White Supremacist Gangs in American Prisons
What Are Their Characteristics? How Do We Provide Trauma Care for Their Victims?

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National Commission on Correctional Health Care
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New Partnership Aims to Reduce Suicide Among the Incarcerated

Suicide remains one of the 10 leading causes of death in the United States and, according to the U.S. Department of Justice, it is the leading cause of death in jails. Incarcerated people are particularly vulnerable to suicide, for a variety of complex reasons.

The nation’s largest suicide prevention organization, the American Foundation for Suicide Prevention, has joined the National Commission’s ongoing efforts to reduce the number of suicides among incarcerated populations. The organizations’ innovative partnership highlights a key focus of AFSP’s Project 2025, which aims to reduce the annual suicide rate by 20% by 2025, and brings AFSP’s depth of expertise to NCCHC’s National Response Plan for Suicide Prevention.

 Crucial Elements of Prevention
In conjunction with NCCHC’s annual Correctional Mental Health Care Conference in July, leaders of both organizations convened with mental health experts from the nation’s largest jail and prison health care providers at a daylong Suicide Prevention Summit, cosponsored by NCCHC and AFSP. Together, participants delved into three areas identified by the group as crucial in suicide prevention: assessment, intervention and training.

The partnership is finalizing elements of the National Response Plan for Suicide Prevention in corrections, which will include needed tools and guidance for correctional facilities across the nation to help them combat suicide.

“Partnering with NCCHC, a longtime national leader in the field of correctional health care, is critically important and will allow us to reach an audience that is especially vulnerable to suicide,” said Bob Gebbia, AFSP’s CEO. “Research tells us that people in times of transition are at especially high risk for suicide. Partnering with NCCHC will enable us to educate both correctional staff and health care professionals who work in the correctional system about suicide risk and how to identify and care for the suicidal inmate-patient. We know we can’t do this alone. Only by working with experts like NCCHC will we be able to save more lives.”

“This partnership creates a real opportunity to bring forth major interventions with the potential for immediately saving lives,” said Brent Gibson, MD, MPH, CCHP-P, chief health officer for NCCHC. “We greatly appreciate AFSP’s focus and support. The collaboration between our organizations and national health care providers underscores the importance of working together to tackle the problem of suicide.”

Target: 1,000 Lives Saved
This was the third in an ongoing series of Suicide Prevention Summits hosted by NCCHC. The initiative was launched in 2017, when senior staff from five national providers of correctional health care met in Chicago for a day of collaborative problem-solving. NCCHC educates health care professionals on suicide risk and outlines current best practices for suicide prevention and intervention in its Standards for Health Services, the basis of its health care services accreditation and professional certification.

AFSP’s Project 2025 focuses on four critical areas where evidence points to saving the most lives in the shortest amount of time, one of which is the correctional system where contact with jails and prisons represents high-risk periods for suicide. By focusing on the correctional system, AFSP believes more than 1,000 lives can be saved by 2025.

Accreditation Portal Update
The new accreditation system and portal is open, and accredited facilities are receiving information about their annual maintenance reports on a rolling basis. If your facility is accredited, the health services administrator should watch for details on how to access the system and complete the AMR. For information, contact accreditation@ncchc.org.

New Educational Meeting for Clinicians
In 2019, NCCHC is launching a meeting called the Correctional Medicine Workshop. This intensive two-day event is designed to help physicians and advanced providers improve patient care through hands-on training and interactive educational sessions. The first meeting will be held Jan. 27-28 in San Diego. Watch your inbox for more information.
Questions, Answers and Ideas Flow on NCCHC Connect

by Barbara A. Wakeen, MA, RDN, CCHP

Fall is in the air, with summer activities winding down and the new school year starting for many. Fall also means that the NCCHC National Conference in Las Vegas is just around the corner. NCCHC conferences are a great way to network, but in the interim, you can interact with your peers and colleagues through the Commission’s new online community, NCCHC Connect.

NCCHC Connect is off to a great start. Within a few weeks of its launch more than 500 members had joined, with 16 groups formed to focus on specific topics and more than 50 conversations underway. To date, the Nursing and Mental Health groups are leading with the most activity.

If you haven’t joined yet, you are missing out! Here are just a few of the many thought-provoking topics that I’ve followed:

• How to handle situations where inmates refuse to take their critical medications (Nurse Practitioners group)
• Legislative mandates for facilities to provide medication-assisted treatment as the standard of care for individuals who use opioids (Quality Improvement group)
• How one’s practice in correctional health care aligns with long-term professional goals (Young Professionals group)
• Professional ethics and “dual loyalty” when working in a correctional setting (Mental Health Professionals group)
• Use of inmate observer/companion programs to assist inmates on suicide precautions (Suicide Prevention group)

Most of the groups are public—no approval is needed to join. Others are set to private because they are for defined categories of individuals, such as state medical directors or health services administrators at facilities accredited by NCCHC.

Helping Each Other
Each group has a moderator to keep discussions on track. In the group for Certified Correctional Health Professionals, Ralf Salke, BSN, RN, CCHP-A, is the moderator, and he has been active in the CCHP and other group discussions. When Ralf was asked how it’s going, he replied with great enthusiasm.

“I started out by focusing on the benefits of CCHP certification,” he said. “The list is long and distinctive, including reputation, moral compass, connections, increased knowledge of NCCHC’s standards, instrumental value and self-regulation. Through public and private dialogue, group members have discussed how to obtain certification, helpful reading materials and how to study for the exam. The participation and assistance is stellar.”

Ralf is a seasoned correctional health care professional with more than 30 years of experience in this field, so he knows a thing or two about professional development—take him at his word when he advocates for NCCHC Connect as an excellent form of “collegial collaboration.” (See page 21 for more about the CCHP group on NCCHC Connect.)

Suicide Prevention Efforts Advance
Speaking of collaboration, NCCHC Connect is serving as a workspace for one of the closed groups, formed to enhance communication and project management for members of the NCCHC Suicide Prevention Summit work group. (See page 2 for more information on the project.)

With suicide being the leading cause of death in jails, it is imperative to put a halt to these tragedies. This year, with the support of the American Foundation for Suicide Prevention, the work group met during NCCHC’s Correctional Mental Health Care Conference. They have made significant progress in developing a National Response Plan for Suicide Prevention and are developing tools and guidance for correctional facilities across the nation. You’ll be hearing more about this initiative soon.

In the meantime, I encourage you to join NCCHC Connect’s public group on suicide prevention, moderated by Lindsay Hayes, MS, the nation’s leading expert on this important topic.

Hope to “connect” with you soon!

Barbara A. Wakeen, MA, RDN, CCHP is the chair of NCCHC’s board of directors and principal of Correctional Nutrition Consultants, Ltd.

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www.ncchc.org
Through the Looking Glass

by Deborah Shelton, PhD, RN, CCHP

Through the looking glass, “things are not what they seem to be” (Alice’s Adventures in Wonderland, Ch.1)

I feel like Alice falling down a rabbit hole when I ponder the struggles of correctional health care systems and the seemingly minimal attention and proactive funding they receive. Through this looking glass, the workplace is sometimes frightening; logic seems upside down and things aren’t always what they seem to be. Many bright and dedicated people are diverted from enacting positive change on behalf of their incarcerated patients, and on behalf of themselves.

Some facilities experience high turnover, debilitating vacancies, staff injuries and difficulties recruiting good quality staff, all of which impact quality care—and that ultimately impacts the bottom line. In these times of tightening budgets and the move once again toward punitive correctional management techniques, the words “minimal standard of health care” as being “good enough” are being spoken. Frontline staff, clinicians and officers who are in the thick of this environment are numbed and worn. It would seem the Queen of Hearts is yelling “Off with their heads!”

The Pool of Tears (Alice, Ch.2)

In a country known for mass incarceration, the 2.2 million people currently in our nation’s prisons and jails reflect a 500% increase over the last 40 years, due in large part to changes in sentencing law and policy, not changes in crime rates (Sentencing Project, 2016). Although the mission of correctional systems is first public safety, I would suggest, in light of this singular statistic, that in contemporary society the mission has expanded. And under this expansion, we are feeling great stress.

What happens to people under stress? They become negative, secretive and closed; they disconnect from organizations and other people, and their commitment to their work falters. Even worse, their personal health and wellness becomes threatened. Some of us make mistakes—mistakes we thought we’d never make. Some of us justify this behavior rather than face a reality we feel unable to do anything about. Like Alice at the tiny garden door when she was 9-feet tall, “to get through was more hopeless than ever, she sat down and began to cry again.”

In contemporary health care, effective strategies to attain quality include education, professionalism and certification, staff competency, appropriate staffing ratios, skilled supervision, teamwork, quality improvement programming and clinical representation in correctional leadership teams. Yet these concepts have not fully taken hold across our field. Some systems are innovating and sharing the evidence demonstrated to produce positive outcomes, but why are we not communicating our successes loudly to other correctional systems, politicians, legislators and funding agencies through our daily work, professional networks, political contacts and voting?

Advice From a Caterpillar (Alice, Ch.5): A Call to Action

I would suggest that each of us take what we know and push in any direction where we feel capable of speaking out. We must call attention to what I believe are the fixable dysfunctions of an under-resourced health care system such as ours. Here are some ideas:

- It is reasonable to communicate to universities our workforce needs—but then we must also facilitate access. Invite clinical rotations, make the processes for access clear, become a partner with a university faculty.
- Respond to the National Institutes of Health when it calls for public input and ensure that correctional health care issues are addressed in the development of NIH goals; simply go to the NIH website and search “public input.” You also can do this with most professional associations, such as medical societies and nursing associations. These groups have lobbyists that promote the agendas of those organizations. Get involved!
- Let’s ensure that incarcerated persons are not blocked from inclusion in research studies. Otherwise, how will we ever know the best practices for this targeted population given these unique settings? Have you welcomed researchers into your system or facility?
- Let NIH know that funding is needed to guide practices and systems toward thoughtful cost savings. This might be achieved simply by ensuring inclusive language in requests for proposals. Call upon the Health Resources and Services Administration to include correctional settings in its funding to promote services and develop a quality workforce targeting perhaps the most challenging of patient populations.

continued on page 20
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A-09 Procedure in the Event of an Inmate Death (important)

The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths. – 2018 Standards for Health Services for jails and prisons

Administrative reviews assess correctional and emergency response actions surrounding an inmate’s death. They entail a review of the incident and facility procedures used; training received by involved staff; emergency response; and recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures. The administrative review should be conducted with the participation of custody staff.

In previous versions of this standard, the administrative review was required to occur within 30 days. In the 2018 Standards for Health Services for jails and prisons, the 30-day requirement has been eliminated. However, we recommend that a preliminary administrative review occur as soon as possible to identify any obvious areas for immediate improvement. As the administrative review continues in the months following the death (e.g., autopsy results, further findings), the review can be appended with applicable information.

Part 2: Clinical Mortality Review

The clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to a death. This review is to be conducted within 30 days to determine the appropriateness of the clinical care provided and the effectiveness of the clinical policies and procedures relevant to the circumstances surrounding the death. At least three key questions should be asked during this review: Could the medical response at the time of death be improved? Was an earlier intervention possible? Independent of the cause of death, is there a way to improve care?

Typically, clinical mortality reviews include a review of the incident and facility procedures that were implemented, training received by the staff involved, pertinent medical and mental health services, and reports involving the inmate. When a death is expected, a modified review process focusing on relevant clinical aspects of the death and the preceding treatment may be used. Similar to the administrative review, the clinical mortality review should also include recommendations, if appropriate, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

A clinical mortality review should be conducted separately from other formal investigations that might be required to determine the cause of death. It could be completed by a unit physician not involved in the patient’s treatment, a central office or corporate physician, or an outside medical group.

Part 3: Psychological Autopsy

A psychological autopsy, sometimes referred to as a psychological reconstruction or postmortem, is required within 30 days for all deaths by suicide. This written reconstruction of an individual’s life emphasizes factors that may have led up to or contributed to the death. It is usually conducted by a psychologist or other qualified mental health professional and is based on a detailed review of all file information on the inmate, a careful examination of the suicide site and interviews with staff and inmates familiar with the deceased.

Tracking Death Review Requirements

Because death reviews typically involve multiple disciplines (e.g., custody staff, health staff, mental health staff; coroner, others), investigatory documentation may not be readily available. Therefore, the 2018 standard requires that the responsible health authority maintain a log that includes the following:

- Patient name or identification number
- Age at time of death
- Date of death
- Date of clinical mortality review
- Date of administrative review
- Cause of death (e.g., hanging, respiratory failure)
- Manner of death (e.g., natural, suicide, homicide)
- Date pertinent findings of reviews are shared with staff
- Date of psychological autopsy, if applicable

Maintaining a log with these components will help health care administrators ensure that all components of a death review are completed in a timely manner.

Corrective Follow-Up

Finally, corrective actions identified through the review process should be implemented and monitored through the quality improvement program for systemic issues, and through the patient safety program for staff-related issues. Pertinent findings of death reviews should be communicated to treating staff to prevent similar situations in the future.

Tracey Titus, RN, CCHP-RN, is vice president of accreditation at NCCHC. To contact her, write to accreditation@ncchc.org.
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Over 30 Years of Corrections Experience
White Supremacist Gangs in American Prisons

What Are Their Characteristics? How Do We Provide Trauma Care for Their Victims?

by Alexandra Pajak, LCSW, CCHP

White supremacist prison gangs are a subgroup within the larger white supremacy movement in the United States. Unlike other white supremacist segments, such as neo-Nazis and the Ku Klux Klan, white supremacist gangs differ in their combination of organized crime, criminal activity related to gangs and hate-motivated behavior.

White supremacist gangs have been growing in number, geographic location and influence over the past 18 years, resulting in increased violence and crime in both incarceration settings and the general public. Since 2006, social media has increased the ability and frequency of prison gang members staying in touch after release as well as recruiting others in the community and distributing propaganda and information.

The largest white supremacist prison gangs include European Kindred, Aryan Circle and Aryan Brotherhood. Some of these gangs have only a few dozen members but others number in the hundreds; the Aryan Circle is estimated to have 20,000 members.

Texas and California have the largest white supremacist gang presence and resulting crime rates, although other states, including Oregon, Tennessee, Indiana, Missouri and Oklahoma, are seeing an increase in white supremacist gang influence. The Anti-Defamation League estimates that at least 35 states in the United States have at least one prison gang presence.

As in other gangs, tattoos often signify allegiance to white supremacist gangs and can help correctional professionals to identify those who may be members. Common symbols include “SS” lightning bolts, swastikas, the letters “AC” (Aryan Circle) and “EK” (European Kindred), diamonds, Celtic symbols and the numbers 1, 2, 12, 13, 133%, 360, 511 and 666.

Common crimes committed by white supremacist gangs inside jails and prisons include race-based violence, retaliatory violence against a member who has broken the rules, violence against members of rival gangs and smuggling tobacco, illegal drugs and contraband into the facility. Hate crimes commonly committed by white supremacists in prisons often target African-Americans, Latinos, homosexuals and transgender people.

Images and descriptions of symbols and tattoos can be found at the Anti-Defamation League’s Hate Symbols Database at www.adl.org/education-and-resources/resource-knowledge-base/hate-symbols.
Physical and Mental Health Effects of Racism in Patients

The rise of white supremacist prison gangs is increasingly posing a challenge to correctional mental health professionals who may encounter members of these gangs as well as victims of hate-based crime in session. Racism—which can include power inequalities, prejudices, stereotypes, discrimination, beliefs and systemic lack of access to housing and health care—has been linked to poorer physical and mental health in racial minorities. Physical effects can include physical injury secondary to racially motivated hate-based violence and lack of access to quality health care. Emotional effects, which, according to research, are the most profound negative effects of racism, include anxiety, depression, somatization and post-traumatic stress disorder.

Correctional mental health professionals may encounter minorities who disclose race-incident-based trauma during a therapeutic session. Importantly, clinicians who are members of the dominant group may not be able to identify the often complex, ambiguous and subtle ways in which racism manifests in the lives of nondominant group members. In fact, research suggests that ambiguous, subtle forms of racist acts can have an even greater negative impact than more overt racist acts.

Understanding the patient’s subjective interpretation of events is important in building rapport and addressing the emotional effects of racist interactions. Emotional responses may include shame, guilt, anger, rage, anxiety and depression. In fact, exposure to racist acts can rise to the level of trauma.

Encountering and Treating Race-Based Incidents in Therapy

Patients may request counseling for reports of general anxiety or depression, while race-based experiences may, in fact, be a major underlying cause of these symptoms. Therefore, clinicians may find it helpful to ask questions about race-based experiences during intake. Regular assessments that inquire about any racist incidents may also be beneficial to the therapy process.

In addition to the identification of race-based violence and prejudice that occurs in the correctional environment, therapists may also benefit from asking about patients’ history of race-based trauma and integrating this psychosocial information into the therapeutic process. For example, patients who have had previous race-based discrimination and trauma may exhibit a stronger reaction to experiencing racism or discrimination in a correctional setting. Institutional forms of racism may include special education assignments while growing up and conflict with teachers. What may appear to be a minor racial conflict to the clinician may be a final culmination of a lifetime of racism that leads to a significant inability to cope.

Victims of race-based trauma can display symptoms similar to those experienced by the victims of violence or sexual assault. Given this parallel symptomology, strategies used in the treatment of post-traumatic stress disorder can be effectively implemented to treat race-based trauma.

Clinicians can teach the client mindfulness techniques, awareness and acceptance of thoughts and feelings without judging them, breathing exercises and relaxation techniques. Other useful strategies to help a client cope with race-based trauma include addressing self-blame and rumination, encouraging physical activity and participation in positive activities, and making referrals to psychiatry as needed.

Another strategy involves the clinician encouraging the patient to use active coping skills. Passive coping skills involve accepting that a trauma occurred and keeping the incident to themselves and not sharing their feelings with others. Active coping, by contrast, involves accepting that a trauma occurred and sharing these feelings with others coupled with a direct action to change and improve the situation. Clinicians should be cognizant, though, that an “action to change a situation” in a correctional environment may lead to additional violence. Informing patients of the unique aspects and potential ramifications in a correctional environment is important.

Finally, questions that explore the patient’s spirituality, religion and life philosophies can help the patient to make meaning of the incident and to cope with feelings of guilt and shame resulting from the incident. Collaboration with facility chaplains may also provide opportunities for patients to expand their social support network within a spiritual or religious community.

The Clinician’s Awareness and Self-Reflection

Racism and prejudice affect all people’s paradigms, including clinicians’. Being mindful of our own prejudices can be important in addressing our own emotional responses during sessions when clients report race-based trauma. Self-reflection can be important to develop a level of comfort to introduce the topic of race within a session and to validate racism’s impact on a patient.

Race does exist and people’s experiences are influenced by race in unjust and inequitable ways. This stands as a deviation from the statements “I’m color-blind” or “I don’t see color in people.” Awareness of race assists clinicians in gaining a deeper understanding of the complex ways in which race affects people in a racial group different from their own. Guidance from supervisors may also be helpful in addressing a clinician’s own prejudices or similar experience as a victim of racist acts.

Through education on the activities of prison gangs, awareness of the psychological impact of violent behavior inflicted upon racial minorities and a working knowledge of trauma interventions, clinicians will be well-equipped to help their patients overcome the harm that arises from race-based incidents.

Alexandra Pajak, LCSW, CCHP, is a mental health clinician with more than seven years of experience working in a jail.
Driving Quality in Correctional Health Care

This is the second in a series of four articles that provide insights on current issues and barriers in correctional health. Presented by Navigant, the goal is to offer thought-provoking suggestions by sharing national best practices in government-sponsored health care that we believe provide actionable solutions.

State legislators continually face the challenge of how to prioritize the finite pool of dollars budgeted for state-run programs, such as health care, education, social services and corrections. In the United States, prison health care spending in 2015 reached $8.1 billion. These health care costs are expected to continue to rise, given the growing number of inmates aged 55+ who have a higher burden of chronic health conditions and disabilities. Since additional funding is unlikely, states must look for ways to optimize the value and cost-effectiveness of prison health care.

However, states that outsource care to contracted providers will need to incorporate new strategies when negotiating contracts to balance payer and provider interests. This article describes current state contracting strategies and introduces value-based purchasing as a method of aligning payer and provider risk, reward and accountability for care in order to achieve improved health care value.

Health care value is defined as quality over cost, or the health outcomes achieved per dollar spent. As with health care outside of the prison system, a focus on quality increases the likelihood of improved health outcomes and can help drive down health care costs. However, few states have quality monitoring systems that can assess whether evidence-based recommended care is provided and whether desired outcomes are achieved. To calculate the value of care, prison health care systems must be able to define outcome-based quality measures to track prison population health.

Although process-focused quality measures are useful in ensuring that care is provided, they are unable to distinguish between what service was provided and how it was provided. In many cases, there is no evidence that just because a procedure was completed, quality has improved. Therefore, to assess the impact and value of care, process and outcome measures should be linked.

Quality measures and outcomes data allow health systems to establish performance benchmarks that contracted providers are expected to meet. These performance expectations, if achieved, can be used as financial incentives for improved value.

Current State Prison Contracting Strategies

More than half of the state prison systems in the United States rely on contractors to deliver some or all their health care services. Prison health care contractors supply medical staff and services as well as administrative services, much in the same way that state Medicaid agencies use managed care entities—i.e., to gain access to networks of providers, specialists and hospitals.

State prisons use two primary contractual payment arrangements: capitation and cost-plus models, described in the table below. However, each of these arrangements comes with opportunities for modification that address a state’s particular goals and needs.

Although some states rely on outsourcing delivery of care, it does not relieve states of their responsibility to oversee quality to ensure that inmates receive appropriate care while containing costs. The capitation and cost-plus payment arrangements do not necessarily align contractor profit margin interests with prison health care goals. In the capitated payment model, the contracted providers retain most of the financial risk and are thereby incentivized to keep spending low, but there is little incentive for them to maintain quality. On the other hand, in the cost-plus model, states retain almost all financial risk and contracted providers are not incentivized to contain costs or make value-based decisions in spending.

Ideally, states can share both the risk and rewards with contracted providers while maintaining spending predictability and transparency. In addition to standard contract requirements, states have an opportunity to negotiate financial incentives that encourage or penalize for certain outcomes and value. Regardless of the payment model used, value-based purchasing strategies can help drive improved quality outcomes.

### Current State Prison Contracting Strategies

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<tr>
<td><strong>Capitation</strong></td>
<td><strong>Cost-Plus</strong></td>
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<td>A capitation-based model establishes a fixed per-inmate payment that contracted providers receive for all inmates under their care.</td>
<td>A cost-plus model is like fee-for-service in that each expense made by the contracted provider is paid for by the state, plus additional payments for arranging and managing care.</td>
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<tr>
<td><strong>Pros for States</strong></td>
<td><strong>Cons for States</strong></td>
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| • States have a clear picture of what their total spending will be.  
• The administrative burden of claims processing of payments and adjudication is reduced. | • The state may gain financially if inmates collectively use fewer or less-expensive services than budgeted.  
• Spending is more transparent.  
| **Cons for States** | **Pros for States** |
| • States cannot benefit from potential savings.  
• Contracted providers may withhold care to avoid costs. | • State are more exposed to financial risk.  
• Spending projections are more difficult to make.  
• This model can inadvertently incentivize excessive use of low-value services. |
Value-Based Purchasing Strategies

VBP is a strategy for contracting for services that ties payments to quality of care or performance. While VBP concepts have been endorsed by the general payer (i.e., government and commercial) community, they are less evident in the prison health care sector, where quality measures, if any, tend to focus on process measures rather than outcomes. Using process measures rewards contracted providers for volume of care instead of value, and more care does not equate to better care—it is just more care with resulting higher costs.

VBP models enable state payers to align aspects of risk, reward and accountability for care with contracted providers. In VBP strategies, performance is defined by state-enforced quality measures that focus on health outcomes to realize associated cost savings and ultimately achieve better value.

Key principles of the VBP model include the following:
- Focus on defined results and outcomes
- Select two or three overarching priority areas
- Align performance incentives with disincentives
- Encourage collaboration between prison and contractor
- Foster a culture of assertive performance management and vendor accountability
- Share and celebrate best practices and successes
- Improve transparency of program goals, performance and vendor compliance
- Use rigorous planning and analysis
- Apply standard measures to enable benchmarking and management efficiencies
- Leverage information technology for reporting and decision support

The first table below outlines the basic financial risk-sharing arrangements in different VBP models; the second presents a high-level overview of how some VBP models are applied.

Ultimately, the goal of VBP in prison health care systems is to transition financial risk onto contracted providers to drive quality and smarter decisions about utilization. It is important to emphasize that the state retains accountability for monitoring quality.

### Challenges and Things to Consider

The VBP operational process requires effective collaboration and communication to achieve a shared understanding of priorities, results and lessons learned. VBP relies on use of real-time data and metrics for rapid cycle feedback. Regularly reviewing data helps identify where certain processes or services are not resulting in improvements.

Currently, uniform quality of care standards and monitoring requirements for prison health care systems are lacking. The lack of reporting and data collection limit health administrators’ ability to assess how VBP strategies affect health care costs and inmate health outcomes. There also are concerns that improved data for quality and cost-effectiveness analysis may not necessarily translate to improved value. However, though barriers exist, building out quality monitoring capabilities is considered a worthwhile investment and surmountable obstacle to the optimization of prison health care value.

There is no denying that significant hurdles face everyone working with prison health care systems. From the inmate, to the provider, to the warden, to the legislature and governor, there are decisions and trade-offs that impact quality of care. Using enhanced quality monitoring systems, specifying clear performance benchmarks in contracting arrangements and integrating value-based purchasing strategies in payment structures together are significant opportunities to drive improved outcomes and value of care.

Catherine Sreckovich is managing director, Stephanie DeKemper is associate director, Gregory Abdouch is managing consultant and Joohy Lee is senior consultant for Navigant Consulting, Inc. They are based in the health practice office in Chicago.

### Value-Based Purchasing Models

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<th>Upside Risk Only</th>
<th>Downside Risk Only</th>
<th>Upside and Downside Risk</th>
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<tr>
<td>Capitated PIPD</td>
<td>Portion of capitated rate is withheld and subject to performance</td>
<td>Capitated PIPD arrangement that allows contracted providers to share in health care savings or lose health care revenue and refund the state if services surpass financial benchmarks</td>
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<td>Capitated PIPD (per-inmate per-day) arrangement that allows contracted providers to earn all or a percentage of health care savings if performance meets benchmarks</td>
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<td>States can still predict what total spending will be</td>
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<td>Encourages waste reduction</td>
<td>Incentivizes reduced health care spending</td>
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<td>Contracted providers may withhold necessary care</td>
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<td>Administrative burden to track quality reporting</td>
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The InMedRx mission is to serve correctional institutions by providing a convenient and cost-effective way to manage all emergency/release pharmacy needs.

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Keep Your Nursing Skills Sharp!

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

In NCCHC’s Standards for Health Services, there are standards that address disaster drills, education, safety and training. Due to the largely autonomous activities of correctional nursing, skills related to these requirements must be reviewed and tested regularly.

Nurses may use some of these skills on a daily basis, and others may be used only during an emergency where time matters. Nurses need to keep their skills sharp and be prepared for whatever medical emergency might occur. I always say, ”If you are prepared for the worst thing that could happen to your patient, then you can handle any situation.”

In this ever-changing world of technology, nurses also need to be aware of current standards of care and be able to provide quality care to each patient during each encounter. Teaching and testing skills through the use of skill stations is one way to ensure that nurses are educated and competent.

What Skills to Teach and Evaluate?

Hospital settings have annual competency training to ensure that their nursing staff is able to employ the skills needed for appropriate and accurate decisions and actions based on the specifics regarding the patient and incident. Correctional facilities also need to provide this training to their nurses.

In NCCHC’s 2018 standard on Professional Development (C-03), one of the compliance indicators requires that “All qualified health care professionals obtain at least 12 hours of continuing education per year or have proof of a valid license in states where continuing education is required for licensure.” Another requires that “All qualified health care professionals who have patient contact are current in cardiopulmonary resuscitation technique.”

So, what should the training address? Some of the skills that should be tested at least annually include use of blood glucose monitors, use of AEDs, bandaging and splinting, use of oxygen adjuncts, use of EKGs and venipuncture. In addition, time management, clinical decision making and appropriate nursing care and treatment in an emergency can be incorporated into this type of learning.

Other topics to consider include wet-to-dry dressing changes, metered-dose inhalers, correct order of laboratory tubes during venipuncture, proper hand-washing techniques, mixing clear and cloudy insulin and PICC line dressing changes. You also can focus on issues that are not common or that are special areas of concern; these can be based on incident reports and statistics for your facility.

In addition, regulations mandate that certain skills must be reviewed or tested, such as bloodborne pathogens and N-95 respirators.

For more help in determining what skills to address, check some of the numerous resources that offer up-to-date guidance. Examples include the Joint Commission’s 2018 National Patient Safety Goals (jointcommission.org), the American Nurses Association’s Correctional Nursing: Scope and Standards of Practice (ana.org) and evidence-based practices for nursing (nursingcenter.com), to name just a few.

Hands-On Learning

Hands-on technical education has been proven to facilitate the understanding of concepts and skills required to provide quality nursing care. And for more effective learning, these skills can be incorporated into patient scenarios so the nurse can practice technical skills and professional nursing skills simultaneously.

In Patient Safety and Quality: An Evidence-Based Handbook for Nurses, chapter 51 states, “Human patient simulation is a relatively new teaching strategy that allows learners to develop, refine, and apply knowledge and skills in a realistic clinical situation as they participate in interactive learning experiences designed to meet their educational needs.” (This chapter addresses nursing education through patient simulation; it is available for free online at www.ncbi.nlm.nih.gov/books/NBK2628.)

To organize a skill station teaching or evaluation session, a few things need to be considered:

- Identify the skills/topics to be evaluated or tested
- Identify the competencies for each skill; use a checklist
- Organize a time frame or schedule; a monthly calendar is helpful
- Have proctors or evaluators for each skill station
- Set up the skill station with patient scenarios, using supplies appropriate for that skill
- Evaluate the process of each skill station and make changes as needed

Nursing is primarily a hands-on profession, so hands-on education is very appropriate. Plus, it can be refreshing to change the format from the traditional classroom approach. Skill station training can be fun and participants may even retain more of the important information since it was presented in a memorable way.

To enhance the nursing staff’s understanding of the expected knowledge and skills, invite them to become involved with the development of the training or competency evaluations.

Another fun way to present education is to have nurses make a patient-teaching pamphlet on a specific disease or drug. Or play “bingo” using game cards with terms specific to the topic, then ask questions that would have an answer on the card. Topics that work well include medications, oxygen modalities, drug calculations, laboratory values and infectious diseases.

continued on page 14
Professional Nursing Skills

Beyond technical skills, there are many professional nursing skills that need to be integrated into each patient contact. To be successful at their jobs, nurses must possess qualities such as critical thinking, good judgment and decision-making, keen observation, attention to detail, organizational skills and strong sense of responsibility.

Let’s add a few more to the list: effective communication, stress management, flexibility, dedication, patience, kindness and compassion. These skills can be incorporated into any training exercise.

One fun way to strengthen these skills is to have all staff participate in activities such as playing “telephone,” where a statement is made and passed from one person to the next. When you get to the last person, see whether he or she recites the original statement correctly. Another game, word search, can help develop observation skills and time management skills.

Nurses should embrace all educational opportunities to develop or sharpen all of their nursing skills on a continuous basis. This will better prepare them to provide the best nursing care to each patient and give them the professional satisfaction of a job well done.

Susan Laffan, RN, CCHP-RN, CCHP-A, is principal of Specialized Medical Consultants. To contact her, write to njailnurse@aol.com.

Sharp Thinking

In a hospital setting, I once was at a competency testing station that evaluated my knowledge of pain reassessment after providing pain medication (Dilaudid).

I was asked, “When would you come back to reassess this patient’s pain level?”

My reply: “Now—since I am giving the dose slowly over two minutes, the effects should already be providing relief to the patient.”

The evaluator said, “I expected the answer, ‘15-30 minutes,’ yet you are correct; proceed to the next station.”

Professional Nursing Skills

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Susan Laffan, RN, CCHP-RN, CCHP-A, is principal of Specialized Medical Consultants. To contact her, write to njailnurse@aol.com.
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• In-Depth Review of NCCHC’s 2018 Standards for Health Services in Prisons
• In-Depth Review of NCCHC’s 2015 Standards for Mental Health Services

Sunday, October 21
9 am - 12:30 pm
• Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care
• Opioid Treatment Programs in Corrections: The Why, the What and the How
• Emergency! Nursing Response and Clinical Decisions
1:30 pm - 5 pm
• A Multidisciplinary Approach to Pain Management
• Principles for a Viable Suicide Prevention Program

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"Attending NCCHC conferences has really helped me think outside of the box in terms of serving our patients and also being able to implement strategies to help patients not only succeed while incarcerated but upon reentry."

— Rachel Ramsay, RN
Pembina County Public Health
Cavalier, North Dakota

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• Difficult Cases in Corrections: Homelessness, Poor Insight and Recidivism
• How to Mitigate Risk Related to Sexual Misconduct
• I Hear Voices: Differential Diagnosis of Psychotic and Personality Disorders
• Mumps: Lessons Learned From a Successful Containment
• Return of the Great Masquerader: Common and Uncommon Syphilis Case Presentations
• The Opioid Epidemic and Medication-Assisted Treatment for Opioid Users

VIVA Las Vegas
They say Las Vegas is the brightest place on earth, and it will light up even more when the brightest minds in correctional health care gather for five days of education, networking and camaraderie. The National Conference returns to the Paris Hotel, one of NCCHC’s favorite gathering spots, where cobblestone streets, quaint cafes and luxurious accommodations offer visitors a taste of France within the Entertainment Capital of the World. Las Vegas has something for everyone, from fine dining and spectacular shows to its famed nightlife and casinos. Don’t miss it!

Reserve your room by Sept. 27 to lock in the NCCHC conference rate of $159 + tax. For a link to hotel registration, go to national-conference.ncchc.org, or call 877-603-4389.
Sometimes you just have to ask for help—you need to turn to independent experts who will ask the right questions, evaluate your situation objectively and provide sound solutions based on broad, deep knowledge.

That’s why NCCHC Resources, Inc., was created. As jails, prisons and juvenile detention facilities strive to deliver constitutional health care, improve quality and reduce liability in an ever-evolving environment, their increasing need for high-quality consulting services led to the formation of the nonprofit company, which launched in 2015.

Thanks to its close relationship with the National Commission, NCCHC Resources offers unparalleled breadth, depth, experience and perspective. Services include health system assessments, performance improvement, subject matter expertise, preparation for accreditation, preparation for CCHP certification, education and training, technical assistance, RFP development and more.

Case Studies
NCCHC Resources has provided consulting services and technical assistance to dozens of correctional health care systems nationwide. Recent projects include work as varied as the following:

- Comprehensive review of health care services with targeted recommendations for improvement
- Focused analysis of nonemergency health care services at a high-security prison
- Assessment of a large jail system’s readiness for an accreditation survey, including on-site assessments at the system’s many sites and crucial feedback
- Development of large and complex RFPs for health services

With the opioid epidemic flooding into the nation’s jails, NCCHC Resources is receiving many inquiries about how best to handle inmates with opioid use disorder. Below is a summary of one client project.

Opioid Use Disorder Training
The Sheriff Al Cannon Detention Center made a smart move in the fight against opioid addiction: It hired NCCHC Resources to teach staff members about medication-assisted treatment in the correctional setting.

The all-day, interactive training seminar at the North Charleston, SC, county jail presented information on the scope of the opioid problem, the role of MAT in treatment and approaches to MAT. The presenters also provided an in-depth review of NCCHC’s Standards for Opioid Treatment Programs in Correctional Facilities and explained how to establish a successful OTP using the standards.

With an average daily population around 1,300, Al Cannon is not a huge jail. The leadership knows, however, how important it is for the staff to understand the most current thinking in how to treat inmates with opioid use disorder. “With the increase in opioid use in our community and the great risk for return to use or overdose after release from detention, we feel it is critical that MAT be implemented in the detention center,” says Chanda Brown, PhD, LMSW, director of the Charleston Center, the county’s public health provider. “It’s the right thing to do medically and it could potentially save lives.”

NCCHC is the only corrections-specific organization that is federally authorized to accredit opioid treatment programs.

Independent Integrity
Importantly, consultation by NCCHC Resources is a professional activity that is completely separate from the National Commission and in no way guarantees accreditation, certification or any other outcome of NCCHC programs. Rather, the goal is to help facilities achieve an efficient, well-managed health care delivery system, whatever the scope of the project or the range of needs.

Learn more about NCCHC Resources at www.ncchc.org/NCCHCResources. To discuss your facility’s needs for training, consultation and technical assistance, please contact info@ncchcresources.org.
When women are incarcerated in prisons, they can expect to gain weight, and often a significant amount, as several studies have shown. Studies have also found a high prevalence of obesity among incarcerated women. These concerns can lead to weight-related health problems and a negative impact on quality of life.

Prison commissary food can play a role in weight gain, but to date this food has not been well studied. A team of researchers from the University of Minnesota conducted a study to evaluate the nutritional quality of commissary food and recipes cooked within eight women's prisons in the United States. Their findings are published in the July issue of the Journal of Correctional Health Care.

**Study Methods**

The study had two objectives: to evaluate the extent to which commissary food offerings are consistent with the U.S. Department of Agriculture’s MyPlate food group serving recommendations, and to determine the nutritional quality of meal and snack recipes prepared using commissary food sold in women’s prisons. MyPlate is a guide designed to ensure that food and nutrient intake follows recommendations in the Dietary Guidelines for Americans.

The prison sample consisted of four federal and four state facilities. Through an Internet search, the researchers obtained commissary lists from these facilities, which are located in seven states. The 1,152 food items on the lists were grouped into one of the seven MyPlate categories: vegetables, fruits, whole grains, refined grains, protein, dairy and other (e.g., condiments, spices, sodas, candy).

To analyze recipes, the researchers used a cookbook titled High Fence Foodie: From the Big House to Your House, written by a female prison inmate. The 203 recipes were labeled as main dishes, soups, sides and salads, dips and sauces, snacks, desserts and beverages. This study excluded holiday recipes, leaving 175 recipes for analysis.

Recipe analysis software was used to determine the nutrient content and food group servings for recipes based on the nutrient content of the commissary foods. The average nutrient content per serving for all recipes combined and by recipe category were calculated, with focus on 15 nutrients: energy (kcal), total fat, saturated fat, trans fat, cholesterol, sodium, total carbohydrates, dietary fiber, total sugars, added sugars, protein, vitamin D, calcium, iron and potassium. The average percent Daily Value per serving was calculated for each nutrient for which a DV exists. A %DV of ≤ 5% was considered low and ≥ 20% was considered high.

**Commissary Foods Don’t Align With MyPlate**

In the federal and state prisons alike, the proportions of commissary offerings in each food category generally did not meet MyPlate recommendations. Food items tended to be high in sodium, saturated fat, added sugars and calories, but low in vitamin D. Commissary items and recipes were both low in fruits, vegetables and whole grains and excessive in refined grains. The highest percentage of items, 38%, were in the “other” category.

Similarly, the recipes were found to be, on average, high in sodium, saturated fat, protein, total fat, added sugars, calories, carbohydrates, fiber and iron, and low in vitamin D.

The authors point to scientific evidence that a diet high in fruits, vegetables and whole grains and low in refined grains, sodium, saturated fat and added sugars may prevent obesity and diseases such as hypertension and coronary heart disease. They suggest that offering more nutritious commissary options may help to address weight-related health concerns and to prevent diet-related chronic diseases.

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- Preparing to Die Behind Bars: The Journey of Male Inmates With Terminal Health Conditions
  – Sara Sanders, PhD, MSW, & Meredith Stensland, PhD, LMSW
- Effectiveness of a Prison-Based Healthy Pregnancy Curriculum Delivered to Pregnant Inmates: A Pilot Study
  – Leigh Tenkku Lepper, PhD, MPH, Sakshi Trivedi, MPH, & Adaobi Anakwe, MPH
- Barriers and Facilitators to Effective Mental Health Care in Correctional Settings
  – Olivia Kolodziejczak, MA, & Samuel Justin Sinclair, PhD
- Evaluation of the Nutritional Quality of Commissary Foods Offered in American Women’s Prisons
  – Laura Rosenboom, MPH, Rebecca Shlafer, PhD, MPH, Jamie Stang, PhD, MPH, RDN, & Lisa Harnack, DrPH, MPH, RD
- Addressing Women’s Unmet Health Care Needs in a Canadian Remand Center: Catalyst for Improved Health?
  – Jonathan Besney, BMSc, Cybele Angel, MA, RN, Diane Pyne, BScN, RN, Rebecca Martell, CACII, RSC, Louanne Keenan, PhD, & Rabia Ahmed, MD
- Depression, Executive Dysfunction, and Prior Economic and Social Vulnerability Associations in Incarcerated African American Men
  – Faith Scanlon, Joy D. Scheidell, MPH, Gary Cuddeback, PhD, Darcy Samuelsohn, David Wohl, MD, Carl Lejuez, PhD, William Latimer, PhD, MPH, & Maria Khan, PhD, MPH
- Risk-Based HIV Testing at Los Angeles County Men’s Central Jail
  – Nazia Qureshi, MPH, Marjan Javanbakht, PhD, MPH, Martha Tadesse, MPA, MSN, MPH, Mark Malek, MD, MPH, & Garrett Cox, MPH
- Preparing to Die Behind Bars: The Journey of Male Inmates With Terminal Health Conditions
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Administrators who are responsible for the overall well-being and specialist physicians to GPs, PAs, nurses, and the correctional administrators designed to benefit every correctional health care provider, from the nation's top experts to provide a comprehensive working guide.

Written to help professionals meet these challenges, this contributed volume brings together the insights and experiences of thirty of the nation's top experts. The work can be incredibly rewarding—yet burnout is a constant threat to the well-being of caregivers and patients alike. Courts and correctional agencies are increasingly subject to severe budget constraints. The work can be incredibly rewarding—yet burnout is a constant threat to the well-being of caregivers and patients alike. Courts and correctional agencies are increasingly subject to severe budget constraints. Courts and correctional agencies are increasingly subject to severe budget constraints.

W

Edited by Fred Cohen, LL.M.

O

rolowski died of a methadone overdose while held in a Milwaukee jail. His estate sued and surprisingly suffered summary judgment with the district court. In Orlowski v. Milwaukee Co. (7th Cir. 2017), the case is reversed and remanded.

Facts

Sgt. Alexander observed Orlowski sleeping fitfully, at times appearing to stop breathing, only to resume. Sgt. Alexander and Sgt. Manns, who was summoned, decided it was not a medical emergency. Somehow they concocted sleep apnea as the cause.

The sad part of this lay diagnosis is the subsequent expert opinion that Orlowski could have been saved with medical care in the interim between discovery that he would not wake up and his death.

Discussion

Defendants claim that while something obviously was wrong with Orlowski, it did not appear to be serious. They cannot be held, they argue, to actual knowledge of a drug overdose.

That is true, finds the court, but what was observed would have seemed serious to a layman. The specific diagnosis is not required either for the threshold requirement of seriousness or for qualified immunity purposes. That is, for the latter, a constitutional right must have been violated and the right clearly established.

The Eighth Amendment right to medical care for a serious medical condition has long been the law. Qualified immunity has its own history and a good deal of expository litigation on the meaning of "clearly established."

Here, Orlowski appeared in serious medical trouble—and that is enough. The specific diagnosis is not required to trigger the duty of reasonable care.

Reversed.

Comment

This decision is important for clarifying the meaning of "clearly established" in a qualified immunity context.

Fred Cohen, LL.M, is editor of the Correctional Law Reporter. This article is reprinted from CLR with permission of the publisher. All rights reserved.

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Looking Glass (continued from page 4)

Some actions have been taken, but challenges remain in the translation, or "trickle-down," to effect change at the front line. Using nurse staffing as an example, legislation to aid in hospital staffing plans and ratios has been discussed on the state and federal levels. Currently, 15 states and the District of Columbia have enacted legislation: seven states require hospital staffing committees, one state requires a minimum nurse–patient ratio to be maintained and five states require public disclosure. If you live in one of these states, do these policies apply to your correctional setting? I would venture not!

Closer to home, take a leadership role in your facility. Be an educator—share your expertise, bring an article to share and discuss with others or conduct a five-minute teaching in a change of shift report. Act as a peer mentor—we all need mentors at different times in our careers. Lead an ad-hoc committee to problem solve a clinical situation. Support and encourage teams.

Let’s not be like the White Rabbit, who fretted, “Oh dear! I’m late!” Rather, follow Alice through the looking glass, with intent—look into the future.

Deborah Shelton, PhD, RN, CCHP, recently retired from the University of Connecticut and is now working as an independent consultant.
NCCHC Connect Provides Forum for CCHPs and Potential Candidates

by Katie Przychodzen, MA

In July, the National Commission launched NCCHC Connect, the first-ever online community specifically for correctional health professionals. With more than 600 members and 20 discussion groups, the community is going strong.

One of the most active groups in the online community is the CCHP group, where members are sharing ideas on a variety of interesting topics and learning from one another in the process. Of particular interest to members is the value of earning the Certified Correctional Health Professional credential.

For instance, after Judy Snow, MA, LPC, CCHP-MH, said, “Power in numbers—the more we have certified, the stronger the influence we will have as a body of correctional health professionals,” a conversation began about how to increase the numbers of CCHPs in the field. One idea that other CCHPs were very excited about is certification sponsorship programs.

Victoria Scotti, MSN, RN, CCHP, shared what happens at the Pinellas County Sheriff’s Office: “We sponsor five staff members each year for CCHP certification. We maintain five complete sets of the required material for the applicants to use in preparation for the test. It has worked out quite well so far!” To this, Christine Richardson, JD, MA, LPN, CCHP, responded, “Sponsoring is a great concept, one that should become viral.”

Exam Prep Tips

CCHPs are also sharing tips on how to prepare for the exam. Daniel Cuscela, DO, CCHP, explained that he worked with the education department at his facility, FMC Butner, when preparing to take the test: “They had a full collection of books and reviews available for loan. They helped me prepare and I was able to pass the test.”

Kelly Ciccone, MSN, RN, CCHP, posted about creating a study group: “I purchased all of the [standards] manuals and organized a study group for staff members who planned to take the CCHP exam. We reviewed the manuals and highlighted focus areas we anticipated might be test material. Next, we made our own list of focus study facts and made a game of answering potential test questions. The exam was not easy, but we all passed!”

Sharing Stories

The community also shares ideas for keeping the standards front of mind. Ciccone said, “I like to use information from the manuals to select a topic each month or quarter to share and review with our staff. These ‘Hot Tips and Hot Topics’ are either randomly selected or they can be identified as ‘opportunities for improvement’ during monthly inspections. Ongoing attention [to the standards] helps people prepare for certification and also helps those who are already certified continue to improve knowledge and skills.”

NCCHC Connect is also a place to hear the stories of other committed correctional health professionals.

Sue Smith, MSN, RN, CCHP-RN, tells this story: “Certification was one of the surefire ways that I could change the minds of my college nursing professors when I told them I was going to become a correctional nurse. One of the first questions I would be asked was, ‘Is there a certification available for correctional nurses?’—I could see the doubt in their eyes. But of course I could respond that, yes, there was. I saw their expressions change every time. Certification is respected throughout the health care professions—it is always seen as a mark of excellence.”

To join NCCHC Connect, send an email to connect@ncchc.org to receive a personalized invitation link. Follow the link to log into your profile and start connecting! connect.ncchc.org

Benefits of Becoming a CCHP

- Encourages sharing of innovations in the field
- Enables one to assist others in field
- Fosters a sense of common identity in correctional health care
- Expands networking opportunities
- Increases competence in corrections
- Supports compliance with standards of care
- Encourages standardization of practices
- Safeguards the patient, staff and public
- Offers justification for investment in professional development activities
- Promotes ethical conduct
- Helps to ensure accountability
- Helps to advance one’s career
- Provides a sense of pride and achievement
- Elevates status and prestige
- Helps as a recruitment tool
- Puts forth a common body of knowledge
- Expands opportunities within corrections
- Enables one to assist others in field
- Supports compliance with standards of care
- Encourages standardization of practices
- Safeguards the patient, staff and public
- Offers justification for investment in professional development activities
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- Elevates status and prestige
- Helps as a recruitment tool

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

Note: The NCCHC Connect posts included in this article have been edited for clarity.

If you are interested in hosting a CCHP exam at your facility, please contact cchp@ncchc.org. To learn more about the CCHP program, visit www.ncchc.org/professional-certification.
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

- Dialysis services
- Education and training
- Health care management
- Infection control products
- Laboratory services
- Medical supplies
- Optometry services
- Pharmacy services
- Substance abuse services
- Treatment programs

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
- Keynote speaker
- Educational programming
- Coffee tumblers
- Ice cream social
- Photo booth
- Conference bags
- Twitter wall
- Exhibit hall aisle sign
- Badge lanyards

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.

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.

www.InfocusLists.com/Datacard/NCCHC

Contact INFOCUS Today!
Kerry Tranfa
ktranfa@infocuslists.com
800.708.LIST (5478), ext 3247

www.InfocusLists.com

Exhibit at the National Conference on Correctional Health Care and participate in one of the world’s largest gatherings of correctional health professionals. Nearly 2,000 attendees representing all segments of the correctional health community — administrators, medical directors, physicians, nurses, mental health professionals and more — come together to share insights, find solutions and identify best practices. Connect with more decision makers than you can in months of sales calls. Sign up for a cost-effective exhibition booth today!
EMPLOYMENT

County of Los Angeles
Assistant Director, Bureau Operations, Sheriff / Prison Rape Elimination Act (PREA) ($116,574.23 - $176,444.41 Annually)

Job Description:
Assists in directing the operations of the Prison Rape Elimination Act (PREA) for the County of Los Angeles Sheriff’s Department.

Serves as a PREA liaison and advisor to leadership, internal Divisions, Bureaus and Units responsible for various Prison Rape Elimination Act (PREA) standards (e.g., Custody Division, Internal Affairs Bureau, Internal Criminal Investigative Bureau, etc.), partnering agencies (e.g., Correctional Health Services, Office of Inspector General, ACLU, etc.), and County Counsel.

Oversees the implementation of PREA-compliant policies, procedures, unit orders, bulletins by conducting facility assessments; working with facilities to develop and document a staffing plan that considers sexual safety and appropriate monitoring and reporting; reviewing sexual assault and sexual harassment allegations; collecting and analyzing PREA-related data; and submitting survey of sexual violence to the Bureau of Justice Statistics.

Manages the facility PREA Compliance Teams by meeting with each facility on an annual basis; working with each facility to prepare for PREA audits; training and assisting facilities with their Pre-Audit Questionnaires; conducting unannounced PREA inspections at all facilities; compiling facility compliance information; and developing recommendations for system changes.

Resolves PREA-related issues by maintaining availability in emergencies or matters of urgency related to PREA in the facilities that operate 24/7; traveling to and attending PREA-related meetings and conferences; acting as the Chair on the Gender Identity Review Board and Incident Review Board; and responding to PREA-related grants.

Supervises the work of subordinate managers and supervisors.

Acts as the Bureau Director in his or her absence, as needed.

For more information and to apply, please use the following link: https://bit.ly/2nzE94D

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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

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 Certified Correctional Health Professionals, key personnel at accredited facilities, members of the Academy of Correctional Health Professionals and other recipients at our discretion. To see if you qualify for a subscription, create an account 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 us sales@ncchc.org or 773-880-1460, ext. 298.

ADVERTISER INDEX
Expert Advice on NCCHC Standards

What Statistics Should Be Reported?

Q During an accreditation survey, do surveyors expect to see our statistics separated into appointments, sick call, pharmacy refill, etc., or is the total number of patient visits each day adequate?

A Standard A-04 Administrative Meetings and Reports requires that statistical reports of health services are made at least monthly. Because they should be used to monitor trends in health care delivery, various categories of information should be collected. We recommend that the reports contain statistics such as service volume, incidence of certain illnesses, infectious disease monitoring, access, timeliness of health services and follow-up, missed appointments, emergency services and hospital admissions, referrals to specialists, deaths and grievances. Simply reporting the total number of patient visits each day would not be adequate to capture these specific trends. Monitoring areas such as these may help with staffing plans, space and equipment needs and facility comparisons when indicated.

Must All Staff Nurses Be RNs?

Q I am an LPN and have worked at a county jail for several years. We are now being told that NCCHC accreditation requires all staff nurses to be RNs. Is this true?

A No, the standards do not require that all nurses be RNs. Standard C-07 Staffing requires that the RHA have sufficient numbers and types of health staff to care for the inmate population. Other than requiring an RHA and a responsible physician (see A-02 Responsible Health Authority), we do not determine type of staff, numbers or ratios for staffing plans.

In C-07, compliance indicator #5 requires that the adequacy and effectiveness of the staffing plan be assessed by the facility’s ability to meet the health needs of the inmate population. Each facility may have differing staffing needs based on the scope of services offered on-site. In addition, qualified health care professionals should not be performing tasks beyond those permitted by their credentials (see C-01 Credentials). NCCHC survey teams and members of the Accreditation and Standards Committee take these variables into account when determining the adequacy of staffing plans at individual facilities.

Is ‘Clinical Preventive Services’ New?

Q In the 2018 Standards for Health Services for jails and prisons, B-03 Clinical Preventive Services was renamed. What was it called before?

A Although the title of the standard is new, much of the content comes from the 2014 standards. Below is a list of the B-03 compliance indicators and a breakdown of where the content appeared in the 2014 manual and/or whether the content is new:

- CI #1 – new content
- CI #2 – from 2014, E-12 Continuity and Coordination of Care During Incarceration (CI #10)
- CI #3 – new content
- CI #4 – from 2014, E-04 Initial Health Assessment (CI #2e) Note that the responsible physician now determines the necessity and/or timing of this testing, rather than a blanket requirement or a letter from the health department regarding the prevalence rate not warranting testing.
- CI #5 – from 2014, B-01 Infection Prevention and Control Program (CI #2b) and E-04 Initial Health Assessment (CI #2f)
Be part of an exceptional team that’s raising the standard.

Wexford Health Sources, one of the nation’s leading providers of correctional health care services, offers fulfilling opportunities for clinical professionals 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 medicine.

Opportunities for Mental Health Professionals are available throughout:
- Alabama
- Illinois
- Indiana
- West Virginia

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.
With rates of mental illness among incarcerated populations exceeding 50%, the nation’s jails and prisons are challenged to provide constitutionally acceptable care. NCCHC has the resources and programs you need to meet this challenge.

**AUTHORITATIVE STANDARDS**

The *Standards for Mental Health Services in Correctional Facilities* present NCCHC’s recommendations for managing mental health services delivery. These standards support adult correctional facilities in achieving and maintaining compliance with NCCHC accreditation requirements.

**VALIDATION THROUGH ACCREDITATION**

Accreditation provides public recognition that correctional mental health care providers and facilities are meeting national standards. It reduces exposure to costly liability and recognizes the institution’s commitment to meeting quality goals and using acceptable practices.

**PROFESSIONAL CERTIFICATION**

The Certified Correctional Health Professional – Mental Health program provides formal recognition for practitioners who have engaged in a process of ongoing, focused and targeted professional development. A CCHP-MH has demonstrated a mastery of specialized content developed by experts in this field.

For more information, visit [www.ncchc.org](http://www.ncchc.org).