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Medical directors from several states’ departments of corrections convened in Chicago on May 13 for a full day of training and discussion on the NCCHC Standards for Health Services in Prisons at the inaugural Executive Curriculum for State Medical Directors program.

Hosted by NCCHC, the meeting was a unique opportunity for correctional health care leaders from around the country to meet one another, learn about contemporary best practices as delineated in the Standards and exchange ideas. The training was conducted by Brent Gibson, MD, MPH, CCHP-P, chief health officer, and Tracey Titus, RN, CCHP-RN, vice president of accreditation. The participants were enthusiastic about the opportunity to connect with their peers. “It’s a great idea to bring state medical directors together to network, share concerns and discuss the Standards,” said Kathleen Maurer, MD, MPH, medical director, Connecticut Department of Correction.

Based on the success of the inaugural program, NCCHC will repeat the Standards for Health Services in Prisons curriculum to give all state medical directors a chance to attend before moving on to another topic relevant to this audience. The next training is scheduled for Nov. 18. If you are a state DOC medical director, please check your email for an invitation, or email info@ncchc.org.

Kudos to Nancy White, MA, LPC (pictured far right), who was recognized by the Kansas City (MO) Police Department for her help in creating the KCPD’s Crisis Intervention Training for Telecommunications program. White is a team leader at Truman Medical Center Behavioral Health in Kansas City.

“Police and mental health professionals have a wonderful partnership teaching mental health awareness throughout the metro area,” said White. An NCCHC board member since 1993, she serves as the American Counseling Association’s liaison to the board.

The training provides dispatchers and call takers with knowledge and skills to identify a caller in crisis, de-escalate crisis calls and respond effectively. Topics include understanding mental illness, a CIT basic overview, gathering information helpful to officers, a consumer panel, verbal de-escalation techniques, scenario-based training, active shooter information, veterans’ issues, stress management and trauma-informed care.

Call for Proposals: 2017 Spring Conference
Share your knowledge and advance the field. NCCHC is seeking presenters to share information, research, innovative solutions and best practices in every aspect of correctional health care at the Spring Conference on Correctional Health Care, being held April 29 to May 2 at the Hyatt Regency Atlanta.

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Speakers receive a discounted conference registration rate and the chance to earn credit for CCHP recertification. The last day to submit a proposal is Sept. 22. Find proposal submission guidelines and an online submission form at www.ncchc.org/SC17-call-for-proposals.

Upcoming Webinars
To register for either webinar, please email brentgibson@ncchc.org and indicate the program name in the subject line. Please note that capacity is limited.

- Juvenile Gunshots Wounds: Perspectives From the Cook County Juvenile Temporary Detention Center, Wednesday, Sept. 7, 10 am to 11 am, CT. Hosted by NCCHC’s juvenile health committee. RSVP by Sept. 1.
- Contemporary Issues in Jail Mental Health Care, Thursday, Sept. 22, 11 am to 12 pm, CT. Cosponsored by the American Jail Association. RSVP by Sept. 15.
NCCHC’s 40th National Conference is shaping up to be the biggest and best ever! In addition to the timely topics, breadth of knowledge and depth of expertise you’ve come to expect at NCCHC conferences, you’ll find extra activities and surprises to make it a truly memorable, fun and festive 40th. Come celebrate correctional health care’s history and welcome its bright future in Las Vegas, the brightest spot on earth!

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www.NCCHC.org/national-conference
Segregation Policies: Change Is in the Air

by Jayne Russell, MEd, CCHP-A

Restrictive housing is a practice that is used in nearly all correctional facilities as a necessary management tool. There are many types of solitary confinement or segregation in jails and prisons, with varying rules and policies regarding isolation.

Due process is required to place an inmate in disciplinary segregation. There must be a policy and process to determine culpability and subsequent terms of the discipline. Protective custody or administrative segregation is used when the inmate poses a serious threat and requires close supervision. Administrative segregation is also used when there is good reason to believe that the inmate may be in danger if housed in general population and should be placed in segregation for protection. “Supermax”—the highest level of classification—can also be considered segregation, and the housing restrictions are similar to any other segregation.

Segregation housing ranges from minimally restricted status to significant isolation. It affects many housing functions and imposes limits on movement and access to routine operations, and may necessitate mechanical restraints for transport. Various forms of segregation can impact recreation, exercise, visits and phone calls, commissary and use of television and radio. Routine hygiene may be reduced to only several showers weekly with minimal clothing and bedding exchanges. These restrictions may be mandated by state legislation. Time out of cell can be greatly reduced; the opportunity for paid work assignments, good time credit, education and programs can be denied or greatly diminished.

Reforms Underway

The practice of long-term isolation has received a great deal of attention in recent years. Studies suggest that extended isolation may lead to psychosis and suicidal behavior. At the very least, long-term isolation, defined as more than 15 days, can lead to depression, maladjustment and despair.

Amid this heightened awareness, last year President Obama ordered the Department of Justice to review the use of solitary confinement. Although firm numbers are difficult to determine, segregation is a widespread practice in the United States, with the DOJ report stating that up to 100,000 prison inmates are held in solitary on any given day. Some facilities employ solitary confinement 23 hours a day for years at a time or indefinitely.

Based on the DOJ’s findings, in January Obama ordered the Federal Bureau of Prisons to adopt the report’s recommendations for reforming the use of solitary. He also expressed the hope that these new policies would serve as a model for state and local correctional systems.

Many prison and jail systems are reexamining their use of solitary confinement and some have begun to minimize it. In some cases, these actions are being undertaken as a result of lawsuits associated with bad outcomes from long-term segregation. One of those is in the State of California, which is reviewing solitary confinement policies; anticipated reforms have the potential to remove a significant number of inmates from long-term lockdown status.

More broadly, there is national movement to eliminate solitary confinement of all incarcerated juveniles. The DOJ report recommended this measure, and it is now banned in the Bureau of Prisons. In New York City, Rikers Island jail has ended solitary confinement for inmates under the age of 21.

Similarly, mentally ill inmates are a population of concern as these individuals often have “acting out” behaviors that result in excessive disciplinary time. Some institutions have eliminated solitary confinement for these inmates.

Devising Strategies

There is no easy solution or expedient answer for enacting reform and change. It is a fact that certain individuals cannot be housed safely with others, and correctional facilities have an unequivocal responsibility to protect everyone: officers, staff and other inmates in danger of being housed with violent inmates or the severely mentally ill.

We need to create strategies for individuals who cannot be housed or mix with others. This is a challenge facing all institutions that manage the most difficult of inmates. Some systems offer controlled program time, enhanced clinical services and daily staff rounds to visit these inmates. Health and welfare checks should become a routine part of monitoring, with a minimum of routine officer checks at every shift.

Socialization activities, even in confinement, can increase positive stimulation and learned coping mechanisms to combat the stress of solitary lockup. Positive behavior changes may allow certain inmates greater freedom and socialization, and eventually a return to general population housing.

Medical and mental health providers should work closely with custody staff to share information and observations, and to help determine meaningful interventions.

Consider the cumulative years of these human beings in solitary incarceration; it is a sad and staggering reality. I am hopeful that we, as a nation, will humanely modify these practices and enact positive solutions and policies that support a better quality of life, one that illustrates the dignity and values of our justice system.

Jayne Russell, MEd, CCHP-A, is chair of NCCHC’s board of directors and serves as the Academy of Correctional Health Professionals’ liaison to the board. She works as an independent consultant in correctional health care.
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Medical Records System Failure as Moving Force in Detainee’s Extended Pain, Suffering

by Fred Cohen, LL.M.

Kevin Dixon arrived at Cook County jail as a pre-trial detainee. About five months later, he left as a corpse. He died from lung cancer following a series of misadventures all too common in correctional health care. Dixon’s mother sued for damages under 42 U.S.C. § 1983 claiming deliberate indifference in her son’s case.

Her various claims were dismissed by the district court. In Dixon v. County of Cook (7th Cir. 2016), the lower court was reversed and the complaint reinstated.

Facts

In September 2008, Kevin Dixon was sent to the Cook County jail as a pretrial detainee. A month later, he developed severe and persistent pain in his back and abdomen. In early December, he had a CT scan that revealed a para-tracheal mass. Over the next few weeks, the mass grew rapidly. Medical personnel at the jail were aware of the problem, but they accused Dixon of malingering, gave him over-the-counter analgesics and ordered him to seek psychiatric care. By Jan. 5, 2009, Dixon’s condition had deteriorated severely. He was finally taken to Stroger Hospital, where he was diagnosed with lung cancer. He died two months later.

Dixon’s symptoms appeared soon after he was jailed. The December X-ray and CT scan led a physician to refer Dixon for an urgent pulmonary consultation.

Dixon reported pain at a 10 out of 10 severity. The pulmonologist ordered a new CT scan for early January and a follow-up. Dixon could not wait that long for the right treatment. He was experiencing intense abdominal pain, difficulty breathing, difficulty moving his legs and an inability to use the toilet. As he lay on the floor in partial paralysis after falling from his bunk, a corrections officer informed a nurse of his condition.

The nurse took no action; instead, the guard scheduled Dixon for “sick call” three days later. Later that day, another nurse relived the first nurse of his shift and got Dixon admitted to the Cermaak acute care facility. Despite the documentation of his tumors, the physician assistant at the acute care facility thought that Dixon was malingering and so ordered a psychiatric consultation.

Dixon soon received additional CT scans, which revealed growth of the tumor and fecal matter in his colon. At that point the supervisor of the hospital ward first saw him. The physician did not have instant access to Dixon’s medical records and previous CT and X-ray results because there was a backlog in the system for scanning medical records into the Cook County system. Nor did she have Dixon’s paper medical records in front of her. She knew about his tumor, but she did not recall making any effort to find out about the results of earlier tests. Critically, she knew that more information was available but proceeded without collecting it. She agreed with the physician’s assistant (based on the incomplete records before her) that a psychiatric consult was in order to rule out malingering. She ordered that, as well as a second consultation with a pulmonologist; she marked the latter request “RUSH.” She noted that she would see him again three days later.

On Jan. 1, Cermaak nurses reported that Dixon was on the floor and had soiled himself. He complained that he could not walk. On Jan. 2, he was taken for the follow-up CT ordered by the first pulmonologist. The notes from that scan described the tumor as “6 x 4 cm in the left upper lung lobe which extends to the level of the aortic arch and invades the mediastinum and posterior chest wall” and stated, “[f]indings are most indicative of malignant neo-plasm.” The scan also identified a 12 x 9 mm nodule in the right upper lobe that was likely metastatic and appeared...
to extend into the spinal canal. The notes also mentioned emphysema and bullous changes in both lungs.

Less than two hours after these words were written, the hospital ward supervisor discharged Dixon from Cermak. She ordered that Dixon be allowed to use his wheelchair only for transport; he was not permitted to use it inside the jail. He was given Motrin, but no other pain medication.

Three days later, Dixon was brought back to Cermak with severe weakness in his legs, bladder and bowel incontinence and pressure sores on his right buttock. The physician who saw him on his arrival transferred him to Stroger Hospital, where he remained until he received compassionate release from Cook County custody and went home, where he died on March 4, 2009, officially from lung cancer. This suit followed.

Discussion
The plaintiff is not arguing that her son might have survived with faster, more appropriate care. She claims that in the 26 days it took Dixon to receive palliative care after jail personnel became aware of the tumor, he suffered terrible and needless pain.

Plaintiff claims a county policy resulted in such poor communication among the medical providers who saw Dixon that nobody put the pieces together and determined what was wrong, how serious it was and how intense the pain.

For those officials who knew, plaintiff alleges deliberate indifference in their treatment of her son.

Plaintiff alleges that the county’s records policy led inexorably to inadequate medical care for inmates. The problem was twofold: First, there were both a paper record-keeping system and an electronic record-keeping system, and the two were not coordinated; second, to the extent that the county, for whatever reason, was still relying primarily on paper records, access to them was haphazard. The predictable result was that its medical providers were hamstrung in their ability to reach a proper diagnosis and treatment. Plaintiff argues that if all of the doctors involved in treating Dixon had access to all of the records, the decedent would not have experienced such a delay in a diagnosis and thus his pain would have been addressed much sooner.

Plaintiff produced a Department of Justice report, a statement by the new chief medical officer at the jail and a report by Dr. Robert Greifinger. Taken together, the court rules that a reasonable jury could find pervasive systemic deficiencies in the jail’s health care system that led to Dixon’s pain and death. This summary judgment was granted in error and is reversed.

Comment
The Cermak hospital ward supervisor also is faulted here. Her actions may well have prolonged the pain. The interesting point here is that even with an incurable condition, deliberate indifference in treatment, in prolonging suffering, may be found to exist.

The records issue is obviously of consequence. With many systems moving toward electronic records and merging medical and mental health files, the problems encountered in Dixon will not be novel.

I should note also the ease with which professional staff found malingering here and resorted to psychiatric diagnosis, hoping for confirmation.

Finally, the twist on deliberate indifference is of consequence. Deliberate indifference, you may recall, requires actual knowledge of risk. This decision may be read for the proposition that where there is systemic failure in medical records access, actual knowledge of the information not made available may be imputed.

Fred Cohen, LLM, is executive editor of the Correctional Mental Health Report. This article appears in the July/August issue of CMHR, ©2016 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.
While the overall prison population may gradually be on the decline, the number of female inmates is on the rise. The popular television series “Orange Is the New Black” reflects this trend. However, few jurisdictions have been able to implement and sustain gender-responsive programs due to lack of funding.

Female inmates tend to be poor, undereducated women who receive public assistance. Most of the crimes that women are currently being charged with are economically driven and are motivated by substance use or poverty. Contrary to what the media portrays, women play no substantial role in the drug trafficking trade. These women are commonly entangled in prostitution and drug-dealing. Female criminal activities usually consist of nonviolent property offenses involving alcohol or other drugs (AOD). Women also typically have co-occurring substance use disorders. In addition to street drugs, the misuse of prescription medications is increasing.

Roughly half of female offenders are under the influence at the time they engage in criminal activity. When female offenders do commit violent crimes, those crimes are often against a spouse, former spouse or boyfriend due to physical or sexual abuse by the person they assaulted. More recently, however, we have noticed a slight shift with an increase in females facing charges of burglary of strangers. Female offenders suffer from post-traumatic stress disorder up to 10 times more compared to their peers in the community. As children and adults, a noteworthy percentage of female offenders have been victims of incest and rape.

These same women are frequently single mothers who have two or three minor children. Being incarcerated during the prime of motherhood often brings up guilt and custody issues. Female inmates often feel helpless as a parent in terms of visitation, given the transportation challenges that their children face. Adding to this barrier is that most women’s prisons are in isolated areas.

Lack of Treatment for AOD Disorders

Only a fraction of female offenders receive treatment for their AOD problems, whereas males seem to consume the lion’s share of addiction and recovery services. According to research conducted by Carla Green, PhD, women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek help for this, in part due to stigmatization. Green suggests that
women tend to seek care in mental health or primary care settings rather than specialized treatment programs. This may contribute to poorer treatment outcomes.

When women do develop substance use problems, the onset and progression are faster. For example, it takes smaller amounts of alcohol for women to get drunk, and women are at greater risk for developing lung cancer and heart attack when they smoke. Health-related problems related to AOD are more severe and affect more areas of a woman’s life, particularly if she is a mother. Therefore, drug screening for women should be sensitive enough to detect these nuances in order to refer appropriately.

Moreover, it is not uncommon for male risk assessments to be used in response to female offenders. This may lead to a systematic misclassification of women and they may be placed in higher security facilities as a result.

High Demand for Health Care
In light of the aforementioned risk factors, female inmates are extensive users of the health care system. However, mental health staffing patterns do not always take this into consideration. General trends show that incarcerated women are high utilizers of mental health services (when available). There seems to be less of a societal bias when women seek help for their problems. Female inmates participate in counseling and pharmacotherapy at higher rates than their male counterparts. Also, their counseling sessions may take longer as women tend to be more verbal.

Yet correctional programs and services geared toward women’s unique needs are lacking. Perhaps in the past this oversight was justified due to the smaller representation of women in the incarcerated population. Now, however, it is incumbent on correctional systems to develop more diverse options to address gender-specific program needs.

How does a gender-specific approach differ from services in general? Implementing a “female-only” group that was originally designed for males does not necessarily equate to gender-specific treatment. Gender-specific interventions recognize that female pathways to criminality may differ from those of males. Given the types of disadvantages prevalent among female inmates, effective gender-specific programming involves comprehensive treatment for drugs and trauma recovery. Education, job training, self-care and parenting skills should also be incorporated in women’s service planning.

Many female offenders who are mothers themselves have had less than optimal maternal role models. Offering parenting classes could help prevent the intergenerational cycle of abuse. Childhood maltreatment is associated with criminal behavior. An investment in strengthening families and children would be an immeasurable benefit to society.

The Female ‘Voice’
In her landmark book on gender differences in moral development, “In a Different Voice,” Carol Gilligan postulated that males develop in relation to the world whereas females develop in relation to others. Gilligan suggested that, generally speaking, the feminine voice emphasizes a care perspective while the male voice is based on logic and individualism. Therefore, an understanding of female biopsychosocial development, mutual caring and empowering relationships serve as useful tools to integrate into a gender-specific treatment approach. These differences should be viewed as strengths instead of weaknesses.

Enlisting the support of role models and mentors would also help create nurturing relationships and capitalize on the interdependent nature of women. Healthy female lifestyles are grounded in relationships, community and care. Attachment and affiliation affirm to women that they are connected and not separate. These needs are foundational to women’s learning and relationship styles and harness their interpersonal skills.

According to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, reducing a sense of isolation may help offset depression, the most widespread female mental health concern and one that has significant ripple effects on well-being. The DSM-5 also states that women’s risk of suicide attempts is higher than men’s, although men have more completed suicides. It has been established that men tend to use more fatal methods to kill themselves, such as hanging or guns versus ingestion of pills.

Despite claims to the contrary, masculinist epistemologies are built upon values that promote masculine needs and desires, making all others invisible.

Themes of power and authority are pervasive in most correctional systems and may unwittingly retraumatize those with histories of being battered and abused. Gender-specific programs foster a sense of physical and emotional safety for female inmates. In the medical arena, universal chlamydia screening at intake for female youth is highly recommended given the prevalence of chlamydia among incarcerated populations. Exploring the use of least restrictive safety measures may also prove helpful. For example, there has been ongoing discussion regarding the removal of restraints (especially around the belly) and shackles on pregnant women during prenatal visits and when they are about to give birth. In this vein, one cannot underestimate the degree of peri- and postpartum depression that may be exacerbated by delivering a baby while incarcerated. Gender-specificity encourages correctional staff to be sensitive to these uniquely female issues.

Programs Targeted Toward Women
A promising evidence-based program observed in some correctional settings is Seeking Safety, a therapeutic pro-
program developed by Lisa Najavits, PhD. Seeking Safety is designed to treat both PTSD and substance use disorder. Primary goals include increasing safe coping in relationships, thinking, behavior and emotions, while reducing trauma and substance abuse symptoms.

In addition, the Systems Training for Emotional Predictability and Problem Solving program has been successfully implemented with incarcerated women, many of whom struggle with trauma and self-esteem/body image issues related to histories of sexual abuse and unhealthy relationships. STEPPS is a psychoeducational group format for those with borderline personality disorder (a common diagnosis among female offenders).

The STEPPS program aims to teach behavior management and emotional regulation strategies. Along with a qualified mental health professional facilitator, the group serves as the inmate member’s “reinforcement team,” which supports the application of newly learned skills. A certificate is typically provided upon completion of the 20-week program for those who participate in the entire series; however, individuals benefit from participation in even a few of these group sessions. Through this program, many women are able to feel a sense of accomplishment for the first time in their lives—and feel personally empowered.

A South Florida prison has experienced success with a self-betterment program designed to empower female inmates to make positive life changes through entrepreneurship training, education and mentorship. The Ladies Empowerment and Action Program is available to women who have a year or less left on their sentence and who have not committed a sexual offense. LEAP also has partnered with a local university to offer business classes to a select group. Participants have expressed that LEAP offers hope for life after incarceration.

The goal of LEAP is to provide opportunities for women upon release and eradicate recidivism. A long-term desire is to open a halfway house for the women to continue supporting each other as they transition out of prison, but funding is still needed for this expansion.

A Holistic Approach

Regardless of the specific program, strength-based interventions that address trauma, mental illness, substance abuse, parenting and financial management are beneficial to incarcerated women and may help reduce recidivism. Concerns surrounding reproductive health also should be part of a holistic treatment plan. It is through these multimodal approaches that we can help improve the lives of incarcerated women by positively impacting their self-image, environment and social conduct.

Sonya Khilnani, PhD, CCHP, is a licensed psychologist with Corizon Health.
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Managing Opiate Withdrawal: The WOWS Method

by Todd Wilcox, MD, MBA, CCHP-P, CCHP-A

Over the course of my medical career, everything about opiate management and treatment has changed. This is particularly true for opiate withdrawal. Like most of us, I learned early in my career that opiate withdrawal could be treated cold turkey. In fact, a well-known correctional medical textbook instructs the following: “Opiate withdrawal is known to be very unpleasant for patients but is not generally associated with life-threatening complications.”

While that may have been true when it was written, we live in a new world of opiates that present far greater challenges clinically. As a result of multiple changes outside of our sphere of practice, we now have more patients coming in on opiates, the prescription strength of opiates is substantially stronger, illegal opiates are now of much higher purity, and opiate withdrawal is more clinically severe and can frequently result in death if not managed appropriately.

As a result of all of these factors, the Salt Lake County Jail practice group felt that it was imperative to redesign how we managed opiate withdrawal to minimize morbidity and mortality. Accordingly, we undertook a comprehensive review of the medical literature and we found that the literature really did not address the issues that we were facing in a correctional setting.

Consequently, the only option we were left with was to design our own program using the literature as a guideline but customizing the program for what could be accomplished and what the priorities are in a correctional setting.

Takeaway Points

- In the modern world, opiate withdrawal is a life-threatening medical condition.
- In large institutional settings, a targeted serial screening tool like WOWS is extremely effective at standardizing treatment.
- Assessment, including vital signs and self-harm assessment, should be done twice per day for five days minimum.
- Assess for dehydration.
- Assess for comorbidities including advanced age, underlying chronic diseases and malnourishment.
- Begin targeted treatment for diarrhea and vomiting early in the withdrawal process.
- Hydrate, hydrate, hydrate using something that the patients will actually drink.
- Obtain lab work on any patients not responding to the basic protocol.
- Admit to an inpatient setting if the patient’s clinical presentation or laboratory results dictate.
- Become buprenorphine certified and use it to treat severe opiate withdrawal.

I was asked to write up this program by several clinicians at a recent NCCHC conference and to disseminate it as quickly as possible to try to improve the care for this serious condition nationally.

Identification and Monitoring

The first major step in redesigning our practices for opiate withdrawal was to develop a targeted tool for opiate withdrawal that was customized to correctional health. We ultimately created the Wilcox Opiate Withdrawal Scale protocol. The primary focus of WOWS is to identify clinical scenarios that cause dehydration and electrolyte abnormalities. These are the two main areas where patients can get in trouble, and an earlier intervention for vomiting and diarrhea and targeted assessment for clinically relevant dehydration became the focus of the WOWS protocol.

In my facility, any patient undergoing opiate withdrawal is assessed twice per day for a minimum of five days by nurses who have been trained in the WOWS protocol. The assessment includes a full set of vital signs, serial tracking of the patient’s clinical progress and interventions as necessary based on clinical presentation. We have used the WOWS protocol for about two years and have found it to be a much more sensitive tool for identifying patients who need additional medical assistance early enough in the withdrawal process to intervene effectively without having to send out patients in crisis.

In running this program, we have found that many of our opiate withdrawal patients are physiologically fragile and require medical support to withdraw from opiates safely. Patients with an abnormally low body mass index are common and they frequently experience extreme distress during opiate withdrawal. One of the changes we made with this program was to implement a mandatory height and weight measurement in the intake process using a standardized industrial scale. Patients with a body mass index less than 18 receive heightened scrutiny during their opiate withdrawal.

We also have found that young patients present a serious diagnostic challenge in the opiate withdrawal syndrome because they have tremendous physiologic reserve and they are able to maintain their vital signs in a normal range right up to the point in which they are in crisis. Thus, we have a high level of suspicion for young opiate addicts and we emphasize relying on laboratory results as opposed to vital signs in these patients to determine their need for additional medical care.

Self-Harm

Severe opiate withdrawal puts patients in such physical distress that self-harm and suicide are extremely frequent in this population. Indeed, many patients who die of opiate withdrawal die as a result of suicide. Therefore, when the nurses assess patients using the WOWS protocol, we found it necessary for them to do an assessment for self-harm.
In this scenario, it is common to encounter patients who are thinking about self-harm, and merely treating their opiate withdrawal adequately resolves the issue for them. Consequently, we view adequate opiate withdrawal treatment to be a critical component of our suicide prevention plan. Since implementation of this protocol, we have seen significant decreases in suicide attempts and suicide completions in our patient population.

**Targeted Outpatient Treatment**

In the general population setting, this program prompts aggressive targeted treatment for diarrhea, vomiting and dehydration. For diarrhea, we typically use loperamide. For vomiting, the first drug of choice is promethazine, followed by ondansetron if the patient has clinical issues with the promethazine.

We also place a significant emphasis on oral hydration. All nurses are supplied with bottles of Gatorade that they hand out freely to any patient on the withdrawal protocol. In addition, custody staff has created “hydration stations” that consist of large coolers of Gatorade that offer open and unlimited access to patients who are withdrawing. This program has proven to be invaluable in minimizing complications from withdrawal syndrome. Say what you want, the water in correctional facilities is disgusting. The pipes are old, the water tastes bad, the water is not cold and inmates will not drink it, especially when they are sick. Believing that your inmates have adequate access to water, that it is sufficient to meet their hydration needs and that they will actually drink it is a deviation from rational clinical thought.

Additionally, patients with a low body mass index are immediately started on double portion diets as well as nutritional supplementation like Ensure, and that supplementation is continued while they are on the withdrawal protocol.

**Targeted Inpatient Treatment**

For patients who do not respond to the early outpatient interventions, more aggressive surveillance and treatment are necessary. We estimate that between 5% and 10% of our patients undergoing opiate withdrawal need care at this level.

The first step in caring for these patients is to obtain basic laboratory assessments, including a CBC and a CMP to assess their electrolytes, renal function and critical blood components. It is common to identify abnormalities that require correction or additional workup in these patients. These individuals are typically admitted to an inpatient setting where they can be monitored much more closely and appropriate interventions, including IV fluids and electrolyte replacement, can occur.

Treatment in the inpatient setting also allows for much more aggressive medical management. When clinically appropriate, a primary therapy used to manage these serious opiate withdrawal patients is the initiation of a buprenorphine/naloxone (Suboxone) taper. We have found incredible, almost magical, success with this medication. We typically start these patients at 16 mg buprenorphine / 4 mg naloxone and cut that dose in half every two to three days. The clinical turnarounds you can see in these patients is nothing short of miraculous.
Pilot Test to Improve the Initial Health Assessment Paves the Way for Change

by Diane Jacobsen, MPH, CPHQ, and Brent Gibson, MD, MPH, CCHP-P

In an effort to improve the initial health assessment (IHA) process, CHORDS-QI—the quality improvement project of NCCHC Resources, Inc.—convened six jails and prisons to pilot test approaches for improvement.

NCCHC’s standard for initial health assessment in jails (J-E-04) requires that, in facilities that opt for full population assessment, all inmates receive an assessment within 14 days of admission (7 days in prisons). Based on analysis of survey data, opportunities exist to improve meeting the IHA compliance indicators (e.g., the assessment is completed within 14 days, positive findings from the receiving screening are reviewed).

The project drew on the willingness of pilot sites to identify and test innovative ways to improve the reliability of the IHA, with an emphasis on the practicality and ease of implementation across jail and prison settings. The participating facilities represented sites of different sizes and locations. The resultant set of recommendations was designed to support facilities regardless of size, mission and location in their efforts to improve the IHA process.

The primary goal of the project was to engage forward-thinking jails and prisons in identifying and testing changes to their current process that would improve the reliability of completing the initial assessment, and to gather information to enable us to share successful approaches with other facilities. The pilot focused on generating the most effective change ideas and practices to ensure that all inmates receive an IHA in compliance with the NCCHC standards.

Getting Started

We held an initial informational call with each facility to outline the project and answer questions. During this call, we explained our expectations for participation, which included the following:

• Commitment from leadership to focus and support efforts to improve compliance with the IHA standard
• Active participation of a core team including a champion, nursing and other members of the health care team, as appropriate, to test, adapt and implement changes
• Willingness to test new concepts and approaches for improving the IHA process
• Commitment to participate in conference calls with the CHORDS-QI team and other sites to share insights, results and challenges to testing
• Willingness to summarize changes tested in the spirit of “all teach, all learn”

We also had a kick-off call with each selected site to support the teams in developing a clear plan to operationalize the work and to coach them in developing specific plans for testing changes and assessing results. The pilot sites took part in ongoing conference calls to discuss their experiences and challenges and the feasibility of changes to improve their processes, and to receive feedback and coaching from NRI and the other pilot site teams.

To prepare for the project, the pilot sites completed a survey to describe the status of their IHA process in the following areas:

• Designating a leader responsible for ensuring the completion of the IHA
• Providing education to relevant staff on the importance of and process for completing the IHA
• Identifying how/whether information on the timeliness and completeness of the IHA is reported to an oversight committee

The survey also asked how these components were accomplished, as well as the types of barriers and challenges encountered.

Barriers and Facilitators

Pilot sites identified the following as the top four barriers to ensuring that the initial health assessment was completed:

• Communication challenges, including communication breakdowns between correctional staff and health services staff
• Timeliness and efficiency of identifying patients with chronic or acute health issues to ensure they are placed in the queue to be seen ASAP
• Large intake volumes with a shortage of providers and lack of staffing
• Detainee movement within the facility and unavailability of patients who were going to court

Participants also identified key facilitators to completing the IHA. They highlighted the importance of a multidisciplinary focus and the commitment on the part of clinicians, administrators and line staff. Other facilitators included communication and collaboration across disciplines, ongoing vigilance in identifying areas to improve (even when there was no overt problem with the current process) and transparency and comfort with performance improvement.

A key emphasis throughout the pilot test was the importance and impact of communication among the health services staff members and the correctional staff members in the IHA process. It is essential to have a good method of communication that everyone is committed to, recognizing that in the most successful programs, medical and custody staff have a collaborative relationship.

Proven Improvements

Specific changes that were tested and reported by the pilot sites to improve the IHA process are as follows:

• Using a “pink form” to manage daily intakes: This form is completed by nursing staff and kept in the detainee’s medical record; a copy also is given to custody for classification purposes. As each IHA is completed, the pink paper is given to intake and the booking clerk checks off that the detainee has been cleared.
• Streamlining the intake process: A “mini-intake” is done

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Recognizing and monitoring the A1C of an inmate with diabetes can help prevent expensive complications and optimize management. The A1CNow+ system can be a significant cost avoidance strategy for correctional healthcare providers.

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¹ PTS Diagnostics A1CNow+ System Professional Procedure Guide PN 91078 Rev. B
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Manage Inmate Grievances to Improve Quality and Reduce Risk

by Lorry Schoenly, PhD, RN, CCHP-RN

This article is the seventh in a series on patient safety.

Managing inmate grievances is a key component of risk management in correctional healthcare. An inmate grievance is equivalent to a patient complaint in a traditional health care setting. Grievances can involve a variety of situations and conditions, with a number of them related to health care. Like adverse events, grievances must be evaluated both individually and in aggregate. They provide clues to unsafe systems and providers, even acting as an early warning system regarding safety issues.

Promptly dealing with individual inmate grievances can often avert future legal action. Even if unfounded, inmate legal claims can tie up considerable time and financial resources while you establish and account for the actual care provided. Reviewing aggregate reports of inmate grievances over time can identify latent system issues for proactive attention. For example, accumulating grievances about lack of attention to dental issues may reveal a delay in the sick-call request triaging system or a need for more dental staff hours to accommodate the number of requests.

Some correctional settings have a culture that trivializes inmate complaints and ascribes manipulative motivations to all inmates filing grievances. On an individual case basis, this is demeaning, but on an organizational level, disregarding patient complaints in the form of grievances can result in a lost opportunity to reduce error and increase patient safety. Using inmate grievances as an opportunity for system and process improvement supports a patient-centered approach to health care provision and harm reduction.

How Grievances Can Help

Here are three important ways to use inmate grievances to help provide quality correctional health care.

Fix System Problems

Last month Doc said I was going for tests about my liver. I haven’t seen my name on the callout list yet. Please help!

Grievances can sometime unearth major system troubles. A common area of weak systems is the process for outside diagnostic testing. No doubt about it, there is no easy way to get our patients scheduled for a liver biopsy, coordinate officer transport and make the various other arrangements necessary for a successful procedure. Investigation of this grievance revealed that several patient tests had dropped off the log during an extended family leave for the medical unit clerk. Staff turnover can lead to system issues if there are no cross-trained staff to keep processes going. This issue was revealed and corrected through an inmate grievance.

Resolve Staff Issues

I keep turning in sick-call slips but no one will see me in medical. I need some attention right now!

Sometimes inmate grievances arise from unreasonable expectations and, after investigation, result in educating the patient about the process of requesting and receiving health care. This request, however, led to the discovery that the evening shift nurse, whose post duties included rounding to collect sick-call slips, was discarding some slips that she determined were unnecessary to process. Resolving the cause of this grievance may have prevented future patient harm by identifying poor staff behaviors. The immediate result of the investigation was termination of the staff member.

Correct Communication Concerns

My toe is swollen and infected. I was told I would get better shoes months ago. No one is listening to me.

This older diabetic inmate rightly needed special footwear and the state prison system he was in had a good process set up for providing it when necessary. However, communication between medical and procurement in this particular prison was faulty. Good investigation of this grievance revealed the disconnect and initiated a change in communication among departments that resulted in faster procurement of medically necessary items such as these shoes.

Incorporating Grievances Into Quality Improvement and Risk Management

It can be easy to become tone-deaf to patient complaints generated through the inmate grievance process. This is a mistake. Granted, some complaints may be unfounded, but all complaints deserve to be investigated. To use inmate grievances effectively, a system is needed for investigating grievances, answering them and tabulating any trends. Here are some tips for a smooth-running grievance process:

• Have a designated individual handle all medical grievances. A single communication point for medical grievances means relationships can be built among those in the facility who regularly handle other types of inmate grievances and complaints, thus speeding results. This also provides a consistent contact point when addressing issues with the patient population.

• Make sure your system is set up to address grievances promptly. Consider grievances to be like sick-call requests and strive to turn around a first response within 48 or 72 hours. A complicated issue may take more time to resolve, but your patients should know they are being heard and that the wheels are in motion.

• Categorize grievances related to common quality issues once an investigation of the situation indicates a primary cause. Here are some suggested categories:
  – Capacity issues: staffing/supplies
  – Communication
  – Patient information/understanding
  – Staff issues: knowledge, accountability, skill
  – System/process issues

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Nurse Leader Survey Sheds Light on Nurses’ Top Educational and Skill Needs

by Sue Smith, MSN, RN, CCHP-RN

The Nursing Advisory Council is a stakeholder group that advises the NCCHC multidisciplinary education committee on the continuing education needs of correctional nurses and assists the NCCHC lead nurse planner in assessing continuing education for correctional nurses and evaluating the quality and effectiveness of the continuing education. The council consists of nine nurse members who represent a wide variety of roles and settings, including staff nurses, nurse managers/administrators, nurse educators and advanced practice nurses who work in jails, prisons, governmental agencies and private correctional health care agencies.

In 2015, the Nursing Advisory Council developed a needs assessment survey directed at nursing leaders, including nurse managers and nurse administrators. The survey questions were determined by consensus and consisted of five primary questions:

Q. 1. How much time should be allotted for training a first-time correctional nurse before the nurse is allowed to work independently? (233 responses)

- Less than 2 weeks: 18%
- 2-4 weeks: 14%
- 5-8 weeks: 49%
- 9-12 weeks: 8%
- 3-5 months: 8%
- 6-12 months: 3%

Q. 2. What are the three most important topics for orientation/training of correctional nurses?

- Safety/Security (134)
  - Inmate manipulation
  - Safety of self and others
  - Security issues and procedures
  - Collaboration with security staff
  - Contraband
  - Infection control

- Nursing Practice (129)
  - Health/physical assessment skills
  - Emergency response
  - Sick call procedures
  - Documentation
  - Medication issues including administration, verification, pharmacology and competence
  - Triage/screening
  - Mental health, including assessment, referrals, suicide prevention, substance abuse
  - Special needs
  - Discharge planning

- Professional Practice (52)
  - Professional boundaries
  - Neutrality

- Legal/Constitutional Issues (37)
  - Access to care
  - Deliberate indifference
  - Policies and procedures
  - Licensure/scope of practice
  - Standing orders
  - Patient confidentiality
  - Standards/guidelines

- Miscellaneous (15)
  - Time management
  - Critical thinking
  - Ethics
  - Electronic medical records
  - Unique practice environment
  - Clinic operations
  - Limitations and restrictions on care provision

Q. 3. What is the single most important piece of knowledge for a correctional nurse to have?

- Professional Nursing Practice Skills (108)
  - Assessment skill
  - Able to see inmates as patients, quality care, respect, patient advocacy, compassion, nonjudgmental attitude, uses nursing process, appropriate follow-up
  - Critical thinking skills, previous clinical experience, good judgment, know where to find the answer
  - Professional boundaries
  - Emergency skills including recognition of critical patients, proper CPR, trauma evaluation, emergent care

- Firm, fair and consistent
- Compassion; patient advocacy; balance of advocacy vs. safety
- Emphasis on patient care
- Autonomy

Legal/Constitutional Issues (37)
- Access to care
- Deliberate indifference
- Policies and procedures
- Licensure/scope of practice
- Standing orders
- Patient confidentiality
- Standards/guidelines

Miscellaneous (15)
- Time management
- Critical thinking
- Ethics
- Electronic medical records
- Unique practice environment
- Clinic operations
- Limitations and restrictions on care provision

The survey questions were distributed via SurveyMonkey to nurses who self-identified as nurse managers or nurse administrators at NCCHC educational conferences. The survey was available to the target audience for two weeks. In total, 273 responses were received; a small number of responses were discarded that did not address one or more of the questions. The collected results were analyzed by the lead nurse planner using simple data reduction techniques.
Safety/Security (74)
• Don’t let guard down, how to get help, staying calm, situational awareness, infection control

Correctional Nursing Practice (16)
• Unique practice, understand population served, understand environment and facility culture, how to navigate security/medical issues, role of health care in corrections, concept of firm, fair and consistent

Legal Issues (16)
• Policies and procedures, inmate rights, scope of practice

Communication/Collaboration (15)
• Manner, effective communication, with advanced providers and DON/HSA, with security, knowledge of chain of command, SBAR technique, professional communication, who and when to call for help

Clinical Nursing Knowledge (9)
• Pathophysiology, medications, current on clinical guidelines, proficiency on treatments

Mental Health (9)
• Inmates, staff

Manipulation (7)
• Inmate-patient behavior

Miscellaneous (2)
• Computer skills, preventive health care

Q. 4. What is the single most important skill for a correctional nurse to have?

Assessment Skills (111)
• Physical, mental health, health, rapid
• Interviewing skills

Interpersonal Skills (46)
• Good listener, nonjudgmental, honest, able to handle manipulation, objectivity, professional behavior, boundary setting, able to get along with others, assertiveness, respect, conflict resolution skills, ethics, flexibility, diligence

Critical Thinking Skills (33)
• Accuracy, think and perform under pressure, good judgment, confidence, problem-solving

Communication (33)
•Written (including documentation), verbal with staff and inmates, therapeutic.

Clinical Skills (25)
• Evidence-based medicine, clinical knowledge, nursing process, CPR, codes, first responder
• Triage/prioritization of care

Personal Skills/Attributes (21)
• Observational skills, including awareness of surroundings
• Organizational/time-management skills
• Autonomy
• Self-motivated learner

Q. 5. What is the ratio of RNs to LPNs/LVNs at your facility? (268 responses)

Overall average – 3 (RNs) : 4 (LPNs/LVNs)
Most frequently occurring ratio – 1 : 1
27 respondents reported all RN staff.
A few respondents reported use of nursing assistants, medical assistants, medication aides and paramedics in addition to or instead of licensed nurses.
103 (38%) did not give information or a ratio could not be determined from the information given.

Q. 6. Which of the following best describes the correctional setting where you work? (236 responses)

Jail 45%
Prison facility 19%
State DOC/agency 17%
Federal agency 8%
Juvenile detention/confinement facility 6%
Private corporation 5%
Other* 12%
* Immigration facility, inpatient acute correctional facility, consultants, tribal jails

Discussion

Total responses were 273. However, not all respondents answered every question and it was necessary to discard a number of unusable responses. Simple arithmetic averages were calculated for questions 1, 5 and 6. Qualitative data received in response to questions 2, 3 and 4 were analyzed and separated into broad categories. The number in parentheses beside each category indicates the number of responses in that category.

There is some overlap in the information requested by questions 2, 3 and 4. This was anticipated by the Nurse Advisory Council, but we felt that there would be enough variation in the responses and/or response rates to ensure that the information gleaned from the survey would be useful. The data analysis does indicate that the weight, or importance, of the topics listed varies between each question. Additionally, there was some variation in the specific topics suggested by respondents.

The information gleaned from this survey is consistent with the results of the general needs assessment survey completed in 2014. The Nurse Advisory Council has been using, and will continue to use, the information collected by these two needs assessment surveys to plan continuing education for correctional nurses who attend NCCHC educational conferences.

Sue Smith, MSN, RN, CCHP-RN, is a correctional nurse educator. She serves as lead nurse planner for NCCHC educational activities and directs the NCCHC Nursing Advisory Council. Contact her at nsuesmith48@yahoo.com.
Designing an HIV/HCV Prevention Intervention That Speaks to Latinos

Latinos represent 17% of the population in the United States, but about 22% of all individuals in the criminal justice system. Furthermore, Latinos experience many health disparities, including HIV/AIDS and hepatitis C virus, and up to 33% of Latino men and 21% of Latina women living with HIV/AIDS in the United States enter a correctional facility in any given year.

Despite these statistics, few risk reduction interventions for HIV prevention target Latino populations. Of the 81 evidence-based interventions identified by the CDC, only eight focus on Latinos or include them in significant numbers, and none of the eight were designed for a criminal justice population.

Culturally adapted interventions have been found to be more effective and to result in better outcomes than traditional treatments, especially when focused on a single cultural group, according to an article in the July issue of the Journal of Correctional Health Care. In the article, author Gladys Ibañez and colleagues examine the dearth of culturally appropriate interventions to prevent HIV and HCV among Latinos in the criminal justice system, and they describe the development of an intervention that was adapted using the ecological validity model.

**Tailoring the Message**

The adapted intervention arose from the National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies. A DVD presented HIV and HCV prevention messages delivered by members of the target populations (Whites and Blacks) and was matched on race and gender, yielding four DVDs. It was shown to individual prisoners prior to release.

Ibañez and colleagues sought to adapt this brief intervention for heterosexual, drug-involved Latino clients in Miami. Similarly, the intervention facilitators and DVD actors were matched to the offender by gender (men and women) and language (English and Spanish), again resulting in four DVDs. One difference is that the clients were in the community under correctional supervision. Another is that the DVD was presented in group settings.

The DVD used HIV and HCV prevention messages along with video segments of Latinos sharing their stories or enacting risky scenarios. Focus groups were conducted to identify important cultural themes that would help tailor the HIV/HCV messages to the Latino clients. A second round of focus groups reviewed the content and provided suggestions, such as defining street slang and drug term use and eliminating actors who were not believable. The process was informed by the ecological validity model, which has eight dimensions: language, persons, metaphors, concepts, goals, methods and context.

**Key Points for Adaptation**

The authors’ recommendations for culturally adapting a prevention intervention for Latinos include an emphasis on language and integrating cultural themes such as familism and machismo.

As to the process of adapting an intervention to a target ethnic/cultural group, they write that the population must be involved in most, if not all, aspects of intervention development, and they must have a forum for providing ongoing feedback, such as through a community advisory board.

Formative research (such as interviews and focus groups) is important for developing the intervention content. Finally, a cultural adaptation model or theoretical framework should guide the intervention.
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For more information, visit www.ncchc.org/CCHP.
Memories Abound in Program’s 25th Year

by Barbara S. Granner

It’s the CCHP program’s 25th anniversary this year, and in preparation for our celebration at the NCCHC National Conference in October, we spoke to several CCHPs, long-timers and those newer to the program, for their memories and reflections on how the program has evolved—and what it means to them and to the field today.

Perhaps no one remembers the early days of the CCHP program as well as Edwin (Ned) Megargee, PhD, CCHP-MH, who is still deeply involved today. Megargee, an expert in testing and analysis, has consistently served on the CCHP board of trustees and chaired the board several times. He remains crucial to leading the program, developing policies and providing guidance. He was chairman of the NCCHC board of directors in 1990 when the idea for the CCHP program was born. “We had the accreditation program for sites, but there was increasing demand for individuals to somehow get involved with the Commission,” he recalls. “What could we do for individuals?”

Megargee says it was NCCHC cofounder Bernard Harrison’s vision to create a professional health care certification program. While Harrison felt that anyone who worked in the field should be eligible to take the certification exam, others on the board felt that only the most experienced should be eligible. The result was a two-tiered system, Megargee explains: “a basic certification that anyone who met the qualifications and passed the exam could aspire to, and an advanced program for those who had been a CCHP for three years and passed a more advanced exam.”

Trailblazers

The original CCHP exam, first administered in 1990, was an open-book test with about 100 multiple-choice questions and eight short essays that test-takers completed at home. (Today the test is proctored and timed, and does not have essay questions.) There also was a reexamination requirement which, Megargee says, “proved vastly unpopular and later was dropped.”

In 1991, the first “graduating class” of 200 CCHPs received certification; many of those trailblazers are still CCHPs and involved in correctional health care today.

One of them is Jim Voisard, BS, CCHP-A, director of correctional health care for Premier of TeamHealth. It was his commitment to advancing the NCCHC mission that led him to pursue his CCHP and, three years later, the CCHP-Advanced certification.

“I wanted to be as effective as possible, to play my part,” he says. “To do that, I needed to know as much about correctional health care as possible: I needed to push my educational limits.” He also understood that his pride in the credentials after his name might motivate others, “who then hopefully would get the same bug, the same passion about correctional health care.”

Someone else who remembers taking the exam at home is Janice Hill, MPH, RN, CCHP-RN, CCHP-A, consultant with the Pinellas County (FL) Sheriff’s Office, who claims it took “days” to complete. Why did she do it? “What [being certified] did was to help me encourage all the nurses I was working with to do the same thing,” she says.

Jo Renee Kerns, BSN, CCHP, a 45-year correctional health care veteran and cofounder of Correct Care Solutions, says that being grounded in the NCCHC standards was particularly helpful in the 1970s, when Estelle v. Gamble was hot and correctional health care was not yet a respected career. “NCCHC helped people like me get a lot done,” she says.

A CCHP since 1993, Kerns explains that her company mandates that certain employees become certified—and many other staff members have followed suit. “We felt it was extremely valuable that employees, particularly the people in the field, have the CCHP. But it bled over to where a lot of people were taking it, even those in the corporate office.” That includes company attorneys, a marketing representative and others, who have found the knowledge gained in the certification process to be helpful in their careers.

Jayne Russell, MEd, CCHP-A, chair of the NCCHC board of directors, also became certified in 1993. “It was a wonderful tool for me to get to know the standards, and that’s the first thing I would recommend for anyone coming into corrections today: Learn the standards, become a CCHP. It gives you that base, that foundation to understand where we’re headed in correctional health care and keep current with best practices,” she says.

Original CCHPs, Still Certified 25 Years Later

| Julie Adetunji, BSN, RN, CCHP |
| Carl Bell, MD, CCHP |
| Lynn Bill, MPA, RN, CCHP |
| Michael Campolo, DO, CCHP |
| Jacinto Garrido, DNP, ARNP, CCHP |
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| Jeffrey Metzner, MD, CCHP-A |
| Ernadene Nichols, LPN, CCHP |
| Kathleen Page, MS, RN, CCHP |
| Debra Palm, BSN, CCHP |
| Dianne Rechtine, MD, CCHP-A |
| Catherine Rigby, BS, RN, CCHP |
| Phyllis Scheiderer, BSN, RRA, CCHP |
| Inez Tann, BS, RN, CCHP |
| James Voisard, BS, CCHP-A |

It’s the CCHP program’s 25th anniversary this year, and in preparation for our celebration at the NCCHC National Conference in October, we spoke to several CCHPs, long-timers and those newer to the program, for their memories and reflections on how the program has evolved—and what it means to them and to the field today.
Another early adopter is Steven Shelton, MD, CCHP-P, CCHP-A, medical director, Oregon Department of Corrections. On occasion, someone will ask why he has so many certifications. It’s not just that he likes having a lot of letters after his name, he tells them. “It’s like wearing a team T-shirt,” he says. “I want people to see that I think this is important. I’m rooting for more knowledge, more expertise, more professionalism. We’re not just back-door physicians or nurses who couldn’t get a job anywhere else. We are a professional organization. We stand for something.”

Program Expansion

As correctional health care has changed over the years, so have the NCCHC standards and, with them, the CCHP program—not only in the content of the exam, but also in the creation of specialty exams. “Several years ago, there was a growing desire, especially on the part of the nurses, to have discipline-specific certification that would get into the clinical area,” says Megargee. “In other areas of nursing like ER or psychiatric nursing, nurses can be certified, but there was nothing similar in corrections. So the CCHP-RN led the way in 2009, followed later by the CCHP-MH for mental health professionals and CCHP-P for physicians.”

Mary Muse, MSN, RN, CCHP-RN, CCHP-A, chief nursing officer, Wisconsin Department of Corrections, had what she calls the “privilege” of being part of the task force that developed the CCHP-RN exam. “Certification not only helps legitimize the specialty, but also is important to the individual,” she says. “It gives people confidence; it allows them to grow and keeps them connected to the field. The CCHP-RN has led to a new level of commitment and energy around what we do.”

Tom Fagan, PhD, CCHP-MH, director of the social and behavioral sciences division at Nova Southeastern University, calls development of the CCHP-MH specialty exam, introduced in 2013, a natural progression. “As mental health needs have increased in corrections, the need for people who understand how to deal with mental health patients in this setting has become progressively more important,” says Fagan, who chaired the CCHP-MH task force.

The newest specialty certification, the CCHP-P for physicians, was launched in 2015; Eileen Couture, DO, RN, CCHP-P, director of emergency services at OSF St. Elizabeth Medical Center in Ottawa, IL, served on the task force. “Correctional physicians can feel like they are out there by themselves,” she says. “CCHP-P recognizes them as a specialty, acknowledges their body of knowledge and says to their counterparts: I’ve taken the next step and I’m recognized as a correctional physician.”

Those who have achieved CCHP certification agree that the continuing education requirement for recertification keeps them up-to-date and on top of trends in the field. “Being certified keeps me at the forefront of changes in the field, because the standards evolve,” says Voisard. “It has really motivated me to stay on top of the changes in correctional health care and health care in general.”

To Rita Torres, CCHP, CEO of Health Care Partners Foundation, the benefit of certification can be boiled down to one thing: quality of care. “It’s the highest quality of care available in corrections,” she tells her employees. “If you deliver the highest quality of care based on accreditation standards and you yourself are certified, then you know you’re doing the best job that you can.”

A Bright Future

What’s ahead for the CCHP program? The future looks bright, says Pauline Marcussen, MS, RHIA, CCHP, vice chair of the board of trustees. “More than 800 people applied to take the exam in 2015, and we anticipate even more this year. We’re growing by leaps and bounds.”

Barbara S. Granner is NCCHC’s manager of marketing and communications.
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New Executive Director for Academy, ACCP

Christine Westbrook has joined the Academy of Correctional Health Professionals and the American College of Correctional Physicians as executive director. She had served as ACCP’s sales and marketing manager for the past five years. Westbrook has 17 years of experience managing nonprofit medical organizations and works with several other small medical societies in a similar capacity. She has associate degrees in accounting and business management, and 31 years of experience in accounting and business.

CDC’s National Survey of Prison Health Care

A new report from the Centers for Disease Control and Prevention presents findings on health care services in U.S. state prisons, focusing on admissions screening or testing for certain risk factors and conditions, where services are delivered (on-site, off-site or both) and use of telemedicine. Findings are based on data from calendar year 2011, gathered through semi-structured interviews conducted in 2012; 45 states provided data. Key findings are as follows:

- Percentages of admissions in states that tested at least some prisoners during the intake process: hepatitis A, 76.9%; hepatitis B, 82%; hepatitis C, 87.3%; tuberculosis, 100%; mental health conditions and suicide risk, 100%; traumatic brain injury, 40.3%; cardiovascular conditions and risk factors using electrocardiogram, 82.5%; elevated lipids, 70%; and high blood pressure, 99.8%.
- Services commonly delivered on-site include inpatient and outpatient mental health care (27 and 44 states), care for chronic diseases (31 states), long-term or nursing home care (35 states) and hospice care (35 states). Inpatient and outpatient medical, dental and emergency care were mostly delivered using both on-site and off-site locations. Most states delivered selected diagnostic procedures and radiologic tests off-site.
- Telemedicine was most commonly used for psychiatry (28 states).
- www.cdc.gov/nchs/data/nhsr/nhsr096.pdf

AAP Aims to Protect Youth From Violence

The American Academy of Pediatrics has launched an initiative to identify new ways to protect children, adolescents and young adults from “the epidemic of violence occurring in their everyday lives.” Led by a group of pediatrician experts, the initiative will address gun violence and the underlying contributors of racism, religious intolerance, homophobia, xenophobia and terrorism. The move came in the wake of the killings of two black men in St. Paul, MN, and Baton Rouge, LA, and of five police officers in Dallas.

Grievances

Diane Jacobsen, MPH, CPHQ, is an improvement consultant to the CHORDS-QI project. Brent Gibson, MD, MPH, CCHP-P, is chief health officer, NCCHC Resources, Inc.

To learn more about CHORDS-QI, write to chords@ncchcresources.org.
Who Attended in 2015?
- Nurse/nurse practitioner: 38%
- Physician/physician assistant: 25%
- Administrator: 15%
- Psychiatrist/psychologist: 8%
- Social worker, therapist, counselor: 6%

Decision Makers With Authority
- State/facility medical director or director of nursing: 25%
- Health services administrator: 10%
- Department manager/supervisor: 15%
- Health services, dental or mental health staff: 19%

Who Do Attendees Represent?
- Jail facility: 44%
- Prison facility: 21%
- State DOC/agency: 11%
- Private corporation: 10%
- Juvenile detention or confinement facility: 4%
- Federal agency: 4%

Categories Attendees Recommend or Buy
- Dental care and supplies
- Disastery planning
- Electronic health records
- Health care staffing
- Information technology
- Medical devices and equipment
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Employment

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Santa Clara Valley Medical Center, a public teaching hospital, affiliated with Stanford University School of Medicine, located in the heart of Silicon Valley in San Jose (San Francisco Bay Area in Northern California) is seeking BC/BE Family Medicine or Internal Medicine Physician for a small group practice in Custody Health. We offer competitive compensation, comprehensive benefits and paid malpractice. Please submit a letter of intent and CV to roya.rousta@hhs.sccgov.org. SCVMC is an Equal Opportunity employer.

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Sherry Thomas
984-255-6025
sherry.thomas@ncdps.gov

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.

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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.

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Is CPR Training Continuing Education?

My question is about the continuing education that is required for nurses in the correctional setting. The Professional Development standard requires 12 hours of continuing education each year. Does CPR training count toward those hours?

Standard C-03 requires that qualified health care professionals participate annually in continuing education appropriate for their positions. Full-time qualified health care professionals need to obtain 12 hours of continuing education per year, and those who have patient contact must be current in cardiopulmonary resuscitation technique. Continuing education may be obtained in a variety of ways, such as staff development experiences, instruction given on-site by a member of the health staff or by guest lecturers and attendance at programs offered in the community. Attendance at a CPR training course is considered continuing education and may be counted toward the 12 hours that are required annually.

Which Standards Manual to Use?

I work in behavioral health for a state juvenile justice department. Historically, we have used the Juvenile Health Standards book, but we see that there is also a Mental Health Standards book that does not specify adult or juvenile population. Which would be appropriate for us to use?

NCCHC publishes five sets of standards, three of which are specific for health services (2014 manuals for jails and prisons and a 2015 manual for juvenile detention and confinement facilities), one for mental health services (2015) and one for opioid treatment programs (2016). Each set of standards may be used alone or in conjunction with another set of standards. When a jail, prison or juvenile facility is accredited using the Standards for Health Services, mental health is included in the overall accreditation. However, if a facility, including jails, prisons and juvenile facilities, is interested in accreditation only for its mental health program, then the Standards for Mental Health Services in Correctional Facilities manual is used. A dual accreditation may also be achieved by following both the health services standards and the mental health standards or opioid treatment program standards.

Can an LPN Serve as HSA?

Can a licensed practical nurse serve as a facility’s health services administrator? Would the LPN be working beyond his or her scope of practice, for example, by performing health assessments? In this facility, the LPN is the only health worker.

Standard A-02 Responsible Health Authority defines a health administrator as a person who by virtue of education, experience or certification is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for inmates. While an LPN may serve as the health services administrator, final clinical judgments must rest with a single, designated, licensed responsible physician.

Your second question refers to Standard E-04 Initial Health Assessment. While states vary in the scope of practice for LPNs, NCCHC standards are clear. An LPN may collect additional data to complete the medical, dental and mental health histories, and may take and record vital signs, but the hands-on physical must be performed by a physician, physician assistant, nurse practitioner or trained RN.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A columns, visit the Resources section at www.ncchc.org.
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