate both the health care and the custody hierarchies to safely accomplish care. The autonomous nature of delivering health care in correctional environments requires staff members to fully understand the limits of their licensure and job descriptions.

Strict boundaries, identified in a traditional health care setting by policies, procedures and organizational accountability structures, may be missing in the correctional setting. The uninformed health care professional can easily be swayed into inappropriate action by assuming that “it must be safe” if the request was made by a person of authority in the organization.

A Foundation for Improvement
These five principles of patient safety provide a foundation for improving clinical processes and outcomes. They are a good starting point for evaluating current risk and developing a framework to reduce patient harm in a correctional health care setting.

Lorry Schoenly, PhD, RN, CCHP-RN, is a nurse author and educator specializing in correctional health care. She provides consultation services on projects to improve professional practice and patient safety. This is an excerpt from The Correctional Health Care Patient Safety Handbook, available in print and Kindle versions from amazon.com. Schoenly may be reached at lorry@correctionalnurse.net.
To achieve the national public health goal of improving immunization coverage among children and adolescents, it will be important to reach the nearly two million youth who are involved with the juvenile justice system each year. In an article in the July issue of the *Journal of Correctional Health Care,* authors Gregory Gaskin and colleagues report that JJS youth have greater vulnerability to vaccine-preventable diseases due to factors such as age, developmental stage, risky health behaviors and poor health care access, as well as congregate living in justice facilities.

The authors conducted a study that aimed to (1) quantify the baseline immunization coverage of adolescents entering the juvenile justice system and (2) assess the effect of detention-based care on immunization coverage in youth. The study was a cross-sectional retrospective review of a random sample of medical records of adolescents aged 11-19 years who were detained at a large juvenile detention facility in Northern California. This facility is a qualified provider in the Vaccines for Children program, which enables the clinic to offer immunizations at no cost to patients.

The immunizations studied include Tdap, MCV4, hepatitis A (two-shot series), varicella-zoster virus (two-shot series) and HPV (Gardasil three-shot series, offered routinely to boys and girls at the facility). “Immunization coverage” was defined as whether the youth had received a particular immunization or group of immunizations. Youth were classified according to the recommended immunizations they had received: “complete” – all nine doses of the immunizations; “age-appropriately up-to-date” – the immunizations for which they were eligible; and “on-track” – all appropriate immunizations, but missing one or more in a series due to the time intervals between shots.

**Findings**

The final sample used in the analyses was 249. The analyses accounted for and stratified juveniles’ age and their age at first detention (a confounding variable in vaccination status). The researchers also compared the data to coverage rates identified in the state’s general adolescent population.

Only 3% of detained adolescents had completed all recommended adolescent immunizations prior to their first detention. However, completion rates increased notably with subsequent admissions to detention: 27% of study participants had received all nine recommended vaccinations as of their latest detention, while 56% were “on-track.” Furthermore, youth with more than one detention episode had significantly higher completion rates.

Compared with the general adolescent population in California, detained youth had significantly lower immunization coverage for all vaccines prior to their first detention except for the first dose of hepatitis A and VZV vaccines. However, for those with more than one detention episode, coverage for most vaccines at the latest detention increased to levels significantly higher than the general adolescent population.

The authors conclude that detention-based clinics can play an important role in providing recommended preventive care to this high-risk population of youth. However, juvenile detention facilities differ greatly in their provision of preventive health services. To be maximally effective, they write, a standardized policy of routine immunization must be implemented on a wider scale in detention facilities throughout the nation.

**JCHC Volume 21, Issue 3**

- The Legal Implications of HIPAA Privacy and Public Health Reporting for Correctional Facilities — Leila Barraza, JD, MPH, Veda Collmer, JD, Nick Meza, JD, MPH, and Kristin Penunuri
- Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature — Linda A. Teplin, PhD, Marquita L. Stokes, MS, Kathleen P. McCoy, PhD, Karen M. Abram, PhD, and Gayle R. Byck, PhD
- Attempted Suicide, Self-Harm, and Psychological Disorder Among Young Offenders in Custody — Elizabeth Moore, PhD, Claire Gaskin, MBBS, MRCPSych, and Devon Indig, PhD, MPH
- Immunization Coverage Among Juvenile Justice Detainees — Gregory L. Gaskin, Jason M. Glanz, PhD, Ingrid A. Binswanger, MD, MPH, and Arash Anoshiravani, MD, MPH
- The Prevalence of Overweight and Obesity Among Female Inmates — Margaret E. Leigey, PhD, and Mary E. Johnston
- Correlates of Preincarceration Health Care Use Among Women and Men in Jail — Megha Ramaswamy, PhD, MPH, Francisco Diaz, PhD, Tyson Pankey, MPH, Suzanne Hunt, MS, Andrew Park, DO, MPH, and Patricia J. Kelly, PhD, MPH, APRN
- Characteristics of Prison Hospice Patients: Medical History, Hospice Care, and End-of-Life Symptom Prevalence — Kristin G. Cloyes, PhD, MN, RN, Patricia H. Berry, PhD, RN, ACHPN, Kim Martz, MSN, RN, and Katherine Supiano, PhD, LCSW

Each issue offers continuing education credit through an online exam. Members of the Academy of Correctional Health Professionals receive JCHC as a member benefit. To obtain JCHC, contact Sage Publications: 800-818-7243, ext. 7100, order@sagepub.com; http://jchc.sagepub.com.
Infectious Disease Medical Director – SC Department of Corrections/USC Internal Medicine

The University of South Carolina 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 based at SCDC and is predominately responsible for directing inmate infectious disease health care delivery services for SCDC and coordinate ID education and training of all medical providers serving in the SCDC 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 at SCDC
  - 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.
  - Supervises medical students, residents and infectious disease fellows.

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@uscmed.sc.edu. The University of South Carolina is an AA/EOE employer.

However, the Society hasn’t always been clear on how best to utilize the wealth of knowledge and expertise of its members to advance its goals. The transformation to the American College of Correctional Physicians will enable us to better serve our members, to collaborate with our colleagues at NCCHC, to advocate for our patients and to become a nationally recognized voice to speak to noncorrectional professional physician organizations. Our new identity, a 501(c)3 not-for-profit organization, will be formally adopted at this fall’s Annual Education Conference, being held October 18 in Dallas in conjunction with NCCHC’s National Conference on Correctional Health Care.

**Leadership and Support**

The board envisions that ACCP will be recognized as a strong physician organization that provides leadership and support to our colleagues struggling with the internal and external challenges facing correctional medicine. To this end, we have already undertaken a number of initiatives. We reinvigorated our own fellowship program and have accepted criteria to endorse academic fellowships in correctional medicine. We also recently endorsed NCCHC’s new CCHP-P certification process and examination (see page 28 for more information — Editor). Additionally, we are collaborating with the American Association of Public Health Physicians to voice correctional medicine issues from its seat on the house of delegates at the American Medical Association.

As many other medical colleges have varying levels of membership, ACCP will maintain its associate membership category, which extends the benefits of full membership without the ability to vote, to dentists, nurse practitioners and physician assistants.

Slowly but steadily, the correctional physician’s voice is growing louder in the professional medical community. ACCP plans to turn that voice into a roar. Working together with NCCHC, correctional medicine can garner the respect, credibility and professionalism that other specialties enjoy.

Rebecca A. Lubelczyk, MD, FSCP, CCHP, is the president of SCP/ACCP. She works as a utilization management physician advisor for the Massachusetts Partnership in Correctional Healthcare.

Academy Celebrates Its 15th Year, and the Professionals Who Work in this Field

by Susan Laffan, RN, CCHP-RN, CCHP-A

The Academy of Correctional Health Professionals is celebrating its 15th anniversary this year! The Academy’s board of directors invites all members to join in the celebration during a members-only special event to be held in conjunction with NCCHC’s National Conference on Correctional Health Care, October 17-21 in Dallas.

Festivities we are planning include the following:

- The annual membership meeting: Learn about the organization, its committees and activities, and how you can participate.
- Entertainment and networking galore
- “Let’s Make A Deal” giveaways: As in the television game show, prizes will be given to participants who bring common items to the event.
- A grand prize: Each person will be given one ticket at the door. Winners must be present to receive the prize.

The Academy is the nation’s community for correctional health care. Through our publications, educational activities and special events, the Academy serves as your portal to the latest information and knowledge specifically designed to help you, the correctional health professional.

Not a member? You may join online, or when you register for the National Conference, or on-site at the conference. The location and time of the celebration will be announced during the conference. To enter the event, be sure to attach your membership ribbon to your name tag.

Appreciation for the Work You Do

Also coinciding with the National Conference, the Academy board of directors proclaims that October 18-24 is Correctional Health Professionals Week. See the proclamation at right and take pride in your profession!

Susan Laffan, RN, CCHP-RN, CCHP-A, is the 2015 chair of the Academy of Correctional Health Professionals. She also is a co-owner of Specialized Medical Consultants, Toms River, NJ.

Neurological Diseases (continued from page 21)

- Abilities as well as for supporting cognition levels.
- Patience and understanding. Aberrant behaviors are usually based in fear. This concept is paramount in dealing with the cognitively challenged. It is natural when we don’t understand something or are fearful that we act out in aberrant ways. Being patient with individuals who have been diagnosed with these types of diseases, and understanding that fear is a basis for these behaviors, can help you mitigate them in the future.
- While there is no one trick to identifying and treating degenerative neurocognitive disease, familiarizing yourself and your staff with the common manifestations and symptoms of these diseases can save time and money and prevent staff frustration as we continue to deal with the wave of aging inmates.

Kori Novak, PhD, MBA, is a gerontologist who studies aging within the correctional system. She works for the Mellivora Group, a consultancy that focuses on mental health, gerontology and counselor education and is based in Lititz, PA. She may be reached at knovak@mellivoragroup.com.
New Specialty Certification Shines a Light on Correctional Physicians

The Certified Correctional Health Professional board of trustees is pleased to announce its newest specialty certification: CCHP-P. The CCHP–Physician credential recognizes expertise among physicians practicing in the specialized field of correctional health care.

Years in the making, this specialty program was spearheaded by a task force comprised of 11 leading experts in correctional medicine. This team worked diligently to define the domain of knowledge unique to practicing in a correctional environment, and then to develop an examination that would accurately measure a candidate’s mastery of that knowledge. After nearly a year of pilot testing, the first exam will be offered in October at NCCHC’s National Conference on Correctional Health Care (see pages 8-9 for information about the conference).

“Correctional physicians are proud of their work in this specialized field,” says Patricia Reams, MD, CCHP, who chairs the task force. “CCHP-P certification gives them the opportunity to be recognized for their professional knowledge and skills.”

Well-Derby Recognition
The CCHP–Physician certification program provides validation of a commitment to maintain the knowledge necessary to augment competent and appropriate clinical care to incarcerated patients. A CCHP-P has shown a mastery of specialized content developed by physician experts in the field of correctional health care. Through exam preparation and annual recertification, the program also encourages ongoing professional development.

This is recognition that is well-deserved, says task force member Steven Shelton, MD, CCHP-A, who has worked in correctional medicine for 32 years. “Correctional physicians are often viewed by those outside the field as less qualified and less credentialed than those in other medical specialties. I know many excellent physicians in corrections whose skill far exceeds that of many community-based physicians. I am glad that NCCHC has a specialty certification to recognize correctional physicians, and I will be proud to display that certification.”

The Society of Correctional Physicians (soon to become the American College of Correctional Physicians; see page 26) agrees, and has officially endorsed the CCHP-P exam. “This is an exciting time in our profession where opportunities for advancement are becoming available,” says Rebecca Lubelczyk, MD, CCHP, president of SCP and a task force member. “SCP supports certification that recognizes and rewards for breadth and depth of correctional health knowledge.”

How to Apply
Applicants must meet the following criteria:
• Current CCHP certification
• Unrestricted license (MD or DO) to practice medicine in at least one state of the United States and be in good standing with that licensing board (for U.S. territories and Canada, credentials are reviewed on a case-by-case basis)
• Practice in the correctional environment over the course of at least three years (no minimum requirement of hours)

Find complete program information and apply online at www.ncchc.org/CCHP-P.

Cast Your Vote to Help Shape CCHP’s Future
The Certified Correctional Health Professional program is administered by NCCHC and governed by a board of trustees comprised of 10 correctional health experts from a variety of health professions. Three of the trustees are elected by their peers; the others are appointed from the field. Elections are held every year to fill a three-year term.

The election begins on August 4 and ends on August 18. Current CCHPs are being emailed an invitation with candidate statements and a link to online voting. If you do not receive the email, first check your spam folder and, if you don’t find it, contact cchp@ncchc.org.

Cast your vote by August 18!
CCHP Specialty Certification for Correctional Physicians

• Recognition for physicians practicing in the specialized field of correctional health care
• Exclusively for physicians already CCHP certified
• From the most widely accepted correctional health care certification program
• Endorsed by the Society of Correctional Physicians 🧡

Specialty certification as a CCHP – Physician provides validation of a commitment to maintain the knowledge necessary to augment competent and appropriate clinical care to incarcerated patients. A CCHP-P has shown a mastery of specialized content developed by physician experts in the field of correctional health care.

For more information or to obtain an application, visit www.ncchc.org/cchp-p. Or contact us at cchp@ncchc.org or 773-880-1460.
National Conference on Correctional Health Care
October 17-21 • Hilton Anatole, Dallas

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

Who Attended in 2014?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse/nurse practitioner</td>
<td>40%</td>
</tr>
<tr>
<td>Physician/physician assistant</td>
<td>25%</td>
</tr>
<tr>
<td>Administrator</td>
<td>13%</td>
</tr>
<tr>
<td>Psychiatrist/psychologist</td>
<td>8%</td>
</tr>
<tr>
<td>Social worker, therapist, counselor</td>
<td>4%</td>
</tr>
</tbody>
</table>

Decision Makers With Authority

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>State/facility medical director, director of nursing, other directors</td>
<td>16%</td>
</tr>
<tr>
<td>Health services administrator</td>
<td>9%</td>
</tr>
<tr>
<td>Department manager/supervisor</td>
<td>11%</td>
</tr>
<tr>
<td>Health services, dental or mental health staff</td>
<td>26%</td>
</tr>
</tbody>
</table>

Who Do Attendees Represent?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail facility</td>
<td>44%</td>
</tr>
<tr>
<td>Prison facility</td>
<td>21%</td>
</tr>
<tr>
<td>State DOC/agency</td>
<td>11%</td>
</tr>
<tr>
<td>Private corporation</td>
<td>9%</td>
</tr>
<tr>
<td>Juvenile detention or confinement facility</td>
<td>4%</td>
</tr>
<tr>
<td>Federal agency</td>
<td>1%</td>
</tr>
</tbody>
</table>

Categories Attendees Recommend or Buy

- Dental care and supplies
- Disaster planning
- Electronic health records
- Health care staffing
- Information technology
- Medical devices and equipment
- Optometry services
- Pharmacy services
- Substance abuse services
- Dialysis services
- Education and training
- Health care management
- Infection control products
- Laboratory services
- Medical supplies
- Mental health services
- Pharmaceuticals
- Safety equipment
- Suicide prevention

Draw Qualified Customers to Your Booth

NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and outreach to local facilities and agencies.

- Three days of exhibit hall activities
- Two free full conference registrations per 10’ x 10’ booth
- Discounted full registration for up to three additional exhibit personnel (per company)
- Access to nearly 2,000 attendees for premium face time
- 50-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Discounts on advertising in the conference programs
- Opportunity to participate in raffle drawings
- Priority booth selection for upcoming conferences
- Continuing education credits for all sessions attended
- Exclusive opportunity to become a sponsor or advertiser

Sponsorship Puts You at Center Stage

Enhance your exposure to conference attendees and provide a memorable conference experience. Sponsors receive extra recognition in conference materials and pre- and post-conference promotion. Ask the NCCHC sales representative to help you maximize your marketing exposure.

- New! Conference app
- Keynote speaker
- Exhibit hall reception, lunch or refreshment breaks
- Premier educational programming
- Product Theater lunch
- Internet kiosks
- CCHP lounge host
- First-timers’ reception
- Conference portfolio
- Conference bags
- Hotel key card
- Show bag insert
- Exhibitor lounge
- Exhibit hall aisle drop

Become an Exhibitor Today!

Make an impact on a cost-effective budget! This premier event is where you can meet with key contacts and raise your profile, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For more information and a reservation form, contact Carmela Barhany: sales@ncchc.org or 773-880-1460, ext. 298. Be sure to ask about sponsorships and advertising.
Position: Primary Care Medical Director

Catholic Health of Buffalo New York in collaboration with Erie County’s Correctional Health Department is seeking a Board Certified Primary Care Physician to serve as the next Chief Medical Officer for Erie Country Correctional Health Department.

Duties - As a Primary Care Medical Director, you will:
- Collaborate with the County Chief Medical Officer and Administrative Director of Erie County’s Correctional Health Department and Lead a multi-disciplinary team of individuals who collectively take responsibility for the ongoing care of patients
- Provide comprehensive primary care for assigned to the Erie County’s Correctional Health Department
- Assign work to subordinates based on priorities, difficulty of assignments, and the capabilities of employees
- Identify developmental and training needs of employees
- Interview candidates for subordinate positions; recommend hiring, promotion, or reassignment

In order to qualify, you must meet the education and/or experience requirements described below. Your CV must clearly describe your relevant experience.

Degree: Doctor of Medicine (MD) or Doctor of Osteopathy (DO) from an accredited medical school in the United States.

Medical Specialty and Board Certification: Family Medicine or Internal Medicine. All candidates must be Board Certified to qualify for this position.

Graduate Medical Education: Completion of an accredited Family Medicine or Internal Medicine Residency Program

Licensure: Candidates must have a permanent, full, and unrestricted license to practice medicine in the State of New York.

Experience: Minimum of 5 years’ experience as a primary care physician in both outpatient and inpatient settings. Preference is given to candidates who have relevant medical leadership experience in correctional medicine.

Interested and Qualified Candidates should forward their CVs to the attention of Terese Lagattuta at: tlagattu@chsbuffalo.org

About CorrectCare*

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

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

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

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

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

ADVERTISER INDEX

Alkermes / Vivitrol ................................................................. IFC-3
California Correctional Health Care Services .......... 18
Centurion ................................................................................ BC
Certified Correctional Health Professional – Physician 29
Correctional Mental Health Report ......................... 14
Corizon Health ................................................................. 15
GEO Group ........................................................................ 7
InFocus Lists .................................................................... 30
Journal of Correctional Health Care ....................... 32
Medi-Dose/TampAlerT ....................................................... 19
National Conference on Correctional Health Care ... 4
Pearson ................................................................................ IBC
Standards for Mental Health Services ...................... 10
University of South Carolina School of Medicine .... 26
Wexford Health Sources ................................................... 11
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Sharing Test Results With Patients

Q In the 2014 standard on continuity of care, compliance indicator 5 says that test results are “shared and discussed with patients.” Although I understand the importance of patients being aware of their test results, having each patient return to clinic, particularly if all test findings are normal, can increase our clinic and facility workload. We already ensure that abnormal findings are communicated to all patients. Is it OK if the clinicians document that they have explained what the tests are for before they are ordered and inform patients that they will be called back only if the results are abnormal or inconclusive? Patients would understand that if they are not called back, everything was normal. Of course, they are welcome to ask to see the doctor on their own if they want further explanation. Would that capture the spirit of the standard?

A Standard E-12 Continuity and Coordination of Care During Incarceration requires that the clinician reviews the findings of specialty consultations and diagnostic tests with the patient in a timely manner. I understand your concern with having each patient return to the clinic for results that are within normal limits. However, the absence of communication for negative or normal findings does not meet the intent of the standard. This presents a risk that information will not be communicated.

One acceptable option that is used by some facilities is a paper notification for results within normal limits with documentation in the health record of the communication. This would eliminate the need to call every patient back to the clinic, yet provide the patient with the results.

Medication Administration Training and Testing

Q Our prison system has medication administration training, as required by standard P-C-05. The standard also requires testing of that training. Does this standard pertain only to correctional officers who pass meds? Or to licensed health staff, as well? Our current practice is that only licensed health staff administer medications, and to be eligible to do so they must meet all of the criteria outlined in the standards, including periodic training.

A Documentation of training and testing is required for all personnel who administer or deliver prescription medications. However, the content of the training may differ for health staff and correctional staff. Testing results normally are kept in each employee’s personnel file.

Notification for Youth in Segregation

Q For facilities that do not have medical staff on-site 24/7, what is considered sufficient notification to medical when a youth is placed in segregation? Is an email sufficient, or does it need to be a phone call to the on-call staff?

A Standard Y-E-09 Segregated Juveniles requires that when health staff are not on duty, a health staff member on-call is notified when a juvenile is being placed in segregation. In this case, an email is not sufficient notification; the on-call health staff member should be contacted directly.

Tracey Titus, RN, CCHP-RN, is NCCHC’s manager of accreditation services. If you have a question about the NCCHC standards, write to accreditation@ncchc.org or call 773-880-1460. For an archive of past Standards Q&A questions, visit the Standards and Resources section at 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. See page 8 for details.
Beta-4 comes from a long line of nonverbal assessments that have been used and trusted by psychologists and counselors since 1934. It is very simple to administer and score with minimal training in a one-on-one or proctored group setting with either English or Spanish instructions, and does not require the test-taker to read. The Beta-4 is tailored toward those suspected to be low-functioning and low-skilled.

Beta-4, offering all you have come to trust from Beta III, with enhancements that make it even easier to use

Order now to save before publication!

Five reasons to choose the Beta-4:

• Shorter, simpler, streamlined instructions ease administration

• Supported by research including several clinical group studies, including a corrections sample that ties directly into the unique needs of that population

• New norms with lower floors and higher ceilings for greater sensitivity to evaluate a diverse population

• New artwork and visuals provide a more contemporary look

• Lightweight components improve mobility when administering at multiple locations

Reserve your Beta-4 now and save with pre-publication pricing before February 29, 2016.

Call 800.627.7271 or visit pearsonclinical.com/beta4 to place an order.
“We coach inmates to better manage their health.”

Cheryl Word
Director, Analytics and Client Services
Nurtur Health, Inc.
10 years of experience

Centurion partners with NurturHealth, an innovative provider of life and health management services, to augment our disease management programs for inmates with serious medical conditions — programs proven in free-world managed care settings and available only through Centurion.

Nurtur® coaches educate and motivate inmates to:
- Improve health literacy
- Comply with treatment
- Engage in personal care
- Understand and access resources
- Adapt to changing circumstances

Our partnership delivers results. A recent study of diabetic inmates in a Nurtur program focusing on weight loss showed that over half lost 5 pounds or more.

Scan the code to learn more.