Strategies to Grow and Stabilize the Correctional Health Care Workforce

‘Get the 9-1-1 Tool—We Have a Hanger!’

2018 Standards for Health Services: What’s New?

Mental Health Conference Preview
THE VERDICT IS IN
Still #1 for tamper-evident unit dose in correctional care pharmacies

Medi-Dose® is the economical answer for packaging and dispensing your solid oral medication. Available in 13 styles, with 6 or 12-month beyond-use dating options, it’s moisture and light resistant. No in-service training is required and it’s barcode ready. Medi-Dose® uses no metal, glass or machinery…so it’s safe to use for both your staff and patient population.

TampAlerT® is the ideal tamper-evident solution for liquids or powders. It’s stocked from 15 to 120 mL, in natural or UV inhibitant polyethylene, with regular or child-resistant screw caps. The TampAlerT® seal goes on automatically when you twist on the container cap.

Call or visit our website for samples and more information.

800.523.8966 MediDose.com
CorrectCare® is published quarterly by the National Commission on Correctional Health Care, a not-for-profit organization whose mission is to improve the quality of health care in our nation’s jails, prisons and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, law and corrections.
Welcome to New Supporting Organization, New Board Members

The National Commission on Correctional Health Care welcomes the American Association of Nurse Practitioners as its newest supporting organization, and Jennifer Clifton, DNP, FNP-BC, CCHP, as the AANP’s liaison on the NCCHC board of directors.

Nurse practitioners assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans, including prescribing medications. They provide health care to millions of patients in a wide variety of settings, including corrections, where approximately 2,000 NPs work. AANP is the largest and only full-service national professional membership organization for nurse practitioners of all specialties.

“I believe that the unique perspective of NPs who serve as primary care and mental health providers to individuals within the correctional system will bring added depth and experience to the NCCHC board of directors,” said Dr. Clifton. “I am honored to represent AANP on the board.”

Focus on Juveniles in the Justice System

Dr. Clifton is executive director of nurse practitioner education and an assistant professor at the University of Utah College of Nursing in Salt Lake City. Her correctional health care experience includes more than a decade as both a primary care provider and clinical director with Utah’s Division of Juvenile Justice Services through a collaboration with the College of Nursing.

Her work and research focus on adolescents in the corrections system. In 2015 and 2016, she was awarded one year of funding for chlamydia and gonorrhea screening in the juvenile justice system. In 2017, ongoing funding was awarded to this project as part of the state’s annual budget.

Dr. Clifton serves on the NCCHC Juvenile Health Committee and has spoken at many NCCHC conferences.

Correctional Psychiatry Liaison

The NCCHC board also welcomes Debra A. Pinals, MD, as the liaison of the American Psychiatric Association.

Dr. Pinals’ career has focused on forensic and correctional psychiatry as well as the treatment of substance use disorders at the interface of corrections and communities.

She has served as a psychiatrist at several correctional facilities in Massachusetts, and worked with numerous jails and prisons in Massachusetts and Michigan on reentry initiatives, training and suicide reviews. Her experience includes several years as assistant commissioner for forensic services for the Massachusetts Department of Mental Health.

She is currently clinical professor of psychiatry at the University of Michigan, as well as director of the Program in Psychiatry, Law and Ethics and director of the forensic evaluation service at UM. She also serves as medical director for behavioral health and forensic programs for the Michigan Department of Health and Human Services.

“My work at the interface of public behavioral health and correctional systems and within jails and prisons has been personally meaningful, and participation as a board member on behalf of the APA is a real honor,” Dr. Pinals said. “Through this role, I hope to contribute to policies for best practices in correctional health care.”

She replaces Henry Weinstein, MD, CCHP, who retired from the board after 28 years of service.

Chronic Pain Position Statement Updated

NCCHC has updated its position statement on Management of Noncancer Chronic Pain. First adopted in 2011, the 2018 version emphasizes the escalation of the opioid epidemic to one of the nation’s most urgent public health threats.

The statement calls for chronic pain to be addressed in a manner similar to other chronic medical conditions—that is, it should be recognized as a multifactorial, complex entity and evaluated and managed relying on national guidelines adapted for correctional use. Complex chronic care patients are common in the correctional environment. Correctional clinicians should attain additional training in assessment, management and the science of chronic pain.

New to the 2018 statement is a recommendation that documentation of clinical encounters to address chronic pain include the patient’s self-reported comments in addition to the clinician’s assessment and the treatment goals, as well as appropriate follow-up.

Find all NCCHC position statements at www.ncchc.org/position-statements.
When We Mentor Our Colleagues, We Improve Our Field

by Barbara A. Wakeen, MA, RDN, CCHP

Happy spring—I think it has finally reached all parts of the country by now! With spring comes growth and revitalization. Speaking of growth, I was heartened to see so many younger professionals at the NCCHC Spring Conference in Minneapolis. This underscores the appeal of this practice area and holds promise for ongoing evolution in our field.

One of the many hats I wear is the coordinator of a worldwide listserv of correctional dietitians and food service professionals. I field queries related to correctional nutrition, diets, and food service to those looking for assistance with guidelines and nationally recognized practice. This role has evolved during the course of my career through networking and involvement in corrections.

When I receive a query about nutrition in corrections, my questions are, what is the population and type of facility, what state are you in, what accreditations does the facility have, and is the facility self-operated or contracted? This information enables me to give an appropriate response to assist my colleagues in meeting their population needs. If the person is a novice to corrections, I explain that we meet needs just as in any other long-term care environment, including the provision of medical and religious diets. I also elaborate that everything varies by state regulations, contracts, and accreditations.

It is rewarding when I eventually meet the newcomers at a corrections conference and they express their gratitude for the guidance that helps in their success; they are so happy to have a network from which to learn and grow.

Mentoring Others to Make a Difference

Many of us in corrections are “lifers”—we “fell” into corrections by varying modes and grew from there. For most of us, we didn’t get a degree with the idea of specializing in corrections, but here we are today making a difference for underserved populations.

Those outside of this field find it fascinating when they learn what we do in corrections. Many years ago, I assisted a university dietetics program with student shadowing experiences at the local jail. The students were so excited and enamored after spending the day at the jail that the remaining students wanted to attend, as well. While future jail shadowing experiences didn’t work out for various reasons, this led to one-on-one shadowing with me, to gain experience and learn about corrections.

Today, I mentor dietetic students and novice dietitians. Some of this evolved through word-of-mouth at the university and some through networking. Word has spread through some dietetic programs, and I now have students from various universities who reach out for shadowing, corrections experience, and writing papers on corrections. For some who are looking for additional experience (and money!), I hire them as student workers to help with projects such as nutritional analyses, medical diets, and menu planning, each with its own unique parameters.

Most recently, I have been working with relatively new dietitians around the country who request assistance with their corrections work, nationally recognized practices, and more. Of course, I always address accreditations and orient them to NCCHC and promote the NCCHC standards.

A New Generation in Correctional Health

I share these insights because our niche is evolving as the millennial generation enters the corrections field. These young professionals are starting out with a focus on corrections, and they seek to grow through mentoring, exposure, and networking. This was evident at the NCCHC Spring Conference, and especially at a session where the speaker queried the audience for years working in corrections. It was surprising to see how many had five years or less experience! Dr. Eileen Couture, my predecessor as board chair, has a daughter who started a correctional medical club, run by medical students, at Midwestern University in Downers Grove, IL. They have a board, invite guest speakers, and have participated in two tours of the Cook County Jail.

With this new generation in mind, I am happy to share two new initiatives that NCCHC is implementing this year:

- The Young Professionals Award, to be helmed by a newly formed Young Professionals Working Group and launched at the 2018 National Conference

Look for information on these activities in the NCCHC e-newsletter and via our social media platforms.

The common thread in the thoughts that I’ve shared is that personal relationships across the generational spectrum and across platforms are essential to growth—both for individuals and for the field as a whole. We benefit, our patients benefit, and we foster the climate for continued evolution.

Barbara A. Wakeen is the chair of NCCHC’s board of directors and principal of Correctional Nutrition Consultants, Ltd.
"2 million people with mental illness are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition."

- National Alliance on Mental Illness

The Correctional Mental Health Conference brings together a diverse group of presenters to share information about therapeutic interventions, recovery, reentry and policies that improve best practices. Our goal is to provide a sharply focused learning experience that advances professional knowledge, promotes partnerships and helps make recovery a reality.

The conference features two full days of focused mental health discussions, 30 educational sessions and special networking events to help you make lifelong connections. Register today!

**Session Topics**

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Development: Trajectories to Delinquency and Effective Interventions</td>
</tr>
<tr>
<td>Conducting a Root Cause Analysis</td>
</tr>
<tr>
<td>Creating a Behavioral Health Unit in a Jail: Reflections After the First Year</td>
</tr>
<tr>
<td>Developing and Providing Mental Health Training for Correctional Officers</td>
</tr>
<tr>
<td>Drug Withdrawal and Suicide: A Deadly Brew</td>
</tr>
<tr>
<td>Effective Crisis Management Strategies: Treatment Beyond Watch</td>
</tr>
<tr>
<td>Fostering Resilience in the Workforce: A Survey of Correctional Health Professionals</td>
</tr>
<tr>
<td>How to Overcome Burnout and Stay Motivated</td>
</tr>
<tr>
<td>Increasing the Use of Court-ordered Antipsychotic Medication in Jails</td>
</tr>
<tr>
<td>Let’s Give Them Something to Talk About: Sexual Harassment in the Workplace</td>
</tr>
<tr>
<td>Malingering: Understanding the Legal Implications of the Term</td>
</tr>
<tr>
<td>Managing Difficult Patientst</td>
</tr>
<tr>
<td>Managing Transgender Patient Care</td>
</tr>
<tr>
<td>Mock Trial: How Medical Records Can Make or Break Your Defense</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mural Painting as a Strategy to Reduce Self-Harm</td>
</tr>
<tr>
<td>National Perspective on Treating Co-occurring Disorders: Struggles and Solutions</td>
</tr>
<tr>
<td>Practical Management of Bipolar and Personality Disorders</td>
</tr>
<tr>
<td>Psychologists in Management: How to Be a Successful Leader</td>
</tr>
<tr>
<td>Psychological, Medical and Pharmacological Approaches to Treating PTSD</td>
</tr>
<tr>
<td>Restoration of Competency: Exploring the Medical and Legal Hurdles</td>
</tr>
<tr>
<td>Schizophrenia: Integrated Treatment Options</td>
</tr>
<tr>
<td>School Violence: Despite the Media, It’s More Than Massacres</td>
</tr>
<tr>
<td>Segregation: Policies to Ensure Quality Care</td>
</tr>
<tr>
<td>Taking Action to Prevent Suicide in Corrections</td>
</tr>
<tr>
<td>The Recovery Plan: Facilitating Reentry</td>
</tr>
<tr>
<td>Transforming Trauma: A Holistic, Trauma-Informed Program for Women</td>
</tr>
<tr>
<td>Treatment of Opioid Use Disorder: Trauma-Informed and Evidence-Based Care</td>
</tr>
<tr>
<td>Using a Rapid Competency Evaluation Process to Reduce Time in Jail</td>
</tr>
</tbody>
</table>

**Continuing Education**

CCHPs, nurses, physicians, psychologists and social workers can earn 15.25 hours of continuing education.

I love being around people who love to do what I love to do! It energizes me and gives me confidence and hope. I plan to take the information and research I have learned back to my facilities and attempt to implement better programming for mentally ill inmates, as well as ALL inmates.

—past attendee

**Hotel Information and Reservations**

All events take place at the Loews Hollywood Hotel, 1755 N Highland Ave, Los Angeles. This luxurious hotel is ideally situated in the center of the action in the Hollywood Hills.

Guest rooms are available for $199 per night. Visit the exclusive NCCHC booking page at [https://aws.passkey.com/go/LICMH2018](https://aws.passkey.com/go/LICMH2018) or call 855-563-9749.

**Conference Registration**

Registration includes breakfast and lunch each day and full access to the proceedings in electronic format. Registration options are available at [https://mental-health-conference.ncchc.org](https://mental-health-conference.ncchc.org).
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!

Together, the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) provide medical, dental, and mental health care to patients in our State-operated correctional facilities. Whether you’re a health care executive, physician, or advanced practice provider, you’ll find robust multidisciplinary teams with like-minded professionals dedicated to providing patient-centered primary care. And with 35 locations throughout California, you’re sure to find your perfect fit!

You’ll also experience more of the California lifestyle with the positive work-life balance found with CDCR/CCHCS. This lifestyle is supported by great State of California benefits, including:
- Generous paid time off and holiday schedule
- Robust 401(k) and 457 retirement plans – tax defer up to $48,000 per year
- Comprehensive medical, dental, and vision insurance plans
- Secure State of California pension that vests in five years

Take the first step in joining one of our outstanding multidisciplinary teams today!
Chief Medical Executives and Chief Nurse Executives, Magdalena Kilmer at (916) 691-5876 or Magdalena.Kilmer@cdcr.ca.gov.
Chief Support Executives, Sarah Price at (916) 691-2745 or Sarah.Price@cdcr.ca.gov.
Physicians, Nurse Practitioners, and Physician Assistants, Danny Richardson at (916) 691-3155 or Danny.Richardson@cdcr.ca.gov.
Psychiatrists and Psychiatric Nurse Practitioners, LaTreese Phillips at (916) 691-4818 or LaTreese.Phillips@cdcr.ca.gov.

To apply online, please visit www.cchcs.ca.gov.
Indications and Important Safety Information:

VIVITROL is indicated for:

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

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

Learn more about a treatment option that is non-addictive and not associated with diversion.

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

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


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 hypersensitivity to naltrexone, polyoctide-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 current method of reversing the blockade produced by a physician 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 unintentional increases in exogenous opioid use. Patients exposed to the risk of hepatic injury and advised to seek medical attention if they experience symptoms of acute hepatitis. Use of VIVITROL should be discontinued in the event of symptoms and/or signs of acute hepatitis. Depression and Suicidality: Alcohol- and opioid-dependent patients, including those taking VIVITROL, should be monitored for the development of depression or suicidal thinking. Families and caregivers of patients being treated with VIVITROL should be alerted to the need to monitor patients for the emergence of symptoms of depression or suicidality, and to report such symptoms to the patient’s healthcare provider. Alcohol Dependence: In controlled clinical trials of VIVITROL administered to adults with alcohol dependence, adverse events of a suicidal nature (suicidal ideation, suicide attempts, completed suicides) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo (1% vs 0). In some cases, the suicidal thoughts or behavior occurred after study discontinuation, but were in the context of an episode of depression that began while the patient was on study drug. Two completed suicides occurred, both involving patients treated with VIVITROL. Depression-related events associated with premature discontinuation of study drug were also more common in patients treated with VIVITROL (~1%) than in placebo-treated patients (0). In the 24-week, placebo-controlled pivotal trial in 624 alcohol-dependent patients, adverse events involving depressed mood were reported by 10% of patients treated with VIVITROL 380 mg, as compared to 5% of patients treated with placebo injections. Opioid Dependence: In an open-label, long-term safety study conducted in the US, adverse events of a suicidal nature (depressed mood, suicidal ideation, suicide attempt) were reported by 5% of opioid-dependent patients treated.
with VIVITROL 380 mg (n=101) and 10% of opioid-dependent patients treated with oral naltrexone (n=20). In the 24-week, placebo-controlled pivotal trial that was conducted in Russia in 250 opioid-dependent patients, adverse events involving depressed mood or suicidal thinking were not reported by any patient in either treatment group (VIVITROL 380 mg or placebo).

When Reversal of VIVITROL Blockade Is Required for Pain Management: In an emergency situation in patients receiving VIVITROL, suggestions for pain management include regional analgesia or use of non-opioid analgesics. If opioid therapy is required as part of an 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 thrombocytopения or any coagulation disorder (eg, hemophilia and severe hepatic failure). Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunoassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunoassay instructions is recommended.

ADVERSE REACTIONS: Serious adverse reactions that may be associated with VIVITROL therapy in clinical use include: severe injection site reactions, eosinophilic pneumonia, serious allergic reactions, unintended precipitation of opioid withdrawal, accidental opioid overdose and depression and suicidality. The adverse events seen most frequently in association with VIVITROL therapy for alcohol dependence (ie, those occurring in ≥5% and at least twice as frequently with VIVITROL than placebo) include nausea, vomiting, injection site reactions (including induration, pruritus, nodules and swelling), muscle cramps, dizziness or syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders. The adverse events seen most frequently in association with VIVITROL therapy in opioid dependent patients (ie, those occurring in ≥2% and at least twice as frequently with VIVITROL than placebo) were hepatic enzyme abnormalities, injection site pain, nasopharyngitis, insomnia, and toothache. Clinical Studies Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In all controlled and uncontrolled trials during the premarketing development of VIVITROL, more than 1100 patients with alcohol and/or opioid dependence have been treated with VIVITROL. Approximately 700 patients have been treated for 6 months or more, and more than 400 for 1 year or longer. Adverse Events Leading to Discontinuation of Treatment: Alcohol Dependence: In controlled trials of 6 months or less in alcohol-dependent patients, 9% of alcohol-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 7% of the alcohol-dependent patients treated with placebo. Adverse events in the VIVITROL 380-mg group that led to more dropouts than in the placebo-treated group were injection site reactions (3%), nausea (2%), pregnancy (1%), headache (1%), and suicide-related events (0.3%). In the placebo group, 1% of patients withdrew due to injection site reactions, and 0% of patients withdrew due to the other adverse events. Opioid Dependence: In a controlled trial of 6 months, 2% of opioid-dependent patients treated with VIVITROL discontinued treatment due to an adverse event, as compared to 2% of the opioid-dependent patients treated with placebo.

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

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 ≥0.30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥0.60 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 tumor necrosis 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.
Federal Judge Finds Jury Question on Civil Rights Liability of ‘Bystander’ Physician

by WILLIAM J. ROLD, JD, CCHP-A

Michael McGovern, an immunocompromised inmate with HIV, died of metastasized cancer while in the custody of the Pennsylvania Department of Corrections. His estate sued the corporate correctional care provider, three physicians and one physician assistant in McGovern v. Correct Care Sol., LLC (W.D. Pa., February 5, 2018) for violation of McGovern’s civil rights and for medical malpractice. The case went to mediation. All defendants except Barry Eisenberg, DO, were represented by the same law firm, and they settled with the estate for an undisclosed amount.

Eisenberg, with separate counsel, filed a motion for summary judgment, alleging inadequate involvement in McGovern’s care for liability. U.S. District Judge Kim R. Gibson denied summary judgment, finding that a jury should be permitted to decide Eisenberg’s liability under both malpractice and Eighth Amendment standards.

Case Background

The crux of the case, according to Judge Gibson, was that “Defendants were dilatory in their diagnosis and treatment of cancer initially found in Mr. McGovern’s left mandible.”

In October 2014, McGovern complained of a painful mass increasing in size. A physician noted his HIV+ status as posing a risk factor for cancer and wrote that the patient presented a “submandibular gland adenocarcinoma until proven otherwise.” Although an X-ray of the mandible revealed “no bony pathology,” a physician assistant scheduled a telemed consultation with an oncologist.

On Nov. 13, 2014, the oncologist diagnosed a probable recurrence of squamous cell carcinoma and ordered a CT scan of the neck with contrast, a needle aspiration biopsy and an ENT consultation. A week later, Eisenberg stamped a chart review entry with his name and the notation “NCS” [not clinically significant].

Numerous delays ensued in follow-up of the oncologist’s orders. The CT scan in December found bone destruction malignancy. By this time, McGovern had difficulty moving his tongue and swallowing. Later that month, Eisenberg noted that McGovern most likely had invasive cancer involving the lymph nodes and mandible, and that his prognosis was “not good.” He noted that his primary purpose for seeing McGovern was to address his “acute presentation” and to “handle” his request for stronger pain medications.

By late December, McGovern was sent to an emergency room for left-side weakness, numbness and headaches. The needle biopsy was performed, revealing an “inflammatory mass” requiring “clinical correlation.” The ENT consultation on January 2, 2015, recommended an open biopsy and exploration of McGovern’s neck, which was not scheduled for almost two months.

By March, another CT scan showed that McGovern had stage IV cancer, while his physician experts opined that the CT scan the previous December, when Eisenberg saw him for pain, showed stage I. After April, McGovern underwent several surgeries at the University of Pittsburgh “from which numerous serious consequences flowed in regard to Mr. McGovern’s quality of life.” He died on January 12, 2016.

An Eighth Amendment Claim

Judge Gibson found that Eisenberg was not McGovern’s primary care provider and that other defendants were more responsible for managing the mass on his left mandible. The estate’s experts, however, declared that Eisenberg violated the standard of care by failing to take independent steps to expedite McGovern’s care after he recognized the severity and time-sensitive nature of his condition. In their opinion, these failures contributed to the spread of the cancer and the ultimate outcome.

In this writer’s view, the opinion that Eisenberg departed from the standard of care would usually suffice to keep him in a malpractice case, but Judge Gibson allows the estate to proceed against him under the Eighth Amendment—even when he is the only remaining defendant, he was not the primary caregiver and everyone else has settled. This is unusual. Physicians with limited patient contact most often are granted summary judgment on Eighth Amendment claims for lack of personal involvement.

Here, Judge Gibson easily found that McGovern’s needs were serious and that Eisenberg knew about them. The question was whether a jury could find his behavior deliberately indifferent. He argued that his treatment was “not focused on Mr. McGovern’s cancer.” This actually seemed to be his undoing. It should have been.

Drawing all inferences in McGovern’s favor, as required in ruling on summary judgment, Judge Gibson found that McGovern “barely satisfies” the test for a jury question: “Dr. Eisenberg had an independent duty to Mr. McGovern—regardless of Mr. McGovern’s treatment being primarily handled by the other Defendants—and Dr. Eisenberg breached that duty by failing to take any action or make any effort to expedite Mr. McGovern’s testing or treatment…. This potential negligence rises to the level of potential reckless indifference because Dr. Eisenberg consciously acknowledged the substantial risk of serious harm.

continued on page 24
Correctional Healthcare:
We have taken systems proven effective in large state Medicaid programs and introduced them to corrections with strong positive results.

Becky Luethy, RN, MSN, LNC, CCHP  |  Director of Operations Development
28 Years of Experience

The Centurion Difference

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.

Centurion™
the next generation of correctional healthcare

800.416.3549
Visit www.centurionmanagedcare.com for more information.
Jails and prisons across the country face persistent and growing staffing challenges that impact access to care. In addition to the increasing health care expenses that result from the aging inmate population with chronic illnesses, adequate access to health care services in correctional facilities remains a critical issue. The delivery of adequate health services ultimately depends on the availability of trained medical staff. Staffing challenges are present not only in recruitment processes but also in retention efforts for existing staff and cannot simply be solved by increased compensation. This article explores the barriers to retaining and recruiting personnel and highlights strategies to grow and stabilize the correctional health workforce.

Barriers to Retention

We often hear of the difficulty in recruiting health care professionals to serve the inmate population. The best strategy to address staffing is to understand the needs of current staff and the causes of low retention. It is helpful to explore what people are seeking from the work environment and address these concerns to keep current staff in place before improved recruiting can help address the workforce shortage. Correctional facilities often experience high staff turnover for many reasons, including the following:

- **Stress-related burnout.** Existing staff shortages perpetuate the problem of retention as physicians and nurses are overburdened with workloads. Having overworked staff decreases morale and leads to high levels of stress-related burnout, which, in turn, impacts job satisfaction and thereafter turnover.

- **Lack of appreciation.** While correctional health professionals receive significantly more autonomy than they do in other care settings, they might perceive this autonomy as a lack of professional support or recognition. Appreciation or reward for high quality care or performance influences employees’ sense of pride and satisfaction in their work.

- **Few opportunities for advancement.** Correctional health care programs need to do more to support highly motivated staff who wish to advance in their careers. Correctional facilities are not as likely to be concerned with
supporting career development by offering clinical ladder skill-building programs.

These are just a few examples of the factors that contribute to overall low job satisfaction that leads to staff turnover. Health care managers should institute programs to effectively engage and empower employees, making correctional facilities a more compelling place to work.

**Barriers to Recruitment**

Attracting quality health care professionals to work in correctional facilities is understandably difficult. In addition to general concerns and misconceptions about working in these institutions, recruiters and staffing agencies must compete for talent alongside other, more well-known health care sectors. Other difficulties in recruitment stem from the following issues:

- **Negative preconceptions.** There are more concerns about personal safety and litigation exposure when working in a correctional setting. Some perceive the work environment to be more stressful because it is a locked facility and staff are often exposed to profanity and antisocial behavior.

- **Lack of exposure to correctional health as a career.** Medical and nursing school curricula have a large influence on career choices; however, correctional health care often remains invisible to students. Few health professional programs offer opportunities to complete rotations in correctional facilities and most students never consider this as a career option.

- **Geography.** In the 1980s to early 90s, the United States experienced a prison-building upswing in nonmetro areas, where 296 prisons opened. Today, rural and small-town communities actively bid to acquire prisons as a means for economic development. The remoteness of many facilities often deters candidates, especially young professionals or others who prefer a different lifestyle. Research shows that it is typically easier to recruit for facilities in urban locations. It can be difficult to convince health professionals to move to rural areas where they may feel isolated, with less visibility in their field and fewer opportunities for advancement.

Despite the demonstrable need, there is an under-recruitment of health professionals into correctional health services and high rates of job vacancies. A Office of Inspector General report from 2016 states that as of September 2014, the Federal Bureau of Prisons vacancy rate exceeded 10%, and 12 BOP facilities were medically staffed at 71% or below.

Some states contract with staffing agencies to fill vacancies in correctional facilities on a temporary basis, while other states contract out all or part of their correctional health care to an outside vendor to manage. Some states impose vacancy penalties on contractors if staffing levels do not meet certain benchmarks, yet these states continue to face employee shortages.

**Retention Approaches**

Retention of qualified correctional health staff is an important step in promoting access to and continuity of health care, which is a constitutionally guaranteed right. It also helps to reduce overall costs of care. Physicians, nurses and other health staff are trained to provide care in a high-security setting under conditions specific to the correctional environment. High staff turnover adds the burden of investing time and resources to train new hires and ensure that patient care is not interrupted. Therefore, it is important for employers to pay attention to what motivates staff retention and foster a culture that supports career development and recognizes and values their work.

A clinical ladder initiative can help improve staff commitment as well as enhance patient care. Health care has evolved over time to elevate standards of care and create new performance benchmarks. It is important for health professionals to stay in tune with what is considered best practice. Employers can improve staff loyalty and appreciation by offering tuition assistance and demonstrating their support of career development by encouraging health staff to pursue further education or skills training programs, and by rewarding their efforts. In Tennessee, for example, the state reimburses correctional health employees for tuition for one course per semester at state universities.

Promoting expertise-building among staff offers new opportunities for shared learning. However, many correctional facilities lack the infrastructure or avenues that foster a culture of teamwork and sense of community. Building such a culture takes time but may prove worthwhile as employees will feel more valued and connected to their work environment. Employee resource groups and mentoring give staff a shared identity that aligns with their work mission and vision. More workplaces are using social media to communicate internally and to connect with potential candidates externally using websites like LinkedIn.

A compelling work environment is one that empowers staff with opportunities for reward and recognition. Staff must feel engaged, heard and valued. Building a platform for communicating with staff will provide more opportunities to show staff that their work is meaningful and promote a sense of belonging. Staff also can use this platform to promote their work externally and build awareness of the correctional facility sector.

Another staff retention strategy that also may attract more applicants is to design staffing models that offer flex-

continued on page 14
ability in schedule. Since most correctional facilities are in remote locations, it is important to afford employees the work–life balance they need to not feel isolated and to be able to pursue other passions and lead fulfilling lives. This can be achieved through compressed workweeks with longer shifts and more days off, such as having family-friendly hours with four-day weeks or little to no on-call shifts.

Health managers should recognize the importance of work–life balance and scheduling flexibility to help overcome stress-related burnout.

Again, current staff are on the front line of recruiting efforts, so more attention should be placed on ways to improve job satisfaction levels.

**Recruiting Approaches**

The challenges of retention and recruitment indicate the need to better inform health professionals about this practice setting. Incarcerated individuals comprise the only civilian subgroup in the United States with a constitutionally guaranteed right to health care, yet correctional health is rarely covered in medical or nursing school curricula. Integrating correctional health into educational curricula using academic partnerships is an upstream solution to future workforce development.

In their third and fourth years, medical students complete rotations in different fields of practice such as psychiatry, pediatrics, general surgery, dermatology and others. Offering core rotations in a correctional setting would offer immense learning opportunities for students interested in population and community health.

In a pilot program at Nova Southeastern University College of Osteopathic Medicine, students conducted histories and physical examinations on inmates and were able to observe care in a correctional facility. This program and others like it have received positive feedback from students and expressions of interest in working in the correctional setting. Students gain confidence from being trained to provide care in a uniquely challenging setting and interacting with inmates. They also gain an understanding of social determinants of health that impact this population.

State and private employers should consider developing relationships with universities and other training programs to include student rotations in correctional facilities.

Academic partnerships are proven to be mutually beneficial. Students gain experience in caring for an underserved, vulnerable population and correctional health professionals receive extra support. Furthermore, early exposure to correctional health will also aid in lifting its negative reputation and addressing misconceptions, such as it being an unsafe work environment or lacking prestige as a profession.

Loan forgiveness or repayment is a way to encourage qualified physicians and nurses to practice in a Health Professional Shortage Area as designated by the Department of Health and Human Services. The National Health Service Corps offers a loan repayment program and considers federal and state prisons as approved service sites. However, only a limited number of applicants are accepted. States should consider instituting their own loan repayment programs. For example, Texas offers a physician education loan repayment program for approved primary care specialties for doctors who agree to provide four consecutive years of service in a federally designated HPSA or secure correctional facility.

Jails, prisons and correctional health vendors should work with legislators to develop loan forgiveness programs for medical professionals who choose to work in correctional settings.

Most government agencies operate under constrained budgets and are limited in the compensation they can offer to correctional health staff. Large gaps exist between BOP salaries and those for similar positions in the areas surrounding BOP facilities. For example, the Bureau of Labor Statistics average salary for a physician in the local area of a facility ($187,734) is 63% higher than a correctional physician salary in a rural area ($114,872). Although a more competitive salary would undoubtedly be leverage for recruiting, higher wages alone do not negate other factors that make it difficult to attract and retain a qualified workforce.

Jails, prisons and correctional health vendors must work to establish competitive compensation and benefits packages to attract and retain quality talents.

**Overcoming the Barriers**

Staffing shortages remain a threat to inmate population health and pose a challenge for employers to fill critical vacancies. As this population’s health care needs continue to grow and corresponding costs rise, there is increased urgency to apply new approaches to concurrently grow and stabilize the correctional health workforce. Jails, prisons and correctional health vendors should seek to understand the barriers to recruitment and retention to make informed decisions on strategies for improvement.

Catherine Sreckovich is managing director, Joohee Lee is senior consultant and Stephanie DeKemper is associate director for Navigant; they are based in the health practice office in Chicago. Contact Sreckovich at csreckovich@navigant.com.

Navigant Consulting, Inc., is a global professional services firm that focuses on markets and clients facing transformational change and significant regulatory or legal pressures. It primarily serves clients in the health care, energy and financial services industries. Learn more at www.navigant.com.
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.

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.

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.

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.

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.
SIGNS AND SYMPTOMS OF STRANGULATION

**FACE**
- Petechiae (tiny red spots - slightly red or florid)
- Scratch marks
- Facial drooping
- Swelling

**CHEST**
- Chest pain
- Redness
- Scratch marks
- Bruising
- Abrasions

**EYES & EYELIDS**
- Petechiae to eyeball
- Petechiae to eyelid
- Bloody red eyeball(s)
- Vision changes
- Droopy eyelid

**NEUROLOGICAL**
- Loss of memory
- Loss of consciousness
- Behavioral changes
- Loss of sensation
- Extremity weakness
- Difficulty speaking
- Fainting
- Urination
- Defecation
- Vomiting
- Dizziness
- Headaches

**SCALP**
- Petechiae
- Bald spots (from hair being pulled)
- Bump to the head (from blunt force trauma or falling to the ground)

**EARS**
- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

**MOUTH**
- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

**NECK**
- Difficulty breathing
- Respiratory distress
- Unable to breathe

**VOICE & THROAT CHANGES**
- Raspy or hoarse voice
- Unable to speak
- Trouble swallowing
- Painful to swallow
- Clearing the throat
- Coughing
- Nausea
- Drooling
- Sore throat
- Stridor

**BREATHING CHANGES**
- Difficulty breathing
- Respiratory distress
- Unable to breathe

**LOSS OF MEMORY**
- Loss of memory
- Loss of consciousness
- Behavioral changes
- Loss of sensation
- Extremity weakness
- Difficulty speaking
- Fainting
- Urination
- Defecation
- Vomiting
- Dizziness
- Headaches

**TRAINING INSTITUTE on STRANGULATION PREVENTION**


Graphics by Yesenia Aceves
‘Get the 9-1-1 Tool—We Have a Hanger!’

Choking, strangulation, hanging, ligature, tying off: Whatever term you use, it has the same meaning and consequences

by Ranee’ M. Wright, MSN, RN, CCHP-RN, and Ambril L. Dorn, BSN, RN, CEN

“Get the 9-1-1 tool—we have a hanger!” This is such a common phrase in a corrections environment, yet it’s something that health professionals who don’t work in this field would not even have a frame of reference for.

Strangulation can be fatal or nonfatal, and there is only a matter of seconds in difference between the two. However, inmates who hang themselves or “tie off” in suicide attempts are still at risk up to 48 hours after the ligature is removed, and can even die days or weeks later. This is how you should think about every person who hangs themselves or ties a ligature around their neck.

Signs and Symptoms
Strangulation is defined as occlusion of blood flow. When blood supply to the brain is blocked, you can be unconscious within seconds and brain dead within four minutes. Here are some signs and symptoms that can be useful in assessing and monitoring individuals who have just compressed the veins and/or arteries to their brain, thus impeding the blood flow and decreasing the oxygen to the brain.

A red mark on the neck
This would be from the item that was tied around the neck or that applied pressure to the neck. It may or may not have broken the skin. The area might need to be cleansed or dressed and should be reassessed often.

Bruising behind the ear, or small discolored spot
This may occur when the sternomastoid muscle in the neck has sustained an injury. This muscle is also at risk for swelling, causing complications after the initial incident. To think about how serious this is, if a person went to the local emergency department and reported being strangled, a CT angiogram would be performed to assess for damage to the veins and arteries. If the damage was significant, the patient would be monitored for 48 hours.

In the past, a CT scan of the soft tissues of the neck was used; however, we now know that the biggest risk for fatality occurs when patency of the vessels in the neck is compromised. This information makes the CT a more valuable tool. If there are issues with patency to the vessels, patients are at increased risk for stroke.

Petechia
These pinpoint hemorrhages may occur around the eyes, inside of the eyelids, in the mouth and in the ears; upon an autopsy, you may even find petechial hemorrhages on the brain. If you see petechia, it means there was jugular vessel occlusion. Occlusion of the carotid artery does not produce petechia.

You may have heard people say, “There isn’t a lot of petechia, so they are OK.” Consider the anatomy of the neck: The jugular vein is near the surface and the carotid is more protected on the inside, so it takes more pressure to occlude the carotids.

• It takes 11 pounds of pressure to occlude the carotids. To put that in context, it takes 20 pounds of pressure to open a soda can.
• It takes only 3 to 6 pounds of pressure to occlude the jugular vein, which is equivalent to squeezing a trigger.
• It takes 33 pounds of pressure to totally occlude the trachea, but it can be injured with less pressure.

Back to the presence or absence of those tiny spots: We must not minimize the importance of petechia as they are significant in showing that an injury was sustained. In fact, if an assailant caused petechial hemorrhages in a strangulation case, it could be charged as great bodily harm in some states.

Other symptoms
Strangulation can produce numerous injuries beyond the visible changes to skin and tissue, and it’s important to assess the patient for these problems.

• Voice changes
• Difficulty swallowing (including oral secretions)
• Difficulty breathing
• Pain in the neck or throat
• Mental status changes
• Incontinence of urine or stool
• Increased risk of bleeding if on blood thinner
• Difficult to arouse

Loss of bladder control may occur in as early as 15 seconds and loss of bowel control at 30 seconds. If your patient has had loss of bowel or bladder, this is a good indicator that they lost consciousness. However, it may go unnoticed if custody staff are busy removing clothing to place the patient in a segregation/security gown and don’t

continued on page 18
Strangulation (continued from page 17)

An ‘Attention-Seeker’ Ties Off Again: What Would You Do?

You are working with five other nurses in the health services unit, which is not connected to the housing units. You are busy completing your daily tasks, trying to finish for the night. It is getting late and it is very cold outside. Then the telephone rings. It is the segregation unit and they have an inmate who has just tied off.

They report that this inmate does this often—this is the fourth time this week—and he is just seeking attention. They say that they were able to cut off the ligature right away and the inmate's color returned, and there are no spots on his face, so it is nursing’s decision whether to come and assess him. He will be in the restraint bed for safety. The patient is safe and security says he is fine. What do you do?

Your initial thought should be that a face-to-face assessment is imperative. Monitor vital signs to check for patient stability. The Glasgow coma scale can be a useful assessment tool. It might also be beneficial to place the patient in a more vertical restraint position—whether using a chair restraint or a wedge device—to assist with any swallowing.

The patient's history of frequent tying-off incidents is concerning and can indicate an increase in suicidal behavior. If the patient is self-harming frequently, the wear and tear on neck muscles and ligaments over time might accidentally cause more permanent damage than he intended. It is important to educate the patient on potential lethality of this type of self-harm.

Documentation should include material/method used, suspended off ground or not, length of time of episode, the patient’s intent/what he thought would happen, loss of control over bowel/bladder, loss of consciousness, tissue damage, neck/jaw pain, swallowing pain/difficulty, weakness in arms/legs, difficulty breathing, coughing, nausea and vomiting. You could also measure the circumference of the patient’s neck to monitor for swelling later.

With suicide the leading cause of unnatural death in correctional settings, it is essential for facilities to develop a suicide prevention program. Excellent guidance is found in NCCHC’s Standards for Health Services.

think to report that the patient’s clothing was soiled. It is important to ask the question.

If your assessment identifies voice changes, difficulty swallowing and breathing, and pain in the neck and throat, these are good indications that the neck is more severely damaged. The hyoid bone is not attached to any other bone, and if it becomes fractured it may puncture the larynx, among other things. Swelling in the neck can happen for a variety of reasons, including fracture of the larynx; it could also be a result of internal bleeding or injury.

That brief physiology lesson highlights the dangers associated with applying any amount of pressure to a person’s neck. If we focus on the occlusion to the brain’s blood supply rather than “another hanger,” we might have better patient outcomes or improved documentation. You could even apply this information to patients involved in fights that have involved a component of strangulation—a forearm or knee pressed against the neck. Cases of recreational asphyxiation are just as dangerous.

The Nurse’s Role

Whether your patient suffers from self-inflicted violence or violence by others, it is essential to collaborate with custody staff to ensure the scene is safe before you enter and perform your nursing assessment and care. It also is important for custody to preserve the integrity of the knot if a ligature was tied so they can determine whether a crime was committed.

In attending to the patient, the nurse should do a thorough assessment and triage the patient to the next level of care as soon as possible. The nurse may minimize complications by frequent reassessment and observations to catch a decline in condition sooner rather than later.

In addition, nurses potentially can prevent such incidents from happening. It is important to identify suicidal or potentially suicidal patients and to report to other staff on the housing units if you notice any signs of depression or suicidal ideation. Nursing is a trusted profession and can create a therapeutic rapport that might foster a person to divulge thoughts of suicide or self-harm. Prior history of suicidal ideation is a significant predictor for future attempts. Take reports seriously and trust your instincts.

Educating nonmedical staff on the importance of prompt intervention after strangulation or hanging is also valuable. If all members of a team are aware of the risks involved, patients are more likely to get the assessments and care they need, which will lead to improved outcomes.

As health care professionals in this field, we see an underserved population with unique needs, and it is our responsibility to educate ourselves on those needs.

Runee’ M. Wright, MSN, RN, CCHP-RN, is a nurse clinician at the Wisconsin Resource Center, Winnebago, WI. Ambir L. Dorn, BSN, RN, CEN, is a lead RN in the emergency department at Aurora Medical Center, Oshkosh, WI. Both authors are also forensic nurse examiners in the Sexual Assault Treatment Center at Aurora Medical Center.

Authors’ statement: We gratefully acknowledge the Alliance for HOPE International and its Training Institute on Strangulation Prevention for allowing us to reproduce information from trainings as well as the Signs and Symptoms graphic. The documents were accessed through the TISP online resource library.

The TISP website and some documents in the resource library are supported in part by Grants No.2014-TA-AX-K008 and No.2016-TA-AX-K067 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions and recommendations expressed in this article are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.
NCCHC Accredited Facilities

Which would you rather carry?

or

Policies
NCCHC
Compliance

Online Collaboration
No more time wasted routing and updating paper documents.

Central Location
Ensure employees attest to and acknowledge comprehension of important policies.

Electronic Signature Capture
Store and manage all of your NCCHC compliance documentation in one place.

TO LEARN MORE, VISIT POWERDMS.COM
The standards have been revised, reorganized and simplified to improve their usefulness. As always, the standards reflect the latest evidence and best practices in meeting professional, legal and ethical requirements in delivering correctional health care.

After two years in the making, NCCHC’s 2018 Standards for Health Services have been published. The manuals have been streamlined and reorganized to create a more user-friendly guide for correctional health professionals using the standards in everyday practice. Each section of standards begins with an introductory paragraph that describes the intent of the section in the overall organization of a correctional health care system. Standard wording has a more global approach, while the compliance indicators give detail that is more specific on requirements to meet the standard.

In this article, we will highlight changes and new concepts in the 2018 Standards.

Reorganization and Consolidation
The first major change that users will notice is that there are now seven sections instead of nine. Most content from former sections F (Health Promotion), H (Health Records) and I (Medical-Legal Issues) was consolidated and/or relocated. For example, all of the 2014 Section F standards were moved into other sections. All of the 2014 Section H standards were consolidated into one standard, A-08 Health Records, although most of the content did not change.

The 2014 standards A-07 Emergency Response Plan and E-08 Emergency Services were consolidated into one standard, D-07 Emergency Services and Response Plan. Similarly, standards G-01 Chronic Disease Services, G-02 Patients With Special Health Needs and G-10 Aids to Impairment were combined into one standard, F-01 Patients With Chronic Disease and Other Special Needs. Section G (formerly Special Needs and Services) now contains standards related to Medical-Legal Issues.

As health administrators update policies and procedures to align with the 2018 standards, the way that policies are organized can follow any format or order that an agency chooses. However, every standard, including compliance indicators and definitions, should be addressed in the policy manual. To help users easily identify which standards have been combined and/or relocated, the introductory section of the Standards manuals has two tables that detail these changes. These tables may prove helpful as policies are updated.

Highlights of Changes by Section
In addition, there are many changes and new concepts within each section. It is important to refer to the complete set of standards when revising your correctional health program as this column will highlight only significant changes.

Section A – Governance and Administration
• A-02 Responsible Health Authority – Requires a designated dental clinician if dental services are under a separate organizational structure; the responsible physician must be available to the facility frequently enough to fulfill clinical and administrative responsibilities
• A-05 Policies and Procedures – Health staff are to review policies when revised or new policies are introduced
• A-06 Continuous Quality Improvement Program – Health record reviews are required as part of the CQI program (previously required under Continuity and Coordination of Care During Incarceration; at least one process and/or outcome study must be done annually
• A-07 Privacy of Care – Requires privacy (e.g., privacy screen, curtain, private area) during physical exams, with special considerations for pelvic, rectal, breast or other genital exams
• A-09 Procedure in the Event of an Inmate Death – Administrative reviews no longer have the 30 day requirement; compliance indicators clarify what content should be in a death review log

Section B – Health Promotion, Safety, and Disease Prevention
• B-01 Healthy Lifestyle Promotion – Requires a nutritionally adequate diet for the general population and a review of the regular diet menu by a registered dietitian nutritionist or other nutrition professional at least annually; a system exists to notify the RDN when a change is made to the regular diet menu; health staff are to promote and provide education on physical activity options in the facility
• B-03 Clinical Preventive Services – The responsible physician determines the medical necessity and/or timing of screenings and other preventive services, including screening for communicable diseases (plus laboratory confirmation, treatment and follow-up); the dentist determines the frequency and content of periodic dental evaluations
• B-04 Medical Surveillance of Inmate Workers – New standard requires facilities to have a program to prevent illness and injury among the inmate worker population
• B-05 Suicide Prevention and Intervention – Clarifies that the monitoring of acutely and nonacutely suicidal inmates is to be completed by facility staff
• B-06 Contraception – Requires arrangements to be made to initiate contraception for women when there is a planned release to the community
• **B-07 Communication on Patients’ Health Needs** – Expanded on the examples of situations where custody staff should be informed of special needs

• **B-09 Staff Safety** – Requires methods of communication (e.g., radio, panic button, voice proximity) between health staff and custody staff; custody staff must be readily available to health staff if a safety concern arises; items subject to abuse must be inventoried on each shift where health staff are present, and discrepancies immediately reported to the custody staff; requires health staff to identify and use contemporary equipment during the course of their duties

**Section C – Personnel and Training**

• **C-02 Clinical Performance Enhancement** – Clarifies which disciplines are required to have a clinical performance enhancement review; reviews are required for all full-time, part-time and per diem employees in each category

• **C-03 Professional Development** – The RHA must document compliance with continuing education requirements and maintain a list of the state’s continuing education requirements for each category of licensure of all qualified health care professionals

• **C-04 Health Training for Correctional Officers** – This standard lists all training required for COs; added requirements for training on dental emergencies and maintaining patient confidentiality

• **C-06 Inmate Workers** – Allows inmate workers to participate in a reentry health care training program but gives inmates the right to refuse care from those enrolled in the program; clarifies permitted activities for inmates in peer health-related programs

• **C-07 Staffing** – Provider and nursing time must be sufficient to fulfill clinical responsibilities, and responsible physician time sufficient to fulfill administrative responsibilities

**Section D – Ancillary Health Care Services**

• **D-01 Pharmaceutical Operations** – Clarifies that the facility must maintain records as necessary to ensure adequate control and accountability for all medications, except those that may be purchased over the counter; a staff or consulting pharmacist must document inspections and consultations of all sites, including satellites, at least quarterly

• **D-02 Medication Services** – A formulary is no longer required but, if used, there must be a process to obtain nonformulary medications in a timely manner

• **D-03 Clinic Space, Equipment, and Supplies** – Additional equipment required: sterilizer for nondisposable medical or dental equipment, pulse oximeter, personal protective equipment

• **D-05 Medical Diets** – Requires a review of the medical diet menu by a RDN or other nutrition professional at least annually (not semiannually); requires a system to notify the RDN when a change is made to the medical diet menu; classification changed to essential

• **D-07 Emergency Services and Response Plan** – Clarified that mass-disaster drills should be conducted so each shift has a chance to participate over a three-year period (eliminated the annual requirement)

• **D-08 Hospital and Specialty Care** – Written or verbal information about the patient and the specific problem to be addressed must be communicated to the outside entity when patients are referred out for care; the health record should contain results and recommendations from off-site visits, or attempts by health staff to obtain these results

**Section E – Patient Care and Treatment**

• **E-02 Receiving Screening** – Added dental problems to the list of inquiries on the receiving screening

• **E-03 Transfer Screening** – Eliminated the 12 hour requirement for review of the transferred inmate’s health record, but the record must still be reviewed and must have evidence of continuity of care and medication administration; inmates who do not have initial medical, dental or mental health assessments done at an intake facility are to be evaluated at the receiving facility in a timely manner

• **E-04 Initial Health Assessment** – Option 2, Individual Assessment When Clinically Indicated, is now an option for jails only (prisons are required to complete the full population assessment); jails have the option of deferring the initial health assessment if there is a documented health assessment on file within the last 12 months and the receiving screening shows no change in health status; the responsible physician should determine the components of the initial health assessment; RNs who conduct the full population health assessments no longer need additional training in order to do so; jails are required to test for TB during the initial health assessment; prisons must perform a pelvic exam (or refer for a pelvic exam) with or without a Pap smear;

**Time Line for Implementation**

Accredited jails and prisons have approximately six months to transition to the 2018 standards. Surveys that occur in May, June or July 2018 will be conducted using the 2014 standards. Surveys in August, September or October will have the option of being surveyed under the 2014 or 2018 standards. Effective Nov. 1, all surveys will be conducted using the 2018 standards.

continued on page 22
requirement for other communicable disease testing and immunizations moved to B-03 Clinical Preventive Services

• E-06 Oral Care – Training for qualified health care professionals who perform the oral screening can be provided or approved by the dentist; for jails, the time line for providing instructions in oral hygiene and preventive oral education was changed from 30 days to 14 days

• E-07 Nonemergency Health Care Requests and Services – Documented face-to-face triage with the patient occurs within 24 hours of receipt of a health care request

• E-10 Discharge Planning – Prisons must develop a process to assist inmates with health insurance application prior to release

Section F – Special Needs and Services

• F-01 Patients With Chronic Disease and Other Special Needs – Clarified that protocols should include mood disorders and psychotic disorders; protocols for sickle cell and seizures no longer required

• F-02 Infirmary-Level Care – Similar to the name change (formerly Infirmary Care), the focus is on the level of care provided, regardless of location of delivery; standard now allows facility staff to be within sight or sound but requires qualified health care professionals to respond in a timely manner

• F-04 Medically Supervised Withdrawal and Treatment – Formerly named Intoxication and Withdrawal; requires protocols to be reviewed and approved annually

• F-05 Counseling and Care of the Pregnant Inmate – Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment with methadone or buprenorphine; emergency delivery kits are to be available at the facility; custody restraints are limited to handcuffs in front of the body, during pregnancy and the postpartum period (but not used at all during active labor and delivery); postpartum care should be provided and documented

Section G – Medical-Legal Issues

• G-02 Segregated Inmates – Eliminated requirement for checks of former category “2c” inmates, those who are allowed periods of recreation or routine social contact among themselves

• G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Actions – Health staff may not participate in disciplinary action nor be compelled to provide clinical information solely for the purposes of discipline; treatments and medications are never withheld as a form of punishment, and segregation and restraints are never clinically implemented as disciplinary action

More Useful for You

NCCHC received many excellent comments and suggestions from experts and users of the standards throughout the country over the last four years. The 2018 Standards for Health Services were crafted after careful consideration of all ideas so they would be useful to facilities seeking an effective and efficient health care delivery system. The result promises to promote improved health services in our nation’s jails and prisons.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. Jeffrey Alvarez, MD, CCHP, was the chair of the 2018 Standards Revision Task Force and is a physician surveyor for NCCHC’s accreditation program. Contact Titus at traceytitus@ncchc.org.
Transgender individuals face potentially harmful conditions behind bars, including correctional policies that limit access to proper medical care and expose them to gender-based victimization, according to a study in the April issue of the *Journal of Correctional Health Care*. Understanding the mental health impact of these experiences is important given the disproportionate risk of incarceration for this population. Leah Drakeford’s article examines the link between correctional policies and lifetime suicide attempt among transgender people who have been incarcerated.

Through literature review, Drakeford cites past research findings that correctional policy frequently fails to address transgender inmates across two domains: provision of transgender-related medical care and housing. In both domains, many states have failed to enact effective policies.

Institutions that do have policies regarding health care are often inconsistent in providing a level of care that can alleviate the distresses of gender dysphoria. As to housing, policies almost always assign transgender inmates based on external genitalia, which exposes them to high risk of physical and sexual assaults by inmates and correctional staff. Such victimization and lack of adequate medical care may have profound effects on mental health.

**Examining the Stats**

Drakeford’s study data came from the 2011 National Transgender Discrimination Survey, which encompassed 6,450 respondents recruited through various convenience sampling techniques. Filtering based on reports of jail or prison incarceration reduced the sample size to 1,007.

The NTDS gathered information about attempted suicide, as well as experiences with five forms of victimization—harassment, physical attacks, sexual attacks, denial of hormones, denial of regular medical care—during incarceration (minimum one year), with separate focus on two groups of perpetrator: correctional staff and other inmates.

Correctional policy on access to transgender-related medical care addressed five domains: psychological evaluations, consultation with an experienced provider, continuation of hormones, freeze-frame hormone dosages and initiation of hormones. Other variables include transgender category (male-to-female, female-to-male, other) and a variety of demographic characteristics.

Regarding level of medical care available, data analysis found that lifetime suicide attempt varies based on length of incarceration. For example, respondents reporting long-term incarceration in states with low levels of care had odds of reporting attempted suicide three times that of those incarcerated short-term.

Data analysis also showed a 42% increase in the odds of reporting attempted suicide when victimized by an inmate and a 48% increase when the victimized by correctional staff. Length of incarceration was not found to be a factor.

According to Drakeford, these results offer evidence of relationships between medical care, gender-based victimization and lifetime suicide attempt, suggesting that correctional policies may negatively impact transgender inmates. These results point to the need for increased transgender care and the evolution of housing policies.
U.S. Judge Strikes Down MO Hormone Therapy Policy
The Missouri Department of Corrections’ “freeze frame” policy regarding hormone therapy for transgender inmates was found to be unconstitutional by a U.S. District Court judge. The MDOC policy denied such therapy to transgender individuals who were not receiving it at the time of their incarceration. The decision comes in a case filed by a transgender woman in 2016. The judge ordered the prison to provide all care the patient’s doctors deem medically necessary, including hormone therapy, as well as access to permanent hair removal and gender-affirming personal items. “The denial of hormone therapy based on a blanket rule, rather than an individualized medical determination, constitutes deliberate indifference in violation of the Eighth Amendment,” the court order said.

• jurist.org/paperchase/2018/05/federal-judge-finds-missouri-transgender-prison-policy-violates-eighth-amendment.php
• See also NCCHC’s position statement on transgender care: www.ncchc.org/position-statements

Naltrexone for OUD Improves Postrelease HIV Outcomes
Use of extended-release naltrexone for opioid use disorder may improve treatment outcomes for HIV-positive people released from prison or jail who have a history of opioid addiction, according to a study in the May issue of the Journal of Acquired Immune Deficiency Syndromes. The randomized, double-blinded control trial found that recently released people who received the drug were more likely to maintain or improve their HIV viral load suppression.

The period when people reenter the community is chaotic and is associated with opioid overdose and loss of HIV care, said study coauthor Frederick Altice, a professor at the Yale School of Medicine. The study findings suggest that preventing opioid use relapse can be stabilizing and allows people to remain engaged in HIV care, he said.

A major implication, said lead author Sandra Ann Springer, a professor at the medical school, “is that for prisoners and jail detainees, who have the highest rates of opioid use disorder and HIV in the country, we … should be offering opioid-use disorder treatment before they get released.”

• yaledailynews.com/blog/2018/04/27/opioid-addiction-treatment-helps-hiv-patients-stay-on-meds

Correctional Population Declines for 9th Year
The number of adults supervised by the U.S. correctional system (probation, parole and incarceration in prisons or jails) fell for the ninth consecutive year in 2016, according to a Bureau of Justice Statistics report released in April. In 2016, 2,640 adults per 100,000 residents were under correctional supervision compared to 3,210 in 2007, an 18% decline. The 2016 number was lower than at any time since 1993 (2,550).

The incarcerated population decreased from 2,172,800 in 2015 to 2,162,400 in 2016 (0.5%). All of this decrease was due to a decline in the prison population (down 21,200); the jail population remained relatively stable. The number of persons held in prison or local jail per 100,000 U.S. adult residents has declined since 2009 and is at its lowest rate (860 per 100,000) since 1996 (830 per 100,000).

• www.bjs.gov/content/pub/press/cpus16pr.cfm

Inmate Mental Health Spending Reduces Costs of Crime
Programs that focus on addressing mental health and substance abuse issues of inmates can reduce the burden of crime on American taxpayers, according to the White House Council of Economic Advisers. In a policy brief, the CEA suggested that every dollar spent on prison reform in these programs could save between $0.92 and $3.31, and up to $1.96 on long-term incarceration costs alone.

• thecrimereport.org/2018/05/21/spending-on-inmate-men-tal-health-cuts-the-cost-of-crime-white-house-study

Federal Judge (continued from page 10)

that existed when cancer is not diagnosed and treated and still failed, according to Plaintiffs’ experts, to take appropriate medical action.” He admitted the prognosis was “not good,” prescribed pain medications, reviewed tests and conceded in his deposition that “every day matters when treating cancer.”

Eisenberg took an “impermissible bystander role by leaving the care of Mr. McGovern to the other Defendants” and not taking independent action, based on what he knew, to expedite follow-up treatment for this patient.

Judge Gibson concluded: “[A]lthough this Court does not agree with Plaintiffs that ‘there is ample evidence from which a reasonable jury could conclude that Dr. Eisenberg was deliberately indifferent to Mr. McGovern,’ this Court does conclude that there is sufficient evidence” (emphasis by the court).

William J. Rold, JD, CCHP-A, is a civil rights lawyer in New York City and a former judge. He represented the American Bar Association on the NCCHC Board of Directors for six years. This article, reprinted with permission, is a slightly edited version of one appearing in LGBT Law Notes © March 2018, published by the LeGal Foundation of the LGBT Bar Association of Greater New York.
HSA Finds That Staff Education Is Key to Progress and Partnerships

by Katie Przychodzen, MA

When Terry Fillman, MBA, RN, CCHP, began working as a correctional nurse for the San Bernardino County Sheriff’s Department in 1991, he was lost—literally. “The facility was so new that none of the housing units were numbered and the directional signs were not yet painted, so I was disoriented for three weeks.” This did not stop him, though. He knew from the very first day on the job that correctional health care was the career for him.

A nurse since 1989, Fillman quickly learned that correctional nursing was unlike anything he had experienced working in a hospital, clinic or outpatient care. This new and unique environment, he says, gave him the opportunity to use his comprehensive skill set for routine, urgent and emergent patient care, often all in the same day. “That’s what got me hooked,” he says, “and still does 27 years later.”

Balancing Operations and Hands-On Care

In 2011, after 20 years with SBCSD as an RN and eventually nurse supervisor, Fillman became the health services administrator. In this role, he manages the daily medical, mental health and dental care operations and staff for the four jails in California’s San Bernardino County, geographically the largest county in the country. These facilities together process about 80,000 new bookings per year and house an average daily population of 6,000 inmates.

For Fillman, a typical day as HSA might include meetings with a hospital partner and pharmacy manager, dialysis licensing, inspections, budget planning, workload analysis and CQI review. Yet his favorite part of each day is providing direct patient care. “No matter how full my calendar, there is not one day that goes by that I do not have direct involvement in individual and systemwide patient health care,” he says.

Fillman admits he had no idea that correctional health care was unlike anything he had experienced working in a hospital, clinic or outpatient care. This new and unique environment, he says, gave him the opportunity to use his comprehensive skill set for routine, urgent and emergent patient care, often all in the same day. “That’s what got me hooked,” he says, “and still does 27 years later.”

In addition to the daily variety, working in corrections allows him to make a difference for many grateful patients who would not have access to care in the community.

Keep on Learning

Each year, SBCSD sends a multidisciplinary group of health and custody staff to every NCCHC conference to learn about new ideas and programs and to network with correctional health care peers. Fillman says continuing education is key to quality patient care: “I have observed significant improvements in cooperation between custody, medical, mental health and dental care staff over the years as a result of education.” As NCCHC standards continue to evolve, he says, ongoing education is essential to developing facility-specific policies, procedures and trainings.

SBCSD also encourages all correctional staff to earn CCHP and CCHP specialty certification. It recently incentivized certification for correctional nurses with salary increases for those who keep their CCHP status current. SBCSD has hosted several on-site CCHP exams and plans to continue to support staff certification now that NCCHC offers computer-based testing. Fillman says he is proud to work for an organization that recognizes CCHP as dedication to professionalism and exceptional health care delivery.

Katie Przychodzen, MA, is marketing and communications manager for NCCHC.

Are you a correctional health care administrator interested in CCHP certification? Visit www.ncchc.org/cchp for more information.
Who Attended in 2017?
Nurse/nurse practitioner 38%
Physician/physician assistant 27%
Social worker, therapist, counselor 8%
Psychiatrist/psychologist 10%
Administrator 9%

Decision Makers With Authority
Facility medical director or director of nursing 22%
Department manager/supervisor 10%
Health services administrator 6%
State medical director 3%

Who Do Attendees Represent?
Jail facility 42%
Prison facility 17%
State DOC/agency 12%
Private corporation 10%
Juvenile detention or confinement facility 8%
Federal agency 4%

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

Draw Qualified Customers to Your Booth
NCCHC will conduct a comprehensive marketing campaign that includes email broadcasts, direct mail, social media, online banners and direct outreach.
• Three days of exhibit hall activities
• Three free full conference registrations per 10’ x 10’ booth
• Unlimited full registration for exhibit personnel (fees apply)
• Access to nearly 2,000 attendees for premium face time
• Electronic attendee lists for pre- and postshow marketing
• 50-word listing in the Final Program and conference app
• Discounts on advertising in the conference program
• Opportunity to participate in raffle drawings
• Continuing education credits for all sessions attended
• Exclusive opportunity to become a sponsor

Amplify Your Brand Through Sponsorship
High-profile sponsorship opportunities can help to ensure recognition for your brand and your company throughout the event. Plus, you gain extra exposure when attendees return home with branded products. Ask your sales rep to help you maximize your marketing exposure.
• Conference mobile app
• Exhibit hall reception, lunch or refreshment breaks
• Product Theater events
• CCHP lounge host
• Conference padfolios
• Hotel key cards
• Relax & Recharge Lounge
• Phone chargers

Where Will You Find Your Next Great Hire?
Find your next lead with the National Commission on Correctional Health Care mailing list, a proven tool to reach over 40,000 physicians, nurses, mental health care providers, medical directors, nurses and other allied health professionals and administrators. Pinpoint your audience by job title, work setting and demographics. No other marketing channel allows you such a targeted marketing opportunity.

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 the exhibits and sales manager at sales@ncchc.org or 773-880-1460. Be sure to ask about sponsorships and advertising.
MARKETPLACE

2018 Standards for Health Services for Jails or Prisons
Newly revised by a task force of leaders in health, law and corrections, the NCCHC standards have been, reorganized and streamlined. The updated standards provide our latest recommendations for managing health services delivery in adult correctional facilities.

Special Savings! 10% discounts for Academy members (single copies) and for bulk purchases of a single item (five or more). Visit the NCCHC Online Store and place your order at www.ncchc.org, or call 773-880-1460.

Take advantage of the field’s top experts and stay current, meet constitutional requirements and be better prepared for the challenges you face every day. Approx. 200 pages. $89.95

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 sales@ncchc.org or 773-880-1460, ext. 298.

EMPLOYMENT

Academy CareerCenter
The #1 Career Resource for Professionals in the Correctional Health Community
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.

ADVERTISER INDEX

California Correctional Health Care Services...........5
Centurion.............................................................11
Certified Correctional Health Professional...............15
InFocus Lists.........................................................26
Medi-Dose/TampAlerT....................inside front cover
NCCHC Products and Services...................back cover
PowerDMS........................................................19
Standards for Health Services.........................22
Standards for Juvenile Health Services..............28
Vivitrol..............................................................6-9
Wexford Health Sources............................inside back cover

Have you visited our new online store? Show your NCCHC pride with a great selection of high-quality products. Many of the items are also available with the CCHP logo!

• Women’s and men’s apparel
• Baseball caps
• Backpacks and totes
• Water bottles
• Padfolios
• And more!

ncchc.duplimall.com
Expert Advice on NCCHC Standards

by Tracey Titus, RN, CCHP-RN

Need Unique Policies for Health Services?

Q We are preparing for NCCHC accreditation and are developing a policy and procedure manual (standard J-A-05). Policies covering some of the NCCHC standards (e.g., medical diets, environmental inspections, grievances, emergency response plan) already exist, but they are part of the jail’s policy and procedure manual. Do we have to write new policies for health services on these topics if they are already covered in the jail’s procedural manual?

A It is not necessary to duplicate efforts. You need not develop a new policy statement for the health services policy manual if the topic has been addressed elsewhere. You simply can place a copy of the relevant institutional policy in the health services policy manual or include a page in the health services manual that cross-references the institutional policy statement. What is most important is that there are policy statements covering all of the specific topic areas listed in NCCHC’s standards, but it is not necessary that all facilities do it exactly the same way.

Is NPDB Part of Credential Checks for Nurses?

Q My question is about standard C-01 Credentials. Could you clarify whether or not an inquiry must be made to the National Practitioner Data Bank for nurses?

A All qualified health care professionals must have credentials and provide services consistent with the licensure, certification and registration requirements of the jurisdiction. As part of the hiring process, verification of credentials should confirm current licensure, certification or registration. This process should include inquiry into sanctions or disciplinary actions of state boards and employers for all qualified health care professionals. However, for accreditation purposes, the 2018 standards clarify that the NPDB inquiry is required only for prescribers; it is not necessary for nurses.

Do Fire Drills Count as Disaster Drills?

Q Our facility has fire drills about four times a year. Do these count as disaster drills under standard D-07 Emergency Services and Response Plan?

A If these are routine fire drills for the whole facility, probably not. This standard focuses on the health aspects of the disaster plan. Practicing emergency response plans enables health staff to better respond to disasters when they occur.

While health staff need to participate in basic fire drills to ensure that they know how and where to evacuate themselves and their patients, they also need to practice their own plans for a disaster. Suppose there was a fire in an inmate housing area or in the medical area and several inmates were injured and/or the medical area was destroyed. You might be interested in learning whether:

- Correctional staff followed procedure in notifying health staff of the disaster and vice versa
- Their responses were timely
- Patients were triaged appropriately
- Emergency/disaster kits were equipped as needed
- Emergency equipment functioned adequately
- Staff knew how to use the equipment

If you practice your plan and then critique it, you can correct any deficiencies and lessen the chances of inappropriate actions in the event of a real disaster.

2015 STANDARDS

for Health Services in Juvenile Detention and Confinement Facilities

Newly revised, the 2015 Standards present NCCHC’s latest recommendations for managing health services delivery in juvenile detention and confinement facilities. This edition represents the culmination of hundreds of hours of careful review by juvenile health experts, including specialists in medicine, nursing, mental health, substance abuse and gynecology, to ensure that NCCHC standards remain the most authoritative resource for juvenile health care in correctional settings.

Notable updated topics include medical autonomy, continuous quality improvement, patient safety, clinical performance enhancement, medication services, health assessment, nonemergency health care requests, contraception and family planning services, emergency psychotropic medication and forensic information. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

To order or to see a list of all NCCHC publications, visit www.ncchc.org.
Be part of an exceptional team that’s raising the standard of correctional psychiatry.

Wexford Health Sources, one of the nation’s leading providers of correctional health care services, offers fulfilling opportunities for psychiatrists who want to make a difference. Work in a setting that is unique, challenging, and always secure. Join the Wexford Health team today and grow with an industry leader that is raising the standard of correctional psychiatry.

Opportunities for Psychiatrists are available throughout:

- Alabama
- Illinois
- Indiana
- Pennsylvania

NOW HIRING

To learn about career opportunities at Wexford Health, or to apply, please visit jobs.wexfordhealth.com or contact a staffing consultant at 1-800-903-3616.
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 individuals 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.