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Meet NCCHC’s New CEO, Jim Pavletich

The National Commission welcomes James R. Pavletich, MHA, CAE, as its chief executive officer. He joined the organization on August 21.

Pavletich brings a wealth of experience in health care association management to his role at NCCHC. He worked at the Accreditation Association for Ambulatory Health Care, Skokie, IL, for nearly 10 years, advancing to become vice president and chief operating officer, with responsibility for accreditation services, education, marketing and communications, finance, administration, human resources and information technology.

Previous experience during Pavletich’s 20-plus years in the health care association field includes positions at the American Medical Association and the American College of Healthcare Executives. More recently, he served as vice president of membership and customer experience at the American Production and Inventory Control Society.

“We are excited to welcome a seasoned health care executive like Jim Pavletich,” says Eileen Couture, DO, RN, CCHP-P, who chairs NCCHC’s board of directors. “With his combination of strong leadership, strategic orientation and governance experience, he is well suited to take the Commission to its next phase of growth.”

Improving the Lives of Others

Pavletich began his career in marketing at ACHE. Although he later earned a master’s degree in health care administration, his career path was inspired by his experience at ACHE. “I worked with many of the nation’s leading health care administrators, and their commitment to their communities and passion for their work appealed to me,” he explains. “I found that my experience in health-care-related not-for-profit associations was also of value, and could still help to improve the lives of others, even though I wasn’t working in patient care facilities.”

After seven years at ACHE, Pavletich moved on to other Chicago-area associations, including the AMA, where he served as assistant director of membership marketing. Here he used his information technology savvy to improve the member database and helped grow membership by 11% over three years. His strong IT skills led him to a software development company that provides customer relationship management solutions for not-for-profit organizations.

It was at AAAHC that Pavletich became an accreditation pro. Among his accomplishments, he developed web-based tools to streamline the survey process and launched an accreditation program for Central and South America. During his tenure, the number of organizations accredited by AAAHC increased by 140%, from 2,400 to 5,800.

These operational successes are impressive, but Pavletich also has the human touch. “Overall, I’m most proud of helping to develop the staff who have worked with and for me,” he says. He helped create a tuition reimbursement program at AAAHC to assist people earning college degrees while working full time. He also has supported his staff members in attaining the Certified Association Executive credential from the American Society of Association Executives.

A Perfect Fit

When Pavletich learned of the CEO position at NCCHC, he knew it was a perfect fit: “It enables me to bring my background and experiences in health care accreditation, certification, IT and marketing to an organization seeking to continue on a growth trajectory,” he says.

Although his knowledge of correctional health care is limited, he’s eager to jump in. “My first priority will be to build positive relationships with staff, volunteer leaders, surveyors, vendors and customers. I’m also learning as much about correctional health care as I can.”

Updated Jail and Prison Standards Coming in 2018

New editions of NCCHC’s landmark Standards for Health Services for jails and prisons will be available in early 2018. First published in 1976 and 1979, respectively, NCCHC’s nationally recognized standards lay the foundation for constitutionally acceptable health services systems and can help facilities improve health services delivery.

These editions have been revised and reorganized to improve their usefulness. Sections have been consolidated into seven categories (previously there were nine), and introductory descriptions have been added to explain the intent of each section. New standards are being introduced and several closely related standards have been combined. In addition, the wording of the standards has been simplified.

For a preview of the 2018 Standards, attend the preconference seminar at the National Conference on Correctional Health Care, Nov. 4-8 in Chicago. See pages 6-7 for information, or visit www.ncchc.org/national-conference.
Reignite the Sparkle in Your Career

by Eileen Couture, DO, RN, CCHP-P

I hope you had a wonderful summer, celebrating the Fourth of July and enjoying the fireworks display and perhaps a parade. For me, the Fourth has always symbolized the halfway point to my summer, with the promise that fall is lurking right around the corner. So it is often a loud cry out to enjoy every remaining moment of summer.

What I find interesting about the Fourth of July is that no matter how many fireworks displays one has seen, the sparkle and spectacle continue to amaze. Hundreds of people patiently wait and are awed by the loud bang and then the momentary beautiful spray of sparkle and color against the dark sky. The message and the celebration never get old.

In my neighborhood, this year was a bit unusual because soon after the start of the show, the fireworks suddenly stopped. The crowd waited and waited. The atmosphere was filled with whispered words of impatience during the delay, and before long people started to leave.

Succumbing to Malaise

In providing health care to the incarcerated, we are reminded of the importance of our own freedom. We see firsthand daily what our freedom means. It takes a special and committed person to choose to practice in a restricted environment. We are touched by our patients’ journey, and as we walk away, like it or not, they affect our journey, as well.

Providing care to the patient behind bars can be an overwhelming task at times, and spirits can become drained. Using the Fourth of July fireworks as an analogy, how is your sparkle? Despite the daily celebration of life, are your colors tiring? Are patients recognizing your impatience or lack of energy to answer questions? Do they walk away disappointed, grumbling about your lack of caring attitude?

I offer a remedy to this malaise: Come to the National Conference on Correctional Health Care, Nov. 4-8 in NCCHC’s hometown, Chicago. What better way to meet and network with others who work in correctional health care? In this supportive and stimulating educational environment, you can replenish your toolkit with fresh ideas and recharge your attitude with positive interactions. You will return to your job with a renewed sense of purpose and lots of information for improving your day-to-day work.

Patience and Persistence

Thirty minutes after the fireworks delay—after most of the audience had gone home—the night sky was filled with spectacular pyrotechnics. Often, when things do not go as expected, patience and persistence pay off. Hope to see everyone in the fall.
Spotlight on the standards

by Tracey Titus, RN, CCHP-RN and Brent Gibson, MD, MPH, CCHP-P

Many Spotlight on the Standards columns highlight standards that are often misinterpreted, leading to a variety of compliance concerns. Standard G-01 Chronic Disease Services is one that often presents challenges, especially to physicians. Each of the compliance indicators must be properly understood and interpreted.

A Closer Look at the Language

The standard requires that patients with chronic disease are enrolled in a chronic disease program. An effective chronic care program depends on an effective receiving screening process (see Standard E-02) to identify these patients. This task is more complicated than it may seem as patients do not always provide an accurate health history at intake. A healthy inmate may have ulterior motives and falsely claim to have a chronic disease—for example, seizures (to be assigned a lower bunk) or diabetes (to get extra food). Conversely, patients may knowingly omit information for reasons such as avoiding certain housing assignments or gaining access to recreational activities. And some patients may be unable to provide information because of communication difficulties, cognitive impairment or even decreased consciousness.

These scenarios pose a challenge to health staff who must identify the patients who need to be enrolled in the chronic care program and maintain accurate lists of these patients and health record master problem lists.

The responsible physician must understand the components of a chronic disease program. A well-designed program includes a treatment plan with regular clinic visits during which clinicians monitor the patient's progress and update the treatment as needed. An effective program also includes patient education for symptom management.

In summary, a high-quality chronic disease program quickly identifies the patient population (e.g., those with diabetes), schedules each patient for an initial evaluation by a clinician and ensures that patients are individually managed. Patient management includes appropriate clinical monitoring (e.g., examinations, diagnostic studies), patient education and adjustment of treatment as needed.

Protocols for Chronic Diseases

The responsible physician should establish and annually approve clinical protocols consistent with national clinical practice guidelines. These are not the same as nursing assessment protocols. Clinical guidelines are for use by physicians and midlevel providers to guide and align clinical practice, especially for well-understood chronic diseases. The guidelines are used to assist clinical decision making, assess and assure the quality of care, educate patients, guide the allocation of health care resources and reduce the risk of legal liability for negligent care.

Clinical protocols are required for, at a minimum, asthma, diabetes, HIV, hypertension, major mental illnesses, seizure disorder, sickle cell disease and tuberculosis. Jails and prisons must also have a protocol for high blood cholesterol and juvenile facilities should have one for ADHD.

Nationally recognized and accepted clinical guidelines exist for many diseases commonly seen in corrections. NCCHC does not promulgate clinical practice guidelines, but our website (www.ncchc.org/other-resources) offers a wealth of resources to help in developing guidelines.

Documentation

The established guidelines should be used consistently and documentation in the health record should confirm that the protocols are being followed. To improve consistency, many health administrators create templates and flow sheets for use when documenting chronic care visits.

The health record should reflect how frequently the patient needs to be seen by a provider; this is commonly determined by the degree of disease control. Providers should note trends in the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating). By reviewing the patient's history and progress over time, the provider can optimize the treatment plan. In contrast, a strictly episodic and symptom-based approach can lead to increased morbidity, mortality and cost.

If diagnostic testing is required, the type and frequency should be noted, as well as orders for special diets, exercise and medication. Success in minimizing symptoms is best achieved through health professional–patient teamwork in understanding how to control chronic diseases. Therefore, patient teaching is crucial. The health record should reflect that the patient has received education on diet, exercise, medication and adaptation to the correctional environment.

While guidelines do not replace clinical judgement nor are meant to restrict sound medical practice, they do serve as a reliable point of reference that can assist providers in selecting appropriate diagnostic studies, medications, referrals and so forth. Finally, when there is clinical justification to deviate from the established protocol, it should be documented in the health record.

The Bottom Line

Compliance with standard G-01 supports efficient and clinically sound management of patients with chronic disease. Patients benefit from regular clinic visits for evaluation and management by health care providers. The best system is one in which treatment plans are based on current chronic care protocols addressing total disease management. System effectiveness should be assessed regularly through the continuous quality improvement program.

Tracey Titus, RN, CCHP-RN, is vice president of accreditation and Brent Gibson, MD, MPH, CCHP-P, is chief health officer for NCCHC.
As a correctional health care professional, you’re already well-versed in the skills needed to care for this diverse and unique patient population. Now imagine taking your skills to the California State Prison System!

Our clinicians benefit from well-defined career ladders and multidisciplinary teams that provide a patient-centered approach to care. Together, the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) provide primary medical and mental health care to patients in our State-operated correctional facilities. With 35 locations throughout California, you’re sure to find your perfect fit.

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For education, camaraderie and inspiration, there’s nothing like the National Conference on Correctional Health Care. The nation’s largest gathering of correctional health professionals attracts attendees from around the country — from small rural jails and large urban facilities, from federal agencies and health care services providers. Come join the conversation.

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• Try your luck at the popular exhibit hall raffle
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• Explore Chicago

MEETING HOTEL AND VENUE
All conference activities take place at the elegant Hyatt Regency Chicago. The hotel offers a chic, downtown retreat just steps from the Magnificent Mile and iconic Chicago destinations, with unparalleled views of downtown and the river, lake and Navy Pier. Slip away for an afternoon at the Art Institute of Chicago, explore the riverfront on the Chicago Architectural Foundation’s boat tour or snap a photo in front of Cloud Gate, locally known as the Bean.

Reserve your room by October 13 to ensure availability and lock in the special NCCHC conference rate of $199 per night. To reserve online, see the Hotel tab at www.ncchc.org/national-conference, or go to https://aws.passkey.com/go/NatlComCorrectionalHealth2017.

Up to 31 hours of continuing education credits for CCHPs, dentists, nurses, physicians, psychologists, social workers and others (includes preconference seminars)

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The conference venue puts you right in the middle of it all. Located in the downtown “Loop,” the Hyatt Regency Chicago is within walking distance to many landmarks, including the Art Institute, the Magnificent Mile, Navy Pier, and Millennium Park and its famous “Bean,” with breathtaking downtown, lake and river views.

SWEET HOME CHICAGO

The Windy City or the Second City, the City of Big Shoulders or the City That Works ... Whatever you call Chicago, NCCHC calls it home.

Having begun as a project of the American Medical Association in Chicago in the mid-’70s, NCCHC became a separate entity in 1983. We’ve been working to improve the quality of health care in the nation’s jails, prisons and juvenile confinement facilities from our Chicago offices ever since.

We are thrilled to invite you to gather with your correctional health colleagues from around the country here in Chicago, the big city with the hometown feel.
Her opioid dependence got her here.

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.

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Now help her get on a path to treatment.

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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.

VIVITROL® (naltrexone for extended-release injectable suspension)

Intramuscular

**BRIEF SUMMARY** See package insert for full prescribing information (rev. Dec. 2015).

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

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

**WARNINGS AND PRECAUTIONS:** Vulnerability to Opioid Overdose: After opioid detoxification, patients are likely to have reduced tolerance to opioids. VIVITROL blocks the effects of exogenous opioids for approximately 28 days after administration. However, as the blockade wanes and eventually dissipates completely, patients who have been treated with VIVITROL may respond to lower doses of opioids than previously used, just as they would have shortly after completing detoxification. This could result in potentially life-threatening opioid intoxication (respiratory compromise or arrest, circulatory collapse, etc.), if the patient uses previously tolerated doses of opioids. Cases of opioid overdose with fatal outcomes have been reported in patients who used opioids at the end of a dosing interval, after missing a scheduled dose, or after discontinuing treatment. Patients should be alerted that they may be more sensitive to opioids, even at lower doses, after 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 overcome the competitive receptor blockade. This poses a potential risk to individuals who attempt, on their own, to overcome the blockade by administering large amounts of exogenous opioids. Any attempt by a patient to overcome the antagonism by taking opioids is especially dangerous and may lead to life-threatening opioid intoxication or fatal overdose. Patients should be told of the serious consequences of trying to overcome the opioid blockade. **Injection Site Reactions:** VIVITROL injections may be followed by pain, tenderness, induration, swelling, erythema, bruising, or pruritus; however, in some cases injection site reactions may be very severe. In the clinical trials, one patient developed an area of induration that continued to enlarge after 4 weeks, with subsequent development of necrotic tissue that required surgical excision. In the 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 and that the needle length is adequate for intramuscular administration. Healthcare professionals should ensure that the VIVITROL injection is given correctly, and should consider alternate treatment for those patients whose body habitus precludes an intramuscular gluteal injection with 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 withdrawal symptomatically with non-opioid medications because there is 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. Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically recognized as a manifestation of opioid withdrawal, opioid withdrawal that is precipitated abruptly may lead to systemic sequelae including acute liver injury. Patients should be warned of the risk of hepatotoxicity 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 no 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 (e.g., 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 (i.e., 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 (i.e., 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 (5%), 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, antiarrhythmic 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 ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). **Labor and Delivery:** The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. **Nursing Mothers:** Transfer of naltrexone and 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.
Correctional medicine is continually competing for qualified primary care services providers, with jurisdictions employing more physician extenders to ensure that inmates’ constitutionally guaranteed right to medical care is met. It is estimated that there will be a 27% shortage of primary care physicians in the next 10 years. At the same time, significant advances in pharmaceutical treatments approved by the Food and Drug Administration have become commonplace.

Clinical doctors of pharmacy can add another dimension in providing the standard of care to incarcerated persons by performing consultation and education services to the medical provider staff and the incarcerated population. Through a multidisciplinary approach, the Delaware Department of Correction, in collaboration with Correct Rx Pharmacy Services, has implemented a clinical PharmD program in which pharmacists work in the correctional facilities providing services such as medication management, disease management and acute care consultation. The goal is to provide multiple avenues to improve medical care while containing costs.

**Education and Qualifications**

A Doctor of Pharmacy degree is a postgraduate professional degree leading to licensure allowing the practice of pharmacy. For the vast majority of PharmD graduates, the Doctor of Pharmacy degree is a four-year program after obtaining a baccalaureate degree. It combines the science of pharmacy and patient care, and many PharmD graduates continue in a one- to two-year residency program to extend their patient care experience.

PharmDs are licensed through individual state boards of pharmacy or through the North American Pharmacist Licensure Examination upon graduation from a doctorate program accredited by the Accreditation Council for Pharmacy Education and performing a yearlong pharmacy internship. Different state boards of pharmacy allow PharmDs different scopes of care within their licensure jurisdictions.

**Medication Management**

Medication management is a consultative process in which the pharmacist reviews the prescribed medications of select populations such as geriatric, dialysis, diabetes and HIV patients and those on oral anticoagulants, or in response to a clinician requesting a consultation. The Centers for Disease Control and Prevention estimates that approximately half of adults in the United States have one or more chronic conditions. In a correctional environment, the percentage of patients with chronic conditions often exceeds community estimates. The pharmacist may make recommendations concerning reduction in polypharmacy, potential drug–drug interactions and dosage modifications based on age or comorbid liver or kidney disease.

The pharmacists have a real-time awareness of changing...
pharmaceutical costs. From a cost-constraint perspective, the pharmacists may make recommendations to both the correctional administrators and prescribers concerning the relative costs of different formulations, such as ointment versus cream and capsules versus tablets. Through these recommendations, significant cost savings may be realized by making changes to the pharmaceutical formulary.

The pharmacists can also have a major impact by their ability to keep the prescribers current on new medications and new indications for specific medicines when they receive FDA approval and are marketed to community providers who, during consultations with inmate-patients, then prescribe these medications.

This service can be particularly important with the availability of newer monoclonal antibody medications, the future potential for “biosimilar” versions of these agents and newer indications for these “biologics.” Some of the newer pharmaceuticals—for example, the thalidomide derivatives and potent vitamin A preparations—have significant possible adverse side effects and the manufacturers have developed registries for patients and prescribers that involve educational efforts to reduce the potential for adverse effects. The clinical pharmacists can have a tremendous role in facilitating the registration and education process on short notice when an inmate is admitted after being prescribed these medications prior to incarceration.

Disease State Management
Disease state management is another consultative function that may be performed by clinical pharmacists. A monitoring process could be developed for the same chronic conditions as above—gestational, dialysis, diabetes and HIV patients and those on oral anticoagulants, or as requested by a prescriber—to monitor the effectiveness of the medications and contact the prescriber with recommendations when a current treatment plan has not been effective.

Many of these disease states have well-documented clinical guidelines, and if the state board of pharmacy allows, protocols could be developed in which the PharmD must make therapeutic changes based on a physician-directed protocol and supervision. Numerous articles report that oral anticoagulation protocols are very successful and cost-effective in monitoring, counseling and prescribing warfarin changes over the long term. Additionally, there are numerous articles concerning pharmacist-managed hypertension and hyperlipidemia clinics. Clearly, the level of engagement of PharmDs in disease state management depends on the decisions of the state boards of pharmacy under which the PharmD is licensed.

One common potential complication of disease state management is the monitoring of patients who are prescribed medications that may alter their ability to tolerate excessive heat. Few prisons are air-conditioned in the warm weather and these medications may pose a significant danger. While monitoring the ambient temperature in the housing areas, the clinical pharmacist can assist the medical personnel with monitoring and counseling these patients about the early signs and symptoms of heat-related complications and help limit the potential for violations of the Americans with Disabilities Act.

Acute Care
Some clinical situations do not lend themselves to protocol-based autonomous practice by PharmDs; however, their presence and advice can be very useful during multidisciplinary rounds in an infirmary setting in which medically complex patients or recent returns from a hospital admission may be housed. Transitions of care present a critical period where patients are particularly vulnerable to medication errors and negative health outcomes.

Examples of pharmacist acute care interventions include verification of hospital discharge medications, procurement of high-risk or urgent medication therapy from sources other than the contracted pharmacy service provider, and pharmacokinetic dose calculations and titrations.

Clinical Pharmacy Program Goals
In Delaware, the goal of the clinical pharmacy program is to provide multiple avenues to improve medical care while containing costs. Determining the outcomes of improved medical care is a subject for another discussion. Reduced costs may be realized by reviewing prescribing habits, patient education and the clinical pharmacist’s role in harmonizing these approaches.

Central in any discussion of cost-effective prescribing is the prescriber, including educational experience, level of experience and prescribing habits. Among all prescribers there is high variability in adherence to clinical guidelines due to a lack of knowledge of the new guidelines and an occasion conflicting guidelines among professional societies. The PharmD clinical pharmacist is able to play a significant role in presenting the newer guidelines to the medical staff along with potential options for how the guidelines could be incorporated, or why they may not be appropriate for the corrections environment.

Recommendations have changed for some guidelines—for example, in hypertension, smaller dosages of multiple drugs are now recommended instead of maximizing the dosage of one drug. In a correctional facility, this may create problems with delays in med-pass lines and more medicines designated as keep-on-person. The clinical pharmacist may be able to simplify a drug regimen to the fewest number of prescriptions and help document the decision to change from an outside prescriber’s treatment plan and why, in the corrections environment, a decreased number of prescriptions is better for the facility overall.

The patient’s ability to understand the diagnosis and pharmaceutical treatment plan is imperative for the success of a medication treatment plan. Adherence is the responsibility of both the patient and the prescriber. Patients need to understand why they are receiving a medication, the dangers of not taking it as prescribed, what to expect and what to do about adverse reactions to the medicine. These are common discussions performed by pharmacists.

continued on page 14
Another goal of Delaware’s clinical pharmacy program is to decrease the number of off-site specialty consultations and emergency room visits. Better documentation will also validate improved patient outcomes for audits and cost-effectiveness for budgetary discussions.

**Patient Encounters**

The most productive aspect of the clinical pharmacist visit is the face-to-face encounter with the patient. Prior to the visit, the pharmacist reviews the patient’s health record for the diagnosis, previous treatments, previous adverse reactions to treatments, lifestyle issues such as prescribed diet and the current treatment regimen.

This individualized approach allows the pharmacist to grasp the patient’s degree of understanding about the diagnosis and the treatment options. The face-to-face encounter allows the clinical pharmacist to interview the patient, identify barriers to proper medication usage, provide counseling concerning diet and the correct way to take the medications and answer the patient’s questions. The consultation is documented in a summary with recommendations to the prescribing providers concerning improved compliance and effectiveness, avoiding drug–drug interactions and possible cost-effective options.

Many pharmaceuticals on the market are restricted by registries to ensure that prescribers and patients have the necessary education concerning the product; examples include Revlimid and the IPlunge registry for isotretinoin. Clinical pharmacists are uniquely qualified to help the prescriber to become registered and to provide patient education and counseling. In addition, for not commonly prescribed medications that must be prepared along with the equipment to administer the medication (e.g., Veltri), the clinical pharmacist can educate the nursing staff in preparing the medication and assembling the equipment.

**Controlled Substance Management**

Controlled substances can be a challenge in the correctional environment, from maintaining the facility licensure to obtaining the stock medications, monitoring the documentation of administration and destroying the controlled substance when it is no longer needed. This is even more difficult in facilities with medication-assisted treatment protocols.

The clinical pharmacist can help the facility leadership walk through the initial and recurring paperwork to ensure compliance with the various federal and state regulations. In conjunction with a registered nurse, the clinical pharmacist can assist in the appropriate destruction and monitor the wastage over time to hone the ordering of stock medications to what is actually needed over time.

**Quality Assurance Activities**

From an administrative perspective, clinical pharmacists offer a wide range of analyses, from the individual patient up through the formulary management for a facility or correctional jurisdiction. At the individual patient level, the disease state management and patient consultation address the patient safety initiatives along with the cost-effectiveness concerns.

Looking at the broader facility, the clinical pharmacist’s teaching and mentoring role adds significant depth to the quality assurance functions of the facility.

Quality assurance activities can greatly help legislators or county executives understand their role in providing the constitutionally mandated health care for the incarcerated persons in the jurisdictions.

Vincent Carr, DO, MSA, CCHP, is recently retired as medical director of the Delaware Department of Correction, Dover; contact him at carrvf@gmail.com.

Valerie Barnes, PharmD, BCPS, CCHP, is vice president of clinical pharmacy for Correct Rx Pharmacy Services, Hanover, MD; contact her at vbarnes@correctexpharmacy.com.

Carr and Barnes will present on this topic at the National Conference on Correctional Health Care, Nov. 4-8 at the Hyatt Regency Chicago. See page 6 for more information, or visit www.ncchc.org/national-conference.
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 offers specialty services collectively referred to as Envolve™.

Envolve™ is a service offering unique to Centurion, encourages inmates to take a more active role in their overall health, and better prepare them for managing their health in the community after release from prison.

The Centurion Difference

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Using the QI Model to Keep Medication Distribution on Track

by Lisa DeBilio, PhD, LPC, Lorraine Steefel, DNP, RN, CTN-A, Christina Prestien-LaPenta, MSN, RN, CCHP, and Magie Conrad, DNP, MPA, RN-C

Medication adherence is vital to quality health care, but it can be derailed when distribution problems occur. At Rutgers University Correctional Health Care, headquartered in Trenton, NJ, a systemwide audit indicated a breakdown in the administration of keep-on-person medication, which could eventually affect approximately 20,000 patients in 14 prisons. To uncover the causes, we formed interdisciplinary quality improvement teams.

Four-Phase Model

The QI purpose—to improve the performance of services and care regarding medication distribution—matches Rutgers UCHC’s mission to provide medical services that are accessible, effective, compassionate, accountable and efficient.

This article discusses how the teams applied a four-phase QI model—plan and design, measure, assess and improve—to streamline, standardize and tailor the medication distribution process to keep things on track and improve outcomes.

Plan and Design

Although the primary focus initially was the KOP medication distribution process, the team soon realized that the breakdowns were greater than expected. The new focus encompassed all phases of the process, from the provider ordering the medication to patient receipt.

Beginning with the plan and design phase, the QI teams at four of UCHC’s largest sites worked through the QI model to identify the causes of their site-specific problems. They brainstormed until ideas about the causes were exhausted, while a scribe recorded them on a flip chart. Using a fishbone diagram—a snapshot of collective knowledge around the problem—the teams categorized the probable causes of medication distribution issues and determined which to address first (see fishbone diagram).

Through another round of brainstorming, the QI teams identified the following potential interventions and established a prioritized schedule for when to implement them:

- Develop an “as it is” workflow (variations occurred even within the same site)
- Develop an “as it should be” workflow (see page 17)
- Identify success indicators (see page 17)
- Create a plan of action including data collection and timelines
- Train site staff and leadership on the workflow process
- Train nursing leadership in a train-the-trainer session, a prerequisite to facilitating staff training at their sites
- Identify interdepartmental teams from the central office for support, oversight, auditing and reeducation of line staff
- Develop a database for tracking, storing and monitoring data and trends over time

Measure

We are now moving into the measure phase, which involves implementing interventions, collecting baseline and outcomes data, comparing these data with past performance and benchmarking with the sites themselves.

Fishbone Diagram
Assess
Based on the data collected in the measure phase, the teams will determine whether the interventions were useful and are working. The staff will be queried monthly via a survey asking for their feedback, recommendations and suggestions.

After interventions are implemented, the teams will continue to monitor changes and trends in order to monitor and maintain gains. If the data show little to no improvement, the interventions will be reevaluated and possibly revised.

Improve
When interventions appear to be working, the information will be shared. The teams will continue to provide education to staff, make sure that work flows are fully implemented and monitor and track progress monthly using a “run chart” that will show trends and patterns. Work flows will be tailored and applied at other UCHC facilities once it is determined that the interventions have contributed to improved outcomes. Staff at facilities where the QI model has reduced problems with medication distribution will have the opportunity to present their project at an annual QI fair (see CorrectCare®, Summer 2007).

Overcoming Challenges
With every change come challenges. The teams had to revise work flows several times as new information surfaced from trainings and staff feedback. It was challenging to get all staff trained prior to the implementation of the new process, and some were resistant to change. Reeducation of staff during the first week of implementation obviated their reverting back to the “way things had always been done.”

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Proof of a ‘Serious’ Medical Condition

by Fred Cohen, LLM

It is by now familiar to readers that prison inmates have an Eighth Amendment-grounded right to adequate treatment for a serious medical condition. In evaluating any responsive care, or the failure to provide care, the constitutional test is the elusive standard of deliberate indifference. Very few decisions turn on the issue of “seriousness.”

The inmate plaintiff must show that a defendant is aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and the inference must be drawn. The risk of serious harm is often a proxy for the seriousness of a condition.

As for the risk of serious harm, the issue on risk is based on probabilities; how likely is serious harm if responsive care is not provided? In Mattox v. Edelman (6th Cir. 2017), a Michigan prisoner claimed that he had a serious heart condition, complaining of pain and tightness in his chest, neck, shoulders and arms, as well as shortness of breath, fatigue and dizziness.

A nurse on duty performed an EKG test that indicated a sinus rhythm with left axis deviation. Mattox was taken to the emergency room where the outside cardiologist did a stress test that suggested a possible ischemia. He recommended a cardiac catheterization (“cath”) procedure to rule out coronary artery disease and determine the possible need for a stent or surgery to prevent a heart attack.

The prison’s medical provider denied approval for this procedure. Thus began a series of requests for care and denials of the cath procedure. Mattox filed unsuccessful grievances along the way, one of which focused also on the denial of Ranexa, an expensive yet highly effective medication.

Was the Condition Actually Serious?

The actual decision in Mattox focused on the tricky business of exhaustion of administrative remedies. Our treatment of the decision, as suggested earlier, deals primarily with the threshold requirement of “seriousness” as the path to mandated care.

The Mattox decision goes on to state,

This Circuit recognizes two theories under which a plaintiff can demonstrate the objective component of an Eighth Amendment deliberate indifference claim. First, if a plaintiff suffered from a minor or non-obvious medical condition, he can show that his condition was objectively serious “if it is one that has been diagnosed by a physician as mandating treatment.” Second, “where a plaintiff’s claims arise from an injury or illness so obvious that even a layperson would easily recognize the necessity for a doctor’s attention,” the plaintiff can meet the objective prong by showing “that he actually experienced the need for medical treatment, and that the need was not addressed within a reasonable time frame.”

Mattox argues that: (i) his heart attack symptoms were so obvious that he does not need to show medical evidence verifying that he needed treatment; and (ii) there is no requirement that he show that he was actually suffering from a serious medical condition as long as he can show that prison staff failed to respond to circumstances that created a substantial risk of serious harm.

Mattox’s arguments flatly misstate the law. As we explained in Blackmore v. Kalamazoo Co., 390 F.3d 890 (6th Cir. 2004), when a plaintiff can show that his need for medical care was so obvious that even a layperson should recognize it, he is not required to provide objective evidence that he needed medical care at the time he was experiencing the symptoms. This makes sense—if a plaintiff has been stabbed, for instance, he should not require a doctor’s diagnosis of internal bleeding before prison staff should be expected to tend to his medical needs. But the “obvious malady” theory does not excuse a plaintiff from showing that he actually needed medical care. As Blackmore itself recognizes, a plaintiff proceeding under this theory must still show “that he actually experienced the need for medical treatment, and that the need was not addressed within a reasonable time frame.”

As the district court correctly noted, it is clear from the face of Mattox’s complaint that he did not actually need medical care on August 14, 2011. The complaint does not allege that Mattox suf-
fered a heart attack that night. Moreover, Mattox was seen by a prison doctor on August 15, 2011, who did not prescribe him any medication. He was then sent to a hospital for consultation with a cardiologist, who also apparently did not prescribe Mattox any medication. When, in April 2012, Mattox received a cardiac catheterization test, it did not show a serious heart problem. Because Mattox has not demonstrated that he actually suffered a heart attack or some similarly serious problem on August 14, 2011, the district court correctly determined that he has not pleaded an objectively serious medical condition.

Finally, the court notes that the purpose of the exhaustion of administrative remedies rule is to give staff a fair chance to remedy a complaint. In the case of one physician, the court states that,

However, we agree that a jury could find that Mattox’s fifth grievance properly exhausted his claims as to [the physician]. That grievance noted that: (i) Mattox suffers from angina pain; (ii) Mattox had been repeatedly prescribed Ranexa to control his pain; (iii) Mattox’s pain was completely eliminated when taking Ranexa; (iv) [the physician] nevertheless denied a request from Mattox’s on-site medical providers to approve the continuation of Mattox’s Ranexa prescription; and (v) this denial allegedly violated Mattox’s constitutional right to be free from pain and suffering when relief was readily available. The grievance was sufficient to give prison officials notice that Mattox was challenging [the physician’s] conduct in contributing to the denial of Mattox’s Ranexa prescription.

Comment
Where an inmate may be in the early stages of coronary disease and part of the inmate’s medical complaint is that he was not provided with a doctor-recommended test (the cath procedure) that can identify seriousness with some precision, that arguably should be enough to create deliberate indifference. Much would depend on the consequences of the failure to do the test.

Running through this decision is a nagging problem related to the place for preventive care in a system driven by cost factors and the low bar of deliberate indifference. Certainly the symptoms Mattox presented support the test that was denied.

Fred Cohen, LLM, is editor of the Correctional Law Reporter. This article will appear in a forthcoming issue of CLR and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

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Q. 1. What continuing education topics should NCCHC offer that would be of the most benefit to correctional nurses? Please name two topics that would best meet your continuing education and professional development needs.

Correctional nursing practice (221)
- Nursing practice (74) – detection of malingering, nursing self-care, patient education, nursing protocols, discharge/release planning, medication administration/pharmacy updates, sick call procedures, women’s issues, diet/nutrition, lab/EKG interpretation, men’s health issues, juvenile/adolescent issues
- Professional behavior (51) – professional boundaries, handling manipulation, challenges, critical thinking, evidence-based care, research, nursing autonomy, breaking the stigma associated with correctional nursing
- Assessment skills (45)
- Emergency care (32)

Mental health (79)
- Mental health practice in correctional settings (43)
- Suicide prevention (9)
- Psychiatric medications (8)
- LGBTQ/transgender (6)
- Staff education (5)
- Mental health/physical aspects of segregation (3)
- Psychiatric emergencies (3)
- Vicarious trauma (1)
- Dementia (1)

Substance abuse (75)
- Withdrawal/detox management (40)
- Drug addiction/dependency (19)
- Illicit drug information (9)
- Overdose management/care (4)
- Medication-assisted treatment (3)

Chronic disease management (69)
- Chronic clinic management (12)
- Diabetes (14)
- Wound care (15)
- Pain management (11)
- Specific diseases (17)

Legal/ethical issues (58)
- General legal issues (20) – risk management, scope of practice, medication errors, depositions, DNR
- Documentation (21) – refusals, safe and legal, emergencies, high-risk situations
- HIPAA/confidentiality (6) – security reports, homicidal intent
- Sexual abuse (6) – detection, assessment, PREA
- Correctional nursing ethics (5)

Management/administration (50)
- Business management (28) – supervision, staffing patterns, program evaluation, time management, recruitment/retention, medication management, policies/procedures
- Staff management (22) – mentoring, staff development, healthy environment, discipline

Infection control/infectious diseases (33)
- HCV infection/treatment protocols (8)
- Infection control procedures (7)
- HIV infection (6)
- TB management (6)
- Infection prevention (3)
- Sexually transmitted diseases (1)
- Immunizations (1)
- Sepsis (1)

Correctional health care standards (18)
- NCCHC-related issues (10)
- Chronic care standards (1)
- Prenatal treatment standards (1)
- Performance improvement plans (1)
- Preparation for reviews (3)
- Certification reviews (2)

Q. 2. Would you be interested in presenting on a nursing topic at an NCCHC educational conference? If so, please include your name and contact information.

A surprising number of nurses responded affirmatively. In total, 52 nurses indicated that they would consider presenting at an NCCHC conference and provided an email address and/or a telephone number.
Discussion

Total responses were 356. Qualitative data received in response to question 1 were analyzed and separated into broad categories. The number found in parentheses beside each category indicates the number of responses counted in that category.

The most frequently requested topics were those related to correctional nursing practice. This is consistent with the results found on the 2014 general nursing survey and 2016 nurse leader survey.

The most notable difference between the 2014 and 2017 survey results was a much greater interest in mental health and substance abuse topics. This finding correlates with what we have known for decades: The closing of community mental health facilities due to deinstitutionalization efforts has led to an increase in the number of inmates with mental illnesses. This finding also reflects the alarming increase of opiate addiction and overdose cases found in our communities; correctional nurses are pleading for guidance in recognizing and providing appropriate care for the large numbers of inmates who present with signs of substance addiction and overdose.

Chronic disease management, legal/ethical issues, nursing management/administration and infection control/infectious diseases rounded out the topics that are of interest to the correctional nurses who responded to this survey. This also is consistent with the findings of previous surveys. The full survey results were forwarded to the Nurse Advisory Council and to nurses who indicated interest in presenting at NCCHC conferences.

For question 3, note that NCCHC currently offers continuing education programming in the top three formats. Questions 4, 5 and 6 collected demographic information used by NCCHC and the lead nurse planner to monitor trends in the profile of correctional nurses. Question 5 reveals that nearly one-third of the respondents have more than 15 years of experience in correctional nursing. Clearly correctional nursing practice can be rewarding!

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.

Q. 3. How would you prefer to get continuing education that is specific to correctional health care?

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<thead>
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<th>Format</th>
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<td>Educational conferences</td>
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<tr>
<td>Webinar</td>
<td>49%</td>
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<tr>
<td>Independent study (JCHC)</td>
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<td>Written independent study modules</td>
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Q. 4. What is your educational level?

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<td>PhD/DNP/DNSc</td>
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Q. 5. How long have you worked in corrections?

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<td>11-15 years</td>
<td>19%</td>
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<td>16-20 years</td>
<td>14%</td>
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<td>&gt; 20 years</td>
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</tbody>
</table>

Q. 6. In what type of correctional facility are you employed?

<table>
<thead>
<tr>
<th>Facility</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail</td>
<td>47%</td>
</tr>
<tr>
<td>Prison (state)</td>
<td>28%</td>
</tr>
<tr>
<td>Federal agency</td>
<td>6%</td>
</tr>
<tr>
<td>Juvenile detention/confinement facility</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
</tr>
</tbody>
</table>

Another obstacle was that, with competing priorities, nursing leadership had difficulty with the daily oversight of the project’s implementation at their sites. We learned that weekly conference calls helped keep up the momentum with site management oversight, which spilled over in nurse leaders’ hands-on approach and support when implementing new work flow processes.

Lisa DeBilio, PhD, LPC, is director of quality improvement; Lorraine Steefel, DNP RN, CTN-A, is nurse educator and clinical coordinator; Christina Prestien-LaPenta, MSN, RN, CCHP, is regional nurse manager; and Maggie Conrad, DNP, MPA, RN-C, is the chief nursing administrator with Rutgers University Correctional Health Care, Trenton, NJ. To contact the authors, email Lisa.Debilio@rutgers.edu or Lorraine.Steefel@Rutgers.edu.

More Quality Improvement From UCHC

To read about the first UCHC PI fair, see Staff Health Fair Celebrates Quality Improvement, CorrectCare® Summer 2007. To read about the challenges to implement CQI, see The Five-Step Challenge to Implement CQI, CorrectCare® Winter 2016. These articles are available www.ncchc.org/correctcare-archive.

An estimated 70% to 80% of people involved with the criminal justice system smoke—a rate three to four times higher than that of the general population—yet they are seldom targeted in smoking cessation efforts. Even after forced abstinence from tobacco in most correctional facilities, 97% of former inmates relapse within six months of release.

Given that nearly 4.8 million people are under community corrections supervision (probation or parole), offering tobacco cessation services to these individuals has the potential to reach a large high-prevalence and vulnerable population of smokers who desire to quit, but lack the resources to succeed.

As described by Christine Garver-Apgar and colleagues in the July issue of the Journal of Correctional Health Care, in 2013 Arkansas Community Correction partnered with the University of Colorado’s Behavioral Health and Wellness Program to implement the DIMENSIONS: Tobacco Free Program in the 33 adult probation and parole offices in Arkansas. The study reported in JCHC was conducted to evaluate the feasibility and efficacy of this statewide effort.

The tobacco-free curriculum was added to the regular substance abuse classes; overall, 962 individuals who reported tobacco use were enrolled in the program and therefore included in the study. (Voluntary tobacco-free sessions were also conducted for drug-court participants.) The study period was October 2013 to June 2015.

The evidence-based DIMENSIONS curriculum was designed for people with behavioral health disorders and promotes tobacco dependence recovery through tailored holistic services. The six-session program offers emotional and informational support for recovery through motivational engagement, provider-led support groups, community referrals and educational activities.

Participants attended the groups weekly. At the end of each session, they completed a one-page “progress form” that collected data on tobacco use and readiness to quit. The forms contained no personal identifying information.

Positive Movement Toward Quitting
Feasibility was measured by group attendance. Overall, 59% of the sample attended at least three sessions, a frequency the authors say is enough to achieve meaningful therapeutic benefits.

Program efficacy was evaluated using three indicators:
• Quit attempts: Of the entire sample, 39% reported making at least one quit attempt; of those who attended the full six-session curriculum, 49% made a quit attempt.
• Frequency of tobacco use: Participants at session 6 reported smoking fewer cigarettes (six to 10 per day, on average) compared to results from the first session (11 to 20 cigarettes per day). In fact, participants who attended only three sessions significantly reduced their tobacco use.
• Readiness to change: Comparing responses at session 1 and session 6, data analysis revealed improvement for all four “readiness” items. Again, readiness was found to improve as early as session 3.

Ultimately, the authors conclude that results demonstrated a significant reduction of tobacco use among participants, as well as increased knowledge, confidence and intent to quit. They also suggest that individuals in community corrections would benefit from access to pharmacotherapy such as nicotine replacement therapies.
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Specialty Exam Content Review Sessions Prepare Candidates for Success

by Katie Przychodzen, MA

Candidates for the CCHP – Mental Health and CCHP – Physician exams held in July were treated to an opportunity to take an in-depth exam content review session on the morning of the exam date. The two-hour sessions were held in conjunction with NCCHC’s Correctional Health Care Leadership Institutes and Correctional Mental Health Care Conference in Las Vegas. The sessions enabled candidates to ask questions and refresh the information they learned while studying for the exam. The sessions were also open to people who were simply interested in learning about the exams.

The CCHP-MH review was conducted by Sharen Barboza, PhD, CCHP-MH, vice president of clinical operations – mental health at MHM Correctional Services. The CCHP-P review was conducted by Brent Gibson, MD, MPH, CCHP-P, who is chief health officer for NCCHC. Barboza served on the task force that created the CCHP-MH program and Gibson on the CCHP-P task force.

In-Depth Review

In the talks, Barboza and Gibson provided background on the purpose of the specialty certifications. As with the basic CCHP certification, attainment of specialty certification shows mastery of national standards and the knowledge expected of leaders in the correctional health care field. It also raises the bar on quality and clearly delineates expectations and best practices. The specialty certifications go further, though, highlighting the unique role of professionals in a given discipline and the legal and ethical obligations of these individuals.

The presenters also described the eligibility requirements for each program as well as the process of becoming a candidate. They explained what candidates need to know about the exam, including what it is intended to measure and the resources used to develop the test items. In each case, the relevant NCCHC Standards (for mental health and for jails/prisons) were reviewed in detail, helping participants to think critically, apply these standards to real-life practice and prepare for the exam.

Responses to the sessions were highly positive, with follow-up surveys yielding high ratings on usefulness of the information and comments such as, “It prepared me to read about things I did not consider, such as legal cases.”

Future Opportunities

The review sessions will also be held at future NCCHC conferences. For NCCHC’s 2017 National Conference on Correctional Health Care, sessions for the CCHP-P and CCHP-RN exams will be offered. For those taking the exam for basic CCHP certification, we recommend attending the daylong preconference seminar on the Standards for Health Services for jails and prisons, and for CCHP-MH candidates, we recommend the preconference seminar on the Mental Health Standards. The conference takes place Nov. 4-8 at the Hyatt Regency Chicago. Visit www.ncchc.org for details.

Katie Przychodzen, MA, is NCCHC’s marketing specialist. If you work in correctional health care and are interested in pursuing CCHP certification to advance your career, visit www.ncchc.org/cchp for information.

What Happened to the Exam Calendar?

The CCHP program is changing the way candidates take the certification exams. In 2018, we will offer them at computer-based exam centers nationwide. Exams available are for CCHP, CCHP-MH, CCHP-P and CCHP-RN.

Here are some great benefits to the new option:
- Select a test date and time that’s conducive to your schedule
- Schedule the exam as soon as your application is approved, or wait for up to one year
- Test close to where you live or work, in one of the more than 300 testing centers in the United States
- Keep it confidential—no one will know you are taking the exam unless you tell them
- Find out your exam results in as little as two weeks

The exams will continue to be administered at all NCCHC conferences in pencil-and-paper format. Watch your email for more information!

And the Winner Is ... Tara Taylor

The top vote-getter in this year’s election to fill a seat on the CCHP board of trustees is Tara Taylor, MSML, BSN, RN, CCHP. Her three-year term will begin at the board of trustees annual meeting on Saturday, Nov. 4.

Taylor is regional director of nursing for Corizon Health – St. Louis Regional. She has worked in correctional health care for 21 years and has been a CCHP since 2005. She also is a surveyor for NCCHC’s accreditation program.

Watch for a profile of Taylor in a future issue of CorrectCare.
CCHP The Mark of Professional Leadership, Commitment and Expertise

A program of the National Commission on Correctional Health Care

For all professionals working in correctional health, including administrative and support staff

CCHP The NCCHC Certified Correctional Health Professional program recognizes your mastery of national standards and the knowledge expected of leaders in this complex, specialized field. The CCHP credential is a symbol of achievement and leadership that provides immeasurable benefits, including professional recognition and pride. It is also a stepping-stone (and an eligibility requirement) toward advanced and specialty certifications.

CCHP-MH Correctional mental health professionals face unique challenges. They must provide effective, efficient care to a high-acuity population while facing strict security regulations, crowded facilities and myriad legal and public health concerns. Specialty certification for qualified mental health professionals recognizes dedication to quality service delivery.

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

CCHP-RN Specialty certification makes a difference—to the patients whose care is provided by certified correctional nurses, to employers who desire top-notch nurses on staff and to the nurses who attain the credential. CCHP-RN certification recognizes registered nurses who have demonstrated the ability to deliver specialized nursing care in correctional settings.

ADVANCED CERTIFICATION

CCHP-A The CCHP – Advanced program recognizes CCHPs who have demonstrated excellence, commitment and contribution to the field of correctional health care and their relative discipline or profession. Advanced certification requires at least three years of participation in the certification program, and demonstration of extensive experience in and 360-degree knowledge of correctional health services delivery.

Exams are administered several times throughout the year. Apply today and join the thousands of correctional health professionals who have earned the distinction of certification from NCCHC.

For more information, visit www.ncchc.org/CCHP.
Who Attended in 2016?

Nurse/nurse practitioner 43%
Physician/physician assistant 23%
Administrator 10%
Psychiatrist/psychologist 9%
Social worker, therapist, counselor 6%

Decision Makers With Authority

State/facility medical director or director of nursing 19%
Health services administrator 8%
Department manager/supervisor 12%
Health services, dental or mental health staff 26%

Who Do Attendees Represent?

Jail facility 45%
Prison facility 21%
State DOC/agency 10%
Private corporation 10%
Juvenile detention or confinement facility 4%
Federal agency 2%

Categories Attendees Recommend or Buy

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

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

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- Access to nearly 2,000 attendees for premium face time
- 50-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and postshow marketing
- Discounts on advertising in the conference programs
- Opportunity to participate in raffle drawings
- Continuing education credits for all sessions attended
- Exclusive opportunity to become a sponsor or advertiser

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High-impact, high-profile sponsorship opportunities can help ensure recognition for your brand and your company throughout the event. Plus, you gain extra exposure when attendees return home with branded gifts. Ask your sales rep to help you maximize your marketing exposure.

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- Exhibit hall reception, lunch or refreshment breaks
- Product Theater events
- CCHP lounge host
- Conference padfolios
- Hotel key card
- Exhibit lounge
- Phone chargers

Become an Exhibitor Today!

Make a cost-effective impact! Standard exhibit booths are 10’ x 10’, double-size and premium spaces are available. For details and a reservation form, download the prospectus at www.ncchc.org, or contact Carmela Barhany at sales@ncchc.org or 773-880-1460, ext. 298. Be sure to ask about sponsorships and advertising.
Looking for a job? This benefit is free to job seekers. Post your resume online and showcase your skills and experience to prospective employers to find the best job opportunities.

Hiring? Receive member discounts on job postings and access the most qualified talent pool to fulfill your staffing needs. Hosted by the Academy of Correctional Health Professionals. For information or to access listings, visit http://careers.correctionalhealth.org.

2015 STANDARDS for Mental Health Services in Correctional Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing mental health services delivery in adult correctional facilities.

This second edition represents the culmination of hundreds of hours of careful review by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain the most authoritative resource for correctional mental health care services.

Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women’s health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

About CorrectCare

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

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

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

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

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

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Tap into the incredible network of the National Commission on Correctional Health Care with the NCCHC Buyers Guide. Powered by MultiView, the Guide is the premier search tool for correctional healthcare practitioners. Find the suppliers and services you need, within the network of the association you trust.

Simplifind your search today at www.ncchc.org.
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Does Partial Compliance Count?

**Q** Our jail is preparing for its first NCCHC accreditation survey. What percentage of compliance is required to “pass” a standard?

**A** We are pleased that you are preparing for initial NCCHC accreditation and our staff is ready to assist with your questions. Each standard is classified as either essential or important. For accreditation purposes, 100% of applicable essential standards must be met, and at least 85% of applicable important standards. Accreditation is not based on partial compliance; each compliance indicator must be met in order to meet the standard. Some standards have only one compliance indicator; whereas others have more than 10. However, not every standard may apply to your facility. For example, if your facility houses only men, the standard regarding pregnancy would not apply.

Now that you’ve applied for initial accreditation, you should contact us to schedule a free webinar on how to prepare for accreditation. The webinar shares preparation tips and discusses what to expect during a survey. It also allows health staff the opportunity to ask questions.

Diagnoses for Chronic Care Clinics

**Q** Our state prison system has implemented a chronic care clinic program. What chronic conditions should we include in our program?

**A** The information you seek is found in standards G-01 Chronic Disease Services and G-02 Patients With Special Health Needs. From NCCHC’s standpoint, any health condition that is considered chronic or that requires multidisciplinary care also requires that an individual treatment plan be developed for regular, ongoing care. Examples of such conditions are listed in G-02. Standard G-01 specifies nine conditions for which the facility is expected to follow national clinical guidelines in treating these diseases. These nine are a first step. The eventual goal is for providers to follow clinical protocols for all chronic conditions.

To find national clinical guidelines, visit www.ncchc.org/federal-clinical-guidelines. Here, links will direct you to various guidelines current in community care, such as those from the Centers for Disease Control and Prevention and the Department of Veterans Affairs, as well as guidelines from the Federal Bureau of Prisons. For more on Chronic Disease Services, see Spotlight on the Standards, page 4.

Timing for Encounters After Sick Call

**Q** When conducting sick call and a face-to-face encounter is required, should the encounter occur within 48 hours of (a) picking up the request or (b) triaging the request?

**A** Standard E-07 Nonemergency Health Care Requests and Services requires that oral or written requests for health care are picked up daily by qualified health care professionals and triaged within 24 hours. When a request describes a clinical symptom, a face-to-face encounter between the patient and a qualified health care professional occurs within 48 hours (72 hours on weekends). The intent is that a patient is seen within 48 hours (72 hours on weekends) from the time the request is picked up. The requests should be triaged in the first 24 hours and the face-to-face encounter should be conducted within the next 24 hours.

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 the National Conference on Correctional Health Care, Nov. 4-8 in Chicago.

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MEDICAL DIRECTOR
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The Delaware Department of Correction is currently accepting applications for a Medical Director. This position is located at the Department of Correction Administration Building in Dover. The position is responsible for directing, planning, coordinating and implementing all health related service of in-patient, clinical or community services. Applicants must possess a Delaware Physician M.D. or Delaware Physician D.O. license or eligibility for a Delaware license; and three years experience in health or human services program administration such as overseeing and directing the development, implementation and evaluation of health or human services programs and services, planning and establishing short and long range program goals and objectives.

Interested candidates must go to www.delawarestatejobs.com to view job requirements and submit a State of Delaware application.

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Amid shrinking budgets and growing challenges, the nation’s jails and prisons are required to provide constitutionally acceptable care. NCCHC has the resources and programs you need to meet this challenge.

VALIDATION THROUGH ACCREDITATION
Accreditation provides public recognition that correctional facilities are meeting NCCHC’s nationally recognized standards for quality health services. Accreditation reduces exposure to costly liability and recognizes the institution’s commitment to meeting quality goals and using best practices.

PROFESSIONAL CERTIFICATION
The Certified Correctional Health Professional program provides formal recognition for practitioners who have engaged in a process of ongoing, focused and targeted professional development.

STANDARDS AND PUBLICATIONS
NCCHC’s highly respected Standards serve as a framework to ensure that systems, policies and procedures are in keeping with nationally recognized best practices. NCCHC also publishes CorrectCare and the Journal of Correctional Health Care, the leading periodicals in the field.

EDUCATION
NCCHC conferences are renowned for their exceptional educational programming, abundant networking and the best commercial exhibitions in this field.

For more information, visit www.ncchc.org.