New Models of Care in Correctional Health

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Spring Conference Preview
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Features

3 Teaching Is a Mission for 2017 Board Chair Eileen Couture
4 Spring Conference Preview
10 New Models of Care in Correctional Health: The California Prison System’s Complete Care Model
14 SANE Nursing in the Missouri DOC Helps Victims, Encourages Reporting
16 Juvenile Voice: Empowering Your Nonmedical Staff With Improved Health Training

Departments

2 NCCCH News
18 Reader Response: ANA Congratulates NCCHC
18 News Watch
20 JCHC Special Section Explores End of Life in Corrections in Europe and U.S.
21 CCHP Page: USPHS Officer’s Leadership Project Helps Colleagues Earn CCHP
22 Exhibitor Opportunity
23 Classified Ads and Ad Index
24 Standards Q&A

Our Independence Matters

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Exceptional Opportunity for an Exceptional Leader

The National Commission on Correctional Health Care seeks a highly qualified and dynamic President & Chief Executive Officer. This individual will lead and expand NCCHC’s position as the preeminent body providing standards, certifications and educational programs for health services in the nation’s 5,000+ correctional systems. Numerous U.S. Supreme Court decisions have affirmed that correctional systems are obligated to provide necessary health care to those they incarcerate. NCCHC, a not-for-profit accreditation organization, is the leader in providing standards that advance the delivery of medical and mental health care in these systems. Its accreditation and other programs guide the field to more effective and efficient patient care, greater organizational effectiveness and responsible use of public resources.

Responsibilities and Qualifications
President & CEO responsibilities include:
• Shape, articulate and promote matters of governance and mission
• Achieve high customer satisfaction, retention and growth
• Build external relationships with diverse constituencies that enhance revenue and help expand the organization
• Develop and promote contemporary and ethical principles, policies and standards for accreditation
The President & CEO position is of national prominence and has high visibility. The ideal candidate will possess:
• A master’s or higher degree
• At least 10 years of progressively responsible management experience, including a minimum of seven years at the executive level
• Demonstrated ability to think creatively, both strategically and tactically
• Broad-based business acumen including in a not-for-profit environment
• Excellent verbal and written communication skills
• The ability to effectively interact at all levels

Additional desirable qualifications include expertise in health care executive leadership, justice system executive leadership, not-for-profit board leadership, public health, national policy formulation and accreditation systems. The President & CEO reports to the board of directors. The board includes liaisons from 33 supporting organizations representing the fields of health care, corrections and the law. Its constituents include a wide variety of health professionals as well as the leadership of adult and juvenile correctional systems at county, state and federal levels.

How to Apply
Interested candidates are strongly encouraged to apply early. For confidential consideration, please send a cover letter (including salary requirements) and CV to CEOsearch@ncchc.org. No phone calls, please.

Educational Webinars Now Offer CE Credit
New in 2017: NCCHC now offers continuing education credit for taking part in our live webinars. Most programs are 1 hour and offer 1.0 hour of CE.
NCCHC’s juvenile health committee recognizes that it can be difficult for those who work in juvenile detention and confinement facilities to travel to educational conferences. That’s why it plans to develop at least three webinars per year. The first webinar of 2017 was Responding to the Opioid Epidemic: Treatment Within Juvenile Detention Centers. This free program was a unique opportunity to learn from one of the nation’s leading experts on treating opioid-dependent youth in juvenile detention, Jennifer Maehr, MD, medical director for the Maryland Department of Juvenile Services. The program examined the growing problem of opioid dependence and overdose, reviewed medication-assisted treatment options for opioid dependence and identified issues related to treatment.

The audio recording and PowerPoint are available at the NCCHC University website: www.ncchc.org/NCCHC-University. Watch your email for future events.

Let’s Get Social!
Do you follow NCCHC on Facebook, LinkedIn or Twitter? If not, you’re missing out! Social media is easy and fun, and it also can be educational. Twitter in particular is great for staying connected at conferences. So look us up and join in!
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Couture’s first reaction when offered a position at Cook County Jail in Chicago. By that time, Couture had built a solid, 20-year resume in health care, primarily in emergency medicine, both as a nurse and as a physician, with both clinical and administrative experience.

With health care her sole career interest since her teens, when her after-school job was as a hospital dietary aide, Couture earned a BSN degree and then an MSN. She took on progressively responsible roles, from staff nurse to nurse manager and director of emergency nursing. It was while working as a clinical nurse manager that a fellow nurse who had enrolled in medical school suggest that Couture follow suit. Four years later, she was a newly minted DO.

She took an emergency medicine residency at Cook County Hospital (now the John H. Stroger Jr., Hospital of Cook County) and became an attending physician there, a job she still performs today. Cook County Jail looked to the hospital when it needed someone to assess, reorganize and improve its emergency services.

Couture’s first visit to the jail triggered that “Absolutely not!” reaction. Two visits later, though, she was intrigued and took the job. “After 2 months, I said, ‘This is such a cool place—there’s so much we can do here!’” Couture recalls. “It was the challenge, the need for advocacy. In the hospital, we only saw the sick people they sent to us, but in the jail there were 10,000 more. It changed my perspective.”

Spreading the Word

That new perspective turned Couture into an evangelist of sorts. She started learning everything she could about correctional health care, as well as educating medical students, residents and her colleagues at the hospital. She discovered the “green book”—NCCHC’s Standards for Health Services in Jails—and learned about health services accreditation.

Her six-month assignment stretched into more than three years. A major accomplishment was to obtain an advanced life support ambulance for the jail, available for inmates 24/7. This greatly improved response time and communication with the receiving hospitals.

In 2005, Couture presented on the ambulance program at NCCHC’s National Conference on Correctional Health Care and made an important connection: William Haecck, MD, CCHP, her predecessor as the American College of Emergency Physicians liaison on the board of directors. For two years, Haecck served as a devoted mentor, grooming her for the board and nominating her as his replacement in 2007.

During her decade on the board, Couture has been an enthusiastic participant on several committees, helping to advance the NCCHC mission. But she says her greatest contribution to the field is lecturing. “I like to teach, to motivate people, to help them improve their practice,” she explains.

As chair, Couture intends to expand her educational outreach, spreading the word about the importance of certification and accreditation to health care quality. “If you look at CCHP certification as a mechanism to educate people, it champions the desire to do well,” she says. “And that knowledge and enthusiasm can drive a commitment to accreditation.”

In Other Board News ...

Barbara Wakeen, MA, RDN, CCHP, has been elected chair-elect. Wakeen has been the Academy of Nutrition and Dietetics’ liaison to the board since 2001, serving on the executive, education and juvenile committees, among others. She is the principal of Correctional Nutrition Consultants, Ltd., North Canton, OH, which provides food service/nutrition consultation to correctional institutions and community-based clients.

The board also welcomes three new members:

- **Wendi Wills El-Amin**, MD, is now the liaison of the National Medical Association. Her career has focused on correctional health care, health disparities and primary care. She is associate professor of family medicine and associate professor of medical education at Southern Illinois University School of Medicine.

- **Elizabeth Lowenhaupt**, MD, is the liaison of the American Academy of Child and Adolescent Psychiatry. She serves as medical director at the Rhode Island Training School, the state’s only juvenile justice facility. She also is assistant professor (clinical) in the department of psychiatry and human behavior at the Warren Alpert School of Medicine at Brown University.

- **Johnny Wu**, MD, CCHP, is the liaison for the American College of Physicians. An NCCHC physician surveyor since 2012, he is the director of medical services for UConn Health Center’s Correctional Managed Health Care program, which provides health services in the state’s 17 correctional facilities.

**At A Glance**

**Eileen Couture, DO, RN, CCHP-P**

**Current Work**

- Medical director at the South Suburban Council on Alcoholism and Substance Abuse outside of Chicago since October 2016
- Emergency department attending physician at several Chicago-area hospitals
- Adjunct professor at Midwestern University (family medicine) and Rush Medical College

**Correctional Health Positions**

- Interim chair of correctional health care, Cook County (IL) Bureau of Health Services, 2007–2008
- Director of emergency services, Cermak Health Services, Cook County Jail, Cook County Department of Corrections, 2001–2004

**Education**

- Doctor of osteopathy, Chicago College of Osteopathic Medicine
- Master of science in nursing, DePaul University, Chicago

**Selected Activities**

- Joined the board of directors in 2007 as liaison of the American College of Emergency Physicians
- Certified since 2009, CCHP-P since 2015
- Physician surveyor for the accreditation program
- Served on the accreditation, policy and standards, and juvenile health committees; CCHP-P and clinical guidelines subcommittees
- Former board member, Academy of Correctional Health Professionals
One of the largest educational gatherings in our field, NCCHC’s Spring Conference is the place to be for networking, collaborating and problem-solving. Join us for an exceptional program that offers myriad opportunities to learn from experts, mingle with peers and return to work refreshed and ready to implement new solutions.

Top 5 Reasons to Attend the Spring Conference

• Targeted education from the nation’s leader in correctional health care education—the only organization dedicated solely to improving health care in the nation’s jails, prisons and juvenile facilities

• Up to 26.5 hours of continuing education credit

• Unparalleled networking with peers and experts from every segment of the correctional health care field: clinicians, administrators, staff and management

• More than 50 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 and more

Choose from more than 50 concurrent sessions

With sessions geared toward basic, intermediate and advanced levels of experience, the Spring Conference delivers unparalleled education and professional development opportunities.

• Addiction to Self-Harm: Identification, Assessment and Treatment

• ADHD Prevalence and Treatment Among Prison Inmates

• Clinical Judgment for the Correctional Nurse

• Emergency Protocols and EMR Order Sets for Nurses

• Environmental Rounds: Breaking the Chain of Infection

• Facilitating Change in TB Programs

• Increasing Timely Access to Specialty Care

• Preventive Medicine 2017

• Vicarious Traumatization in Correctional Health Care Workers

The A Is the Place to Be

Hot ‘Lanta is hot indeed. With sophisticated cuisine, world-class museums, beautiful modern architecture and an abundance of trees and parks, this historic city is quickly becoming one of the most cosmopolitan in the country. The perfect blend of down-to-earth and chic, “the Big Peach” has something for everyone. So grab a glass of sweet iced tea, brush up on your U.S. history and join us for educational programming, CE opportunities and networking galore.

Meeting Location and Housing

All conference activities will take place at the Hyatt Regency Atlanta, 265 Peachtree Street NE, Atlanta, GA. NCCHC has reserved a block of rooms at the special rate of $169 + tax. Make a reservation by April 12 to ensure availability and lock in the special NCCHC conference rate. Go to https://aws.passkey.com/e/14295704 or call 888-421-1442. Be sure to mention NCCHC when you make your reservation.

Continuing Education Credit

The Spring Conference offers up to 26.5 hours of CE credit: 12.5 for the conference and 14 for the preconference seminars. See the conference website for details: www.ncchc.org/spring-conference.

• Certified Correctional Health Professionals: Category 1 credit

• Dentists: American Dental Association (ADA CERP)

• Nurses: American Nurses Credentialing Center

• Physicians: Accreditation Council for Continuing Medical Education

• Psychologists: American Psychological Association

• Social Workers: National Association of Social Workers
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VIVITROL® (naltrexone for extended-release injectable suspension) is a non-narcotic, non-addictive, 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 the 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 her get on a path to treatment.

Learn more about a non-addictive, non-divertible treatment option.

Visit TreatWithVIVITROL.com to learn more about how VIVITROL and counseling can help.

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, polylactide-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.

administration. Healthcare professionals should ensure that the VIVITROL injection provided in the carton are customized needles. VIVITROL must not be injected as an intramuscular gluteal injection, and inadvertent subcutaneous injection of reported cases occurred primarily in female patients. VIVITROL is administered

debriement of necrotic tissue. Some cases resulted in significant scarring. The

VIVITROL® (naltrexone for extended-release injectable suspension)

is also the possibility that a patient who is treated with VIVITROL could overcome to the patient of this increased sensitivity to opioids and the risk of overdose. There

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 VIVITROL treatment is discontinued, 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 overcame 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 post marketing 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 1/2 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. 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 one 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 extensive 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 generally believed to be severe or necessitate hospitalization. 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 opioid withdrawal (which may be precipitated with opioid antagonists) should there be no completely reliable method for determining 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. In some cases, clinical signs of opioid withdrawal were not accompanied by a positive urine toxicology screen, and subsequently precipitated withdrawal was not observed in association with VIVITROL exposure during the clinical development program and 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 sequelaes including, but not limited to, liver failure. Patients must be informed 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. Depression and Suicidality: Alcohol- and opioid-dependent patients, including those taking VIVITROL, should be monitored for the development of depression or suicidal thinking. Families and caregivers of patients being treated with VIVITROL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s healthcare provider. Alcohol Dependence: In controlled clinical trials of VIVITROL administered to adults with alcohol dependence, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo (1% vs 0). In some cases, the suicidal thoughts or behavior occurred after study discontinuation, but were in the context of an episode of depression that began while the patient was on study drug. Two completed suicides occurred, both involving patients treated with VIVITROL. Depression-related events associated with premature discontinuation of study drug were also more common in patients treated with VIVITROL (~1%) than in placebo-treated patients (0). In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, adverse events involving depressed mood were reported by 10% of patients treated with VIVITROL 380 mg, as compared to 5% of patients treated with placebo injections. Opioid Dependence: In an open-label, long-term safety study conducted in the US, adverse events of a suicidal nature (depressed mood, suicidal ideation, suicide attempt) were reported by 5% of opioid-dependent patients treated
with VIVITROL 380 mg (n=101) and 10% of opioid-dependent patients treated with oral naltrexone (n=20). In the 24-week, placebo-controlled pivotal trial that was conducted in Russia in 250 opioid-dependent patients, adverse events involving depressed mood or suicidal thinking were not reported by any patient in either treatment group (VIVITROL 380 mg or placebo).

When Reversal of VIVITROL Blockade Is Required for Pain Management: In an emergency situation in patients receiving VIVITROL, suggestions for pain management include regional analgesia or use of non-opioid analgesics. If opioid therapy is required as part of anesthesia or analgesia, patients should be continuously monitored in an anesthesia care setting by persons not involved in the conduct of the surgical or diagnostic procedure. The opioid therapy must be provided by individuals specifically trained in the use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. Irrespective of the drug chosen to reverse VIVITROL blockade, the patient should be monitored closely by appropriately trained personnel in a setting equipped and staffed for cardiopulmonary resuscitation.

Eosinophilic Pneumonia: In clinical trials with VIVITROL, there was one diagnosed case and one suspected case of eosinophilic pneumonia. Both cases required hospitalization, and resolved after treatment with antibiotics and corticosteroids. Similar cases have been reported in postmarketing use. Should a person receiving VIVITROL develop progressive dyspnea and hypoxemia, the diagnosis of eosinophilic pneumonia should be considered. Patients should be warned of the risk of eosinophilic pneumonia, and advised to seek medical attention should they develop symptoms of pneumonia. Clinicians should consider the possibility of eosinophilic pneumonia in patients who do not respond to antibiotics. Hypersensitivity Reactions Including Anaphylaxis: Cases of urticaria, angioedema, and anaphylaxis have been observed with use of VIVITROL in the clinical trial setting and in postmarketing use. Patients should be warned of the risk of hypersensitivity reactions, including anaphylaxis. In the event of a hypersensitivity reaction, patients should be advised to seek immediate medical attention in a healthcare setting prepared to treat anaphylaxis. The patient should not receive any further treatment with VIVITROL. Intramuscular Injections: As with any intramuscular injection, VIVITROL should be administered with caution to patients with thrombocytopenia or any coagulation disorder (eg, hemophilia and severe hepatic failure). Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunoassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunoassay instructions is recommended.

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, anorexia, 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 (2%), pregnancy (1%), headache (1%), and suicide-related events (0.3%). 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 angesics.

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 ≥66 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 6-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, nausea, abdominal pain, somnolence, 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.
Health care providers in prisons and jails are beginning to consider adopting new models of care that have gained wide acceptance in community primary care settings. Models include the patient-centered medical home (PCMH) and integrated behavioral health and primary care. Both are evidence-based models that successfully address health care’s “triple aims” of improved outcomes, lower cost and improved patient experiences. They also both contribute to provider satisfaction, a factor that is critically important in retaining a high quality workforce in correctional health.

Transition from traditional primary care practice to these new models is challenging and in community settings most often occurs through learning collaboratives of multiple practices that use a structured change process, a consistent road map, well-developed tools and common outcome measures. This article describes how the California prison system used these techniques to adapt the PCMH model of care in its 35 prisons serving 135,000 inmates.

California Correctional Health Care Services decided to transition its entire system to the Complete Care Model in response to the effective new models of primary care in the community. The intent of the Complete Care Model is to improve patient safety and increase the effectiveness and efficiency of prison-based primary care by focusing on the following:

- Improved communications among licensed clinicians caring for the same patient
- Improved continuity in transitions of care such as inpatient to outpatient settings and between correctional facilities
- Efficient and effective use of health care staff, equipment and clinic space
- Appropriate preventive, routine and urgent primary care services provided to all patients throughout the system

CCHCS designed the Complete Care Model around five components that closely mirror the PCMH model. Several components have been fully implemented and are continually being refined. The remaining components are scheduled for rollout in 2017.

COMPONENT 1: Care Teams

CCHCS primary care providers, nurses and ancillary staff have transitioned from traditional, line-based, reactive care to care teams that jointly share the patients in their panel. Each care team is responsible for the clinical outcomes of each patient on its panel and for the collective outcomes of the various clinical populations within its panel. Care teams use a variety of tools and techniques to work more productively together to advance their goals and to enhance the outcomes for their patients at the highest clinical risk.

Daily Huddles

In these daily 15-20 minute sessions, the entire care team prepares together for the day. Structured discussion addresses topics such as the following:

- Which patients are coming in today and how can we be best prepared for their visits? Are there lab results to gather? ER reports? Can mental health or custody tell us anything we need to know about them?
- Who refused or missed medications or appointments yesterday?
- Who went off-site for care since yesterday’s clinic?
- Who came back from off-site care?
- What inmates are new to our clinic? What inmates are leaving?
- Which of us have time off scheduled? Who has something to share or celebrate?

This article is based on a presentation made by the authors at NCCHC’s 2016 National Conference and is the second in a series on innovation in correctional health practice.
The huddle is not a report—it is the opportunity for the team to decide what to do about each question and who will do it so that at the end of the day, all important matters have been owned and addressed.

**Team Roles and Responsibilities**

In team-based care, all of the disciplines and jobs share responsibility for the team’s performance. Traditional clinical hierarchies fade and all members step forward within the limits of their licenses to take on tasks. When the CCHCS med nurse reports that an inmate has refused meds for the past two days, the RN may offer to bring him in that day for a discussion. When an inmate arrives from another prison and is known to be undergoing cancer treatment, the provider may offer to review the medical record that day and the medical assistant will offer to assist.

In a high-functioning care team, members do not say, “That is not my job.” Rather, each member looks for ways to contribute to completing all of the tasks necessary to proactively manage the patient panel. The team credo is to “take care of today’s business today” and take care of any important health care needs as they present.

**Nontraditional Patient Visits**

Traditional visits do not always meet the needs of high-risk, complex patients, so CCHCS primary care teams use innovative nontraditional visits. These may be one-on-one patient visits for education in self-management, or group visits with patients who share a diagnosis or condition. The visits may center on medications, self-management, diet, clinical progression of the condition, indications for special care and so forth. They can be led by peers, pharmacists, nurses, providers or a combination.

Nontraditional visits may also be joint visits where the patient meets with the nurse and provider together, or where a mental health clinician joins the nurse or provider in meeting with the patient for specific objectives.

**Single, Integrated Care Plan**

For each high-risk patient, CCHCS care teams develop a single plan of care that identifies clinical goals, treatment plans and the patient’s personal goals. All team members refer to these shared goals and plans when interacting with the patient. This reinforcement and consistency effectively engages the entire team, including the patient, to achieve the clinical goals.

Over time, each care team determined the best place and time to hold the huddle, how to acquire the necessary real-time data and how best to operate and document the huddle. CCHCS regional leaders observed and critiqued the huddles at each clinic until they were functioning at expected levels. The transition required an enormous commitment from leaders and from line staff, but has engendered high levels of support from the care teams and is producing very positive clinical and administrative outcomes.

**COMPONENT 2: Population Health Management**

Population health management science calls for a systemic approach to assess risk within a patient population and uses data to focus the care of a population in order to reduce risk and most effectively use resources. The care team identifies unique patients (case finding) that merit focused interventions and increased resources. The team also monitors the status of the population as a whole (surveillance), tracking health maintenance and screening services using rules set by the system to notify when someone is due for service based on need and status.

Using surveillance and case finding to drive care focuses resources in the most effective way. The approach allows patients in excellent control to be managed with very few provider resources. Those in poor control receive different and more frequent interventions tailored to their needs until they reach treatment targets.

Implementing population health management in corrections requires a fundamental change from reactive to proactive care that focuses resources on patients with complex needs and aggressively manages patient and population risk. Care teams must be empowered to develop and test interventions and teams must develop a culture of collaboration and open communication. Care teams also need timely, accessible and easily understood data.

CCHCS developed a learning collaborative around population health management that taught providers the science; engaged them in developing, testing and improving tools; and coached them in using the tools. CCHCS leadership collaborated with care teams to develop data profiles to meet
Complete Care Model (continued from page 11)

their needs. The system relied on paper medical records, but data profiles were built over time using simple Excel and Sequel programs. Today, a robust panel of information is used by the care teams, facility leaders and regional and statewide administrators.

Care teams are given protected time to meet as a team to conduct population health management activities twice a month. At these sessions, clinical leaders assess team performance and provide mentoring and guidance in problem solving. The focus is in two areas. The team reviews its data on team performance and discusses strategies for improvement. For example, if data show an increase in avoidable hospitalizations, the team openly discusses root causes and contributing factors and devises a plan to address them. If the data show a growing backlog in patients needing colon cancer screenings, the team considers the problem similarly.

The team also reviews clinical performance data on high-risk subpopulations. Using data that identify patients with diabetes who have suboptimal clinical management, for example, the team can decide which patients to proactively engage to reduce their risk of poor outcomes. The team can also identify patients who have developed newly complex clinical profiles and can plan their care to mitigate their risk.

COMPONENT 3: Scheduling and Access to Care

For prisons and jails, access to care usually pivots on never-ending cycles of backlogs and on supply-and-demand issues unique to corrections. In addressing this component of the Complete Care Model, CCHCS trained and empowered care teams to do all of the following:

- Understand and balance demand and supply
- Reduce demand
- Optimize care teams to enhance supply
- Eliminate current backlogs of work
- Develop plans to address variation

Access-to-care variables differ across prisons based on the prison’s mission/correctional focus, security level and clinical population variations, and so this component calls for considerable flexibility from prison to prison. Care teams are trained to assess team-specific demand and supply issues by studying data such as no-shows and refusals, policies driving mandatory visits and variations in the frequency of chronic care visits by patient risk level.

Additionally, the primary care nurse and primary care provider are encouraged to co-consult on sick-call visits as needed and to keep a few open slots for same-day access for patients who needed urgent care overnight or have returned from a community hospitalization or a high-priority specialty service. Again, the team works together to “take care of today’s business today.”

At a management level, access across and among care teams is evaluated to identify variation in nursing referrals, variation in frequency of visits based on level of control or acuity and other factors. CCHCS continues to refine its access measures and approaches.

COMPONENT 4: Care Coordination and Care Management

CCHCS is developing a learning collaborative for the care management and care coordination component of its model of care, and plans to introduce it in 2017. Mirroring the PCMH model in community primary care, care teams will assign a care manager to highly complex patients. The care manager will serve as the primary contact for the patient and for all members of the care team. This may include mental health providers, off-site medical specialists, community hospital staff, state utilization management staff, custody, family members and regional clinical leaders. The care manager will most often be an RN or, in cases where the patient has a serious mental illness, a behavioral health specialist.

Care coordination refers to processes that assure continuity of care in all transitions of care. For prisons, care transitions involve hospitals, nursing homes and residential treatment settings but also transitions within prisons from one care team to another and transitions from one prison to another. Transitions within and across prison cause some of the most egregious breakdowns in continuity of care and carry the highest risk for poor outcomes. The care team will serve as the hub for organizing, coordinating and scheduling health care services, follow-ups and associated delivery of care. This will assure timely continuity of care, medication reconciliation, resolution of custody matters and proper management of information.

COMPONENT 5: Quality Management System

The final component of CCHCS’ Complete Care Model—a quality management system—has been organically evolving as the model has been implemented. Performance measures, working tools and processes have been designed, tested and refined by users at the patient level, the highest leadership level and everywhere in between. The culture and practice of quality improvement are incorporated throughout the model. Teamwork, continuous learning, innovation and evaluation are everyone’s privilege and responsibility, and the quality of care is improving every day.

In just six months following implementation of the care teams, CCHCS saw measurable improvement in 25 of 26 indicators measuring continuity of care, access to care, population health management, care management and availability of health information. Improvements continue and variation is measured and addressed as the full implementation of the Complete Care Model nears completion. The results continue to exceed expectations and CCHCS remains fully dedicated to its model of care. Next steps also include more fully integrating behavioral health and dental services into the care teams.
Lessons Learned
CCHCS faced many challenges in its transition to the Complete Care Model. There were no road maps for this transition in a correctional setting. Very few team members had ever seen team-based care in action in community settings and no one had seen it in a prison. Leadership studied materials and tools from community settings and adapted them to prisons, developing videos of effective huddles, huddle scripts and many other tools for other components of the model. Obstacles like team members’ differing work hours, lack of communal space for huddles and the absence of a single repository for the data necessary to the team’s functions all had to be addressed, and one team’s solution did not necessarily work for another. Implementation required extensive training for cohorts of prisons, which took clinicians offline and required adjusting staff coverage. CCHCS consistently uses learning collaboratives that allow groups of clinics and prisons to share their experiences and learn from one another. Teams learn to use rapid-cycle improvement strategies to test small changes in their settings to work through the barriers to high-functioning teams. Teams suggest and test data tools and scheduling processes, communication strategies and innumerable work process modifications. Through the collaboratives, all parties learn from one another and the practitioners truly own the resulting process.

The transition to the Complete Care Model has been an enormous culture change for CCHCS and the prison health and custody staff. The system’s champions note, though, that nothing they did required more than basic computer tools, a passion and vision for change, diligent work, a willingness to stumble and try again, and commitment to better care for their patients. Any correctional health setting can do the same.

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CCHCS Staff React to Team-Based Care
“This has been the most significant process in creating culture change in the field during any time in my tenure.”

“This has been the most significant process in creating culture change in the field during any time in my tenure.”

“Having the daily huddle and planning our day together has improved staff morale, which has had a positive effect on the patient’s care experience. All team members know what to expect and support each other when the unexpected occurs.”

Quality service for our patients.
Successful partnerships with our clients.
An engaging work environment for our employees.

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Rape in prison is a reality that too often goes unreported. In Missouri’s prison system, our sexual assault nurse examiner program is making victims more willing to report the crime, receive the forensic exam they are entitled to under the Prison Rape Elimination Act and get the medical and mental health attention they need.

Passed in 2003, PREA established national standards to prevent rapes of those incarcerated. The law also calls for mandatory reporting by anyone with information that a sexual assault has occurred. But in a prison setting, many victims are unwilling to come forward due to fears of stigmatization or threats of violence.

Corizon Health serves the health care needs of the 32,500 individuals incarcerated in the state’s 22 prisons under a contract with the Missouri Department of Corrections. We learned of the positive benefits that a sexual assault nurse examiner brings to the rape exam experience and believed such services would be valuable to our patients and our state partner. In July 2015, I was assigned to work with our team to develop a statewide SANE prison program.

This proved a difficult task. I reached out to several states, but could find no similar program in a statewide prison setting to model or from which to seek guidance. Colleagues working in the Philadelphia jail system had an established SANE nurse program and lent their expertise. Nevertheless, expanding to a statewide program and introducing a new approach to rape examinations required a lengthy process of program development, recruitment, staff training and inception. On Sept. 1, 2016, more than a year after we started, our team offered our first SANE nurse examination to our patients.

In our program, one of our 28 SANE-certified nurses responds to the facility where the victim is located. Previously, a sexual assault patient was taken to an outside provider to receive a SANE exam. At times this meant victims waited up to 12 hours, depending on the distance between the prison and the hospital and the availability of a SANE nurse at the hospital.

Benefits of a SANE Nurse Prison Program

On-site SANE exams benefit the victims of prison sexual assaults as well as the public. Our program is still young, but it is helping those who have been sexually assaulted feel more comfortable reporting the attack. Inmates are very observant and gossip spreads fast in a prison. Prior to our SANE program, inmates would be aware of patients leaving the facility. On-site SANE exams help protect patients’ privacy, reducing the disincentive to reporting that comes with stigmatization or fears of violent reprisal.

Furthermore, our SANE nurses are also correctional nurses who work with patients on a daily basis within their normal job duties. At times the SANE nurse will know patients through past encounters during clinic or chronic care visits. Patients may be more trusting of a familiar nurse and be more forthcoming in discussing the event than they would with strangers.

The SANE nurses are part of a coordinated response that includes investigators, advocates and mental health professionals. Having the entire sexual assault response team under one roof facilitates the investigation and provides better continuity of care to the victim. The SANE nurse may directly schedule appointments for follow-up and STD prevention with the staff at the patient’s assigned facility.

Other benefits of having the SANE nurse respond directly to the facility include the following:

- Patients can report sexual assaults without the trauma and potential embarrassment of reporting the details multiple times to multiple individuals.
- Patients are cared for by correctional nursing professionals trained to deal with this specific population.
- Minimizing off-site inmate transportation increases public safety.
- Facility staffing is not affected by transporting the patient to an outside hospital.

The SANE nurses are part of a coordinated response that includes investigators, advocates and mental health professionals.
Challenges of Maintaining a SANE Program

Staffing has been one of the most significant challenges for the program. All SANE programs seem to have nurse retention issues, but they are exacerbated in the correctional setting where nursing turnover already is high. I am engaged in a continual cycle of recruitment and training.

A sustainable SANE program requires anticipating and preparing for turnover. Training a replacement may take six to 12 weeks. SANE certification is typically a 40-hour online self-study program followed by competency testing that the recruit must complete in addition to normal scheduled duties and outside commitments.

The prison environment itself poses several challenges, such as availability of supplies and access to patients. Equipment, such as syringes and flushes, is secured and counted. When working in the community, I have taken for granted the ease of obtaining supplies. In a prison, it can be a challenge to acquire a needed item simply because of the security measures that must be followed to retrieve supplies from another area of the facility.

In the community, patients are easily accessible. In the prison setting, patients may be in a locked cell and the correctional nurse may have to wait for custody staff to move the patient to an examination room or for an escort to a patient’s location. Depending on what is occurring at the facility or the institution’s security level, this may create a delay for the nurse to complete the task at hand.

What else is required to sustain a SANE program? This is something I think about frequently. Our program is only in its infancy, but I find myself thinking about its future and long-term sustainability. At $2,000 to $3,000 per nurse, the cost of training alone can take a large portion of budgeted funds. Requirements for length of employment prior to being accepted to the SANE nurse program can decrease the number of eligible applicants. I don’t yet know the solutions, but I am optimistic that our committed team will overcome any obstacles that arise.

An Extension of Our Mission

Correctional nursing is challenging but highly rewarding work. Patients aren’t always cooperative or honest with staff and sometimes have ulterior motives for seeking care. Nurses must provide care while being aware of their environmental surroundings.

But the reward is delivering care to appreciative patients with significant health needs who typically have had little access to care in the community. We play a vital role in turning around the lives of our patients, and our SANE nurse program is a natural extension of our mission to provide quality care to our patients.

Masonda Wheatley, RN, CCHP, is the SANE nurse coordinator for Corizon Health in its Missouri Regional Office, serving the Missouri Department of Corrections. Wheatley also serves as CQI coordinator and clinical educator. To contact her, email Masonda.Wheatley@CorizonHealth.com.
Empowering Your Nonmedical Staff With Improved Health Training

by Celeste C. Barker DNP, FNP-C

Nonmedical staff are important in your daily success as a health care provider. These staff members are in a prime position to be included as part of your health care team and are frequently the first to respond to problems since they are supervising the youth 24 hours a day, seven days a week. They should know what actions to take to ensure the best outcomes for the youth in emergency situations.

At our nine juvenile justice system facilities in northern Utah, a medical provider is not always present. We have 21 registered nurses on-site approximately 40 to 80 hours per week, depending on the facility. A health care provider, such as a nurse practitioner, is present approximately three to 12 hours per week. This means that for more than half of the 168 hours each week, no medical provider is on-site to provide medical care. For these reasons, we deem it imperative to provide basic health education to nonmedical staff.

Have you read the National Commission’s juvenile standards regarding health training for child care staff? If not, or if you’re looking for ideas on how to implement these recommendations at your facility, please read on.

NCCHC advises that all staff members who work with juveniles should receive health-related training at least every two years on the following eight topics:

- First aid administration
- Recognizing emergency or life-threatening situations
- Recognizing acute manifestations of chronic illness, intoxication and withdrawal, and adverse reactions to medications
- Recognizing signs and symptoms of mental illness
- Suicide prevention procedures
- Procedures for referral of youth with health complaints
- Precautions for infectious and communicable diseases
- Cardiopulmonary resuscitation

How does your facility measure up?

Within our nine JJS facilities, only four of the eight recommended health-training benchmarks for nonmedical staff were being met. As a quality improvement project, we decided to create health care modules that would help us address the topics we were not meeting. We chose the free BlackBoard CourseSites online learning management system. We chose the BlackBoard LMS because it provided a perennial platform for education of nonmedical staff. Another beneficial feature of the LMS was having all written protocols and supplementary medical information available as hyperlinks in one central location for timely and up-to-date access.

Surveying Staff

To determine what we should focus on when building the module content, we decided to survey the employees, directors and medical staff. We hoped that by obtaining input from all involved groups, it would lead to improved acceptance of the education.

We learned some interesting things from our survey. There is a wide range of current health knowledge among our nonmedical staff. One director commented, “We have some seasoned employees, but also a lot of new employees, where this is their first job out of college working with youth.”

Medical staff and nonmedical staff perceive some education needs differently. None of the medical staff survey responses indicated that mental illness should be an education topic covered for nonmedical staff, yet mental illness was most frequently mentioned by nonmedical staff as a desired education topic. Health training is currently provided by on-site nurses in informal meetings and general staff meetings. Nurses currently teach only four topics to nonmedical staff members: health services procedures (e.g., how to call the on-call provider), simple medication dispensing, infection control (e.g., washing hands) and first aid.

Six out of eight directors’ answers indicated a desire for an education intervention that was basic (could apply to new staff) and had a versatile format (information could be used in staff meetings or handouts, or accessed by employees during downtime at work). One director wrote, “Sometimes time and coverage can be an obstacle, so the more variety of ways to get the information out to all would be better.”

Standardized Training, Better Outcomes

There is need for improved health education among nonmedical staff. With variable and nonstandardized education training, variable results can be expected across facilities. One director commented that his goal was “For all staff to be comfortable in dealing with a situation that would require medical attention within their scope of work to ensure safety for themselves, their coworkers and the youth we work with.” With standardized training, we can take comfort in knowing that all employees received the training necessary to do their jobs with appropriate confidence.

Celeste C. Barker DNP, FNP-C, completed her doctoral project on improving nonmedical staff health competency in the juvenile justice environment at the University of Utah in Salt Lake City in 2016.
Leveraging NCCHC’s expertise in correctional health care, NCCHC Resources, Inc., 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. NRI will put together a team of experts – clinicians, educators, administrators or other thought leaders – to address any sized project or challenge. A nonprofit organization, NRI works to strengthen NCCHC’s mission: to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities.

NRI provides:

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—Medical Director, Department of Youth Rehabilitation Services, Washington, DC

For more information on how NRI can help your facility improve the quality of health care delivery, contact info@ncchcresources.org or 773-880-1460.
Newswatch

PLWH More Likely to Develop Diabetes
New research suggests that adults with HIV are predisposed to developing diabetes. The researchers calculated the prevalence of diabetes among people living with HIV and compared it with that of the general U.S. population. (Data were taken from the Medical Monitoring Project and the National Health and Nutrition Examination Survey.) After adjusting for all variables, the diabetes prevalence was 3.8% higher among HIV-infected individuals than in the general population. The authors caution that their study is purely observational and does not look at cause and effect.

- www.medicalnewstoday.com/articles/315555.php

New Antibiotic for Gonorrhea in Development
Gonorrhea has progressively developed resistance to the antibiotic drugs prescribed to treat it. However, researchers at the University of York, United Kingdom, have developed a new antibiotic specifically targeting Neisseria gonorrhoeae, the strain that has become highly drug-resistant. The approach is to use carbon monoxide-releasing molecules that bind to the bacteria, preventing them from producing energy and thereby dying. The next stage is to develop a drug in the form of a pill or cream to test in clinical trials.


Inadequate Assistance for Elderly Releasees
A report from the National Association of Area Agencies on Aging examines trends in the U.S. aging prison population and finds that only 9% of social service organizations that provide support for older adults have programs for older prisoners or people being released. Between 2007 and 2010 the number of state and federal prisoners age 65 and older grew at a rate 94 times the overall prison population. Many of these individuals have chronic health conditions or physical disabilities and may need assistance with activities of daily living; they also face additional challenges with reentry. The report calls for more data to support a sustainable business model for providing services, foundation or government funding to test new models, and more advocacy directed toward policy makers and public officials.

- www.n4a.org/Files/n4a_AgingPrisoners_23Feb2017REV%20(2).pdf

Correctional Populations Decline in 2015
At year-end 2015, an estimated 2,173,800 people were under the jurisdiction of state or federal prisons or in the custody of local jails in the United States, down about 51,300 persons from a year earlier. This was the largest decline in the inmate population since it first decreased in 2009, and the lowest total number seen since 2004.

Overall, 40% of the decline in the prison population (down 35,500) was due to a decrease in the number of federal prisoners. The Federal Bureau of Prisons population decreased by 7% (14,100 inmates). The state prison population decreased by almost 2% (21,400 inmates), with 29 states recording a decrease. The decreases reflect both fewer admissions and more releases.

County and city jails had an average daily population of 721,300 inmates in 2015, down from a peak of 776,600 inmates in 2008. From 2008 to 2015, annual total admissions to jails steadily declined, reaching 10.9 million in 2015.

- www.bjs.gov/index.cfmmty=pbdetail&rid=5870

ANA Congratulates NCCHC on Its History, Successes
The American Nurses Association adds its congratulations as the National Commission on Correctional Health Care celebrates its 40 years of advocating for and improving the quality of health care in jails, prisons and juvenile facilities within the United States. ANA appreciates and supports the continuing efforts of NCCHC to contribute to improving the health of such vulnerable populations, and improving community and public health for our nation.

As NCCHC continues its journey toward assuring that safe, quality health care is characteristic in every corrections environment, ANA remains a partner in professional practice standards development for the corrections nursing workforce and supports your activities advocating for registered nurses and advanced practice registered nurses as correctional health care clinicians, leaders and decision makers. Please consider our professional development and educational products and government advocacy and practice team members as resources for your future health care safety and quality initiatives.

Again, congratulations on your 40 years of organizational success!

Sincerely,
Pamela Cipriano, PhD, RN, NEA-BD, FAAN
President

Editor’s note: NCCHC was incorporated in 1983 after serving as a project of the American Medical Association since 1975. The first national conference was held in 1977. For a time line of NCCHC history, see www.ncchc.org/time-line.
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.

The A1CNow+ system provides healthcare professionals with critical and immediate information to help manage an inmate population with diabetes without the cost and time delay of sending blood to the lab. Obtaining A1C results from behind the wall is possible with A1CNow+ system.

For more information visit corrections.a1cnow.com.

How could pre-diabetes or diabetes assessments improve the overall health of your inmate population and reduce costs?

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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For more information visit corrections.a1cnow.com.

A1CNow+ Key Features

- No waiting days for results from outside lab
- Small (5μL) blood sample
- Fingerstick testing may improve inmate population compliance
- 99% consistent with reference lab, on average

PTS Diagnostics

1) PTS Diagnostics A1CNow+ System Professional Procedure Guide PN 91078 Rev. B
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Life in prison can be a challenge to healthy inmates, but is increasingly difficult as one grows older. Aging men and women are one of the most rapidly growing populations within our nation’s prisons. The Human Rights Watch 2012 report “Old Behind Bars: The Aging Prison Population in the United States” documented the dramatic increases in the number of older prisoners. Using data from the U.S. Bureau of Justice Statistics, they reported that the number of sentenced federal and state prisoners age 65 or older grew 94 times faster than the total sentenced prisoner population between 2007 and 2010. The older population increased by 63%, while the total prison population grew by 0.7% during the same period.

While most of these individuals entered prison when they were young or middle-aged, most have long sentences and are not likely to be released before they are aged and infirm. Many will die there. Prisons were not designed to be geriatric facilities and health care providers face many challenges as older inmates present with mobility, hearing and vision impairments and also often suffer from chronic conditions or terminal issues. These are major challenges that prison administrators and health care providers face as they seek to provide quality end-of-life care and services.

**EOL Practices at Home and Abroad**

I am very pleased that our collaboration with Dr. Marina Richter and her colleagues from the prison research team at the University of Berne in Switzerland on end-of-life care in prisons is now a reality. Dr. Richter’s team has researched the legal standards and institutional practices for end-of-life care in Switzerland and she has included current research and scholars from several other countries (including the United States).

The result of this collaboration is a special section of seven articles representing views from the United Kingdom, Switzerland, France and the United States. These articles present differing perspectives on end of life in prison, debate the ethical issues concerning humane ways of dying behind bars and contribute to the knowledge to support institutional practices that will ensure a humane end of life in prison.

Five other articles are presented dealing with jail care, chronic health conditions among women in Canadian prisons, the influence of childhood victimization on women’s health and interdisciplinary communication in correctional settings.

As always, I welcome your opinions and insights.

John R. Miles, MPA, is the editor of NCCHC’s Journal of Correctional Health Care. This article is the Editor’s Letter from the January issue of JCHC. To subscribe, contact Sage Publications: (800) 818-7243, ext. 7100; order@sagepub.com. Articles are also available as pay-to-view downloads.
USPHS Officer’s Leadership Project Helps Colleagues Earn CCHP Credentials

by Katie Przychodzen, MA

When Lieutenant Commander Denise VanMeter, BSN, RN, a nurse at the Federal Correctional Institution in Cumberland, MD, became a CCHP in 2011, she did not realize just how much certification would benefit her career as a U.S. Public Health Services officer. “In 2015 I found out that this certification is a verified national specialty certification that is recognized by the USPHS,” she recalls. Realizing that her status as a CCHP made her eligible for a career advancement, she completed the requisite documentation and was promoted from Clinical Nurse Intermediate to Nurse Consultant Level 1. Wanting to share the benefits of CCHP status with her colleagues, VanMeter made it her goal to help other FCI Cumberland health services staff become certified.

FCI Cumberland is a medium-security federal prison with an average daily population of between 1,200 and 1,300 male inmates. USPHS Commissioned Corps officers like VanMeter work for the prison’s health services division and provide and manage a variety of physical and mental health care services. These officers are encouraged to pursue career development and advancement opportunities and, to this end, VanMeter applied for the Bureau of Prisons Leadership Program in 2015. She was accepted that August and immediately began working on her leadership project—getting her fellow health services staff CCHP certified.

In 2016, VanMeter proctored two CCHP exams at her site. “I had great success and participation,” she says. As a result of her efforts, eight of the 15 staff members in the health services department are now certified, including seven of the eight USPHS officers. “That gives our department bragging rights!” she says.

A correctional nurse since 1994, VanMeter explains that the mission of the BOP, as part of the U.S. Department of Justice, centers on the intersection of public health and correctional health care. The goal, she explains, is to keep society at large safe through the humane confinement of offenders, which necessarily includes access to quality health care.

VanMeter sees the CCHP credential as evidence of her commitment to correctional nursing and her dedication to ensuring quality of care. It’s important to demonstrate knowledge and commitment not only to superiors, she explains, but to the inmates, as well. She says inmates often ask about staff credentials that they see posted on the facility’s communication board and always have a positive response when they learn what CCHP stands for. “This speaks volumes to inmates. It shows that the staff has gone the extra mile and is aware of the national standards, policies and procedures that drive our diverse field,” she says.

To arrange for an on-site CCHP exam for your employees or coworkers, contact Matissa Sammons, MA, CCHP, vice president of certification, at matissasammons@ncchc.org. Visit www.ncchc.org/cchp for more information.

Katie Przychodzen, MA, is NCCHC’s marketing assistant.

Two Great New Benefits of Certification!

You asked us to help you earn continuing education toward recertification and enrich your professional development, and we listened. CCHPs are now eligible for these exciting new benefits:

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- A complimentary online subscription to the Journal of Correctional Health Care—JCHC offers peer-reviewed content, practical information and opportunities to earn CE by completing the self-study exam in each issue, or by writing an article or serving as a peer reviewer.

CCHP Exam Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 30</td>
<td>Atlanta, GA</td>
</tr>
<tr>
<td>June 10</td>
<td>Regional sites</td>
</tr>
<tr>
<td>July 29</td>
<td>Las Vegas, NV</td>
</tr>
<tr>
<td>August 26</td>
<td>Regional sites</td>
</tr>
<tr>
<td>November 5</td>
<td>Chicago, IL</td>
</tr>
</tbody>
</table>

We are seeking sites for regional exams and CCHPs to proctor the exams. To participate, contact the certification specialist at 773-880-1460 or cchp@ncchc.org. See the complete calendar at www.ncchc.org/cchp.
Who Attended in 2016?
Nurse/nurse practitioner 42%
Physician/physician assistant 21%
Administrator 12%
Psychiatrist/psychologist 9%
Social worker, therapist, counselor 6%

Decision Makers With Authority
State/facility medical director or director of nursing 17%
Health services administrator 11%
Department manager/supervisor 13%
Health services, dental or mental health staff 20%

Who Do Attendees Represent?
Jail facility 42%
Prison facility 15%
State DOC/agency 13%
Private corporation 12%
Federal agency 6%
Juvenile detention or confinement facility 5%

Categories Attendees Recommend or Buy
• Dental care and supplies
• Discharge 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
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for Mental Health Services in Correctional Facilities

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To order or to see a list of all NCCHC publications, visit **www.ncchc.org**.

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**ADVERTISER INDEX**

California Correctional Health Care Services.............15
Centurion.................................................................IBC
Corizon Health......................................................13
GEO Group..............................................................24
InFocus Lists..........................................................22
Medi-Dose/TampAlerT...........................................IFC
NCCHC Resources, Inc...........................................17
PowerDMS..............................................................BC
PTS Diagnostics.....................................................19
Standards for Mental Health Services.......................23
Vivitrol.................................................................6-9
Wexford Health Sources........................................5
**Standards Q & A**

**Expert Advice on NCCHC Standards**

by Tracey Titus, RN, CCHP-RN

**Timing of TB Tests**

Q: I have reviewed the 2014 NCCHC Standards but I cannot locate the timeline for a tuberculosis test to be completed from the date of booking. Am I missing it, or is it the facility’s preference?

A: The answer varies depending on whether you are referring to a jail or a prison.

For jails, this is addressed in standard E-04 Initial Health Assessment. Whether you are using the full population assessment or individual assessment when clinically indicated, it is expected that TB testing is done at the time of the health assessment unless there is documentation from the health department that the prevalence rate does not warrant it (see compliance indicators #2e and #6e). The health assessments must be conducted within 14 calendar days after admission for facilities that conduct full population assessments, and within two days for facilities that choose the individual health assessment option.

For prisons, the Receiving Screening standard (E-02) states that a tuberculosis test must be completed during the screening (see compliance indicator #11).

**Health Care Liaison**

Q: Our facility has health staff on-site 19 hours per day, seven days a week. Does the Health Care Liaison standard (C-08) apply to us?

A: No. According to the standard, a designated, trained health care liaison coordinates the health services delivery in the facility on those days when no qualified health care professionals are available for 24 hours. The intent of this standard is that health care service continues to be coordinated when health staff are not available for an extended period of time. The presence of a qualified health care professional for any part of 24 hours eliminates the need for a designated health care liaison post for those 24 hours. However, there still must be a plan in place that tells custody staff what to do when a health situation arises when health staff are not present (compliance indicator #2).

**Dental Exam for Newly Admitted Juveniles**

Q: If a juvenile is already under the care of a community dentist, has seen the dentist recently and then is admitted to a detention center, does the youth still need a dental exam within 60 days?

A: Yes, an oral examination by a licensed dentist would still be required. The E-06 Oral Care standard for juvenile detention and confinement facilities states that an oral examination is performed by a dentist within 60 days of admission. An oral examination by a licensed dentist includes taking or reviewing the patient’s oral history, an extraoral head and neck examination, charting of teeth and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination.

However, if a juvenile who has received an oral examination in the correctional system within the past year is readmitted, a new exam is not required except as determined by the supervising dentist. The intent of this standard is that juvenile’s serious dental needs are met. Oral care is an important component of an individual’s overall health care. Poor oral health has been linked to numerous systemic diseases.

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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 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 Spring Conference on Correctional Health Care, being held April 29 - May 2 in Atlanta.
Centurion is committed to improving the health of the community one person at a time through healthcare programs for incarcerated patients. Our commitment includes specialty services that support our focus on whole health. To help us achieve this, Centurion has access to all Centene specialty service offerings, collectively referred to as Envolve™.

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