Communicable Disease Dilemmas in Correctional Health Systems

Anatomy of a Lawsuit and Strategies in Your Defense

Triaging Intake Exams to Identify High-Risk Patients

The 2018 Award Winners

Spring Conference Preview
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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.
NCCHC and the National Sheriffs’ Association are pleased to present a resource to support jail administrators and health professionals in providing effective treatment for individuals with opioid use disorder and helping to halt the opioid epidemic in the United States.

Jails are on the front lines of this epidemic, and they also are in a unique position to initiate treatment in a controlled, safe environment. Pharmacotherapy—i.e., medication-assisted treatment—is a cornerstone of best practice for recovery from substance abuse. Treatment using MAT, particularly when coupled with evidence-based behavioral therapy, improves medical and mental health outcomes and reduces relapses and recidivism.

**Key Features**

Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field introduces what has been learned from sheriffs’ and jail administrators’ innovative use of MAT, describes the essential components of these programs and discusses the latest research on how the programs are best implemented, as well as the medications approved for opioid use disorders.

Key features of the guide are as follows:

- An overview of general tenets and best practices associated with developing, implementing and sustaining a jail-based MAT program. This outline of key issues and questions is well-suited for a quick read by criminal justice executives.
- A deeper exploration of the topics highlighted in the overview, including existing standards, related guidelines and examples from the field. While suitable for the range of readers, this section delves into technical details and may be most appropriate for MAT program developers and practitioners involved in hands-on activities.
- The Programs in Action section provides a window into several real-world, jail-based MAT programs, including outcomes and lessons learned.
- Throughout the report are tools, treatment programs, references and supporting documentation.

The Promising Practices, Guidelines, and Resources document is the result of an extraordinary collaboration of federal, national and private partners. The inception of this project was a February 2017 roundtable discussion with representatives from several federal agencies, model MAT programs in criminal justice and correctional settings, professional associations and organizations involved in policy, research and training.


## Young Professional Award and Networking Group Off to a Great Start

NCCHC presented the inaugural Young Professional Award at the 2018 National Conference in Las Vegas. The award was created to recognize emerging correctional health care leaders, age 45 and under, who demonstrate dedication to the field and inspire others through their commitment to quality health care. A newly formed Young Professionals committee developed criteria, solicited nominations (and received excellent response!) and evaluated the candidates. Read about the recipient, Pamela San Miguel, RN, PHN, CCHP-RN, on page 21.

The YP committee is also initiating new activities to engage and support this group. The first-ever reception for young professionals was held at the National Conference. We met, mingled and had the opportunity to network with seasoned leaders in the field, and another mixer will be held at the Spring Conference in Nashville. Webinars are being planned to help meet the needs of these professionals, and a dedicated group now exists on NCCHC Connect, the online community for our field.

**Calendar of events**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>April 6-9</td>
<td>Spring Conference on Correctional Health Care, Nashville</td>
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<tr>
<td>April 7</td>
<td>CCHP exams, Nashville</td>
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<tr>
<td>April 7</td>
<td>Accreditation Committee meeting</td>
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<td>May 3</td>
<td>Accreditation Committee meeting</td>
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<td>July 27</td>
<td>CCHP exams, Las Vegas</td>
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<tr>
<td>July 28-29</td>
<td>Correctional Mental Health Care Conference, Las Vegas</td>
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See the list of all CCHP exams at www.ncchc.org/cchp.

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**Coming Soon: MyNCCHC Account Interface**

In early 2019, NCCHC constituents who visit our website will be prompted to log in to MyNCCHC—a new, state-of-the-art interface—for a better user experience. MyNCCHC will be a one-stop-shop for creating and updating your profile, applying for CCHP exams and recertification, purchasing Standards and registering for educational events. Stay tuned for more information!
Board Chair Tom Fagan Sets His Sights on Continued Growth and Improvement

Thomas J. Fagan, PhD, CCHP-MH, has become chair of NCCHC’s board of directors. After serving one year as chair-elect, he took the helm on Oct. 21 during the board’s annual meeting in Las Vegas.

Fagan is a clinical psychologist with a long and distinguished career as an advocate for health and mental health care in corrections. In his nearly 25 years with the Federal Bureau of Prisons, Fagan worked as a psychologist and psychology administrator, ultimately serving as director of clinical training. At the BOP, he helped develop correctional mental health programs, policies and procedures, and also trained professional, paraprofessional and correctional staff. For many years, he was the prison system’s chief hostage negotiator, and he has presented programs on correctional hostage negotiation to departments of correction across the country.

After retiring from the BOP, Fagan returned to academia, serving as a professor and associate dean of psychology at Nova Southeastern University in Florida. There, he says, he worked to “motivate the current generation of students to consider careers in corrections.”

Professional Commitment and Expertise

Few people know more about NCCHC’s work than Fagan. In his 22-year tenure on the board as liaison of the American Psychological Association, he has served on and chaired numerous committees, including a term as chairman in 2004. He also has been instrumental in spearheading programs to help meet the challenges presented by the growing population of inmates with mental illness. Notable activities include the following:

• Co-chaired the task force that developed the latest edition of the Standards for Mental Health Services in Correctional Facilities
• Helped to create NCCHC’s annual Correctional Mental Health Care Conference
• Chaired the committee that developed a certification for correctional mental health professionals; he also was among the first to become certified as a CCHP-MH

Fagan has widely shared his wisdom and expertise as a consultant, teacher, researcher, author and lecturer. Earlier in his career he taught at several colleges in Virginia, and throughout his career he has given countless presentations on a wide range of mental health topics. His resume lists dozens of published articles, book chapters and textbooks, including the highly regarded books “Correctional Mental Health Handbook” and “Correctional Mental Health: From Theory to Practice,” both coauthored with Robert Ax.

From Intern to Eminent Leader

What draws Fagan to this line of work? A BOP internship was Fagan’s first job after grad school in 1976, and while his classmates could not understand that choice, he explains, “I loved the clinical diversity and intensity of correctional work and I simply didn’t leave.”

At a Glance

Thomas J. Fagan, PhD, CCHP-MH

Professional Experience

• Consultation and training services, 2000-present
• Federal Bureau of Prisons, 1976-1999
  – Director of clinical training, psychology services, 1991-1999
  – Psychology services administrator, Northeast Region, 1984-1991
  – Chief psychologist, FCI Petersburg, 1982-1990
  – Clinical psychologist, FCI Petersburg, 1977-1982
• Private psychology practice, 1984-1988

Academia (selected appointments)

• Nova Southeastern University – 2005-2016
  – Associate dean and professor, College of Psychology
  – Director, Division of Social and Behavioral Sciences
  – Professor of psychology, Farquhar College of Arts and Sciences

Professional Honors

• American Psychological Association
  – Award for Distinguished Contributions to Practice in the Public Sector
  – Society of Clinical Psychology, Fellow
  – Psychologists in Public Service, Fellow
  – Special Achievement Award

Education

• PhD, clinical psychology – Virginia Polytechnic Institute & State University

At that time, the enormous surge in correctional mental health populations was right around the corner, and he witnessed prevalence rates of seriously mental illness rise from about 2% or 3% to 20% of jail and prison inmates, and a much higher percentage with less severe disorders. This dramatic shift changed correctional mental health practice, Fagan says, and presented huge challenges.

That’s why he was excited to learn about NCCHC in the mid-1990s, when his boss brought him to copresent at a conference. “It was one of those WOW experiences for me,” he recalls. “For the first time, I was with people who were doing exactly what I was doing. I had found my professional home.”

Now he is a leader and caretaker of that home. And his goals as chair are as expansive as his achievements to date: “I will work closely with the board and staff to improve and grow NCCHC’s accreditation program, expand educational program offerings to new audiences and through additional venues, and enhance NCCHC’s reputation as the preeminent organization dedicated to correctional health care.”
Join hundreds of correctional health care colleagues in Music City USA to learn, share, problem-solve and network. NCCHC’s Spring Conference promises a professional pick-me-up for clinicians, administrators and anyone who cares about delivering quality health care to incarcerated individuals. Choose from among 60 educational sessions, browse the exhibit hall and enjoy ample opportunity for talking shop with others who understand the challenges and rewards of your work.

Between all that professional development, find some time to kick up your heels in Nashville. The crossroads between country and cosmopolitan, Nashville is the place to be, famous for its friendliness, history, charm and, of course, music. From honky-tonks to high-end dining, there is something for everyone.

DISCOVER AND LEARN

• Choose from over 60 content-rich educational presentations plus roundtable discussions
• Learn how other organizations have implemented successful programs
• Deepen your knowledge by taking part in the preconference seminars
• Earn up to 26.75 continuing education credits (includes weekend seminars)
• Gain insights from leading experts in correctional and public health
• Network with colleagues, from top decision makers to in-the-trenches staff
• Visit the bookstore for essential publications, CCHP products, NCCHC apparel and more
• View problem-solving products and services in the bustling exhibit hall
• Explore Nashville, world-renowned as America’s “Music City”

PRECONFERENCE SEMINARS

Topical, informative seminars will help you stay up-to-date on critical issues facing the field. Maximize your education and CE hours while you learn about NCCHC standards and other vital subjects. Separate registration and fee required. See the conference website or preliminary program for details.

SATURDAY, APRIL 6
9 am - 5 pm
• In-Depth Review of NCCHC’s 2018 Standards for Health Services in Jails
• 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, APRIL 7
9 am - 12:30 pm
• Beyond Good and Evil: The Soul of the Psychopath
• Emergency! Nursing Response and Clinical Decisions 1:30 pm - 5 pm
• Principles for a Viable Suicide Prevention Program
• Continuous Quality Improvement: Strategies and Techniques to Improve Patient Care

CONTINUING EDUCATION

Up to 26.75 hours of CE credit may be earned in each category below. This maximum number includes credits offered at preconference seminars. See the Preliminary Program or conference website for details.

• CCHP
• Dentist
• Nurse
• Physician
• Psychologist
• Social Worker
PROGRAM HIGHLIGHTS

Join an all-star lineup of correctional health care speakers, leaders and colleagues for top-notch educational programming, CE opportunities and networking. Quality correctional care gets top billing at the Spring Conference with more than 60 presentations like these:

- Beyond Wet to Dry: Advanced Wound Care Techniques
- Bipolar Disorder, Borderline Personality Disorder and PTSD: Improving Diagnostic Accuracy
- How to Perform a Psychiatric Nursing Assessment
- Keys to Motivating Staff to Get the Job Done
- Outbreak! 12 Steps to an Effective Response
- Physical Restraints: Assessment and Risk Mitigation for Nurses
- Preventing Domestic Minor Sex Trafficking
- Preventive Health Care for Incarcerated Women
- Triaging Dental Emergencies for Advanced Providers
- Why Some Cases Settle and Others Go to Trial: What Factors Go Into These Decisions?

WHO SHOULD ATTEND?

Whether you’re new to the field or a correctional health care veteran, you’ll find valuable connections, inspiration and ideas! The Spring Conference delivers unparalleled education and professional development opportunities for:

Administrators | Counselors | Custody staff | Dentists | Legal professionals
Nurses | Nurse practitioners | PAs | Pharmacists | Physicians | Psychiatrists
Psychologists | Social workers | All correctional health professionals

MEETING LOCATION AND HOUSING

All conference activities will take place at the Gaylord Opryland Resort, 2800 Opryland Drive, Nashville. This premier hotel offers all the excitement and energy of Music City under one spectacular roof.

NCCHC has reserved a block of rooms at the hotel at a special rate of $199 + tax per night. Reserve your room by March 11 to ensure availability and lock in the special NCCHC rate.


For more information: www.ncchc.org/spring-conference • info@ncchc.org • 773-880-1460

REGISTER BY MARCH 1 FOR THE BEST VALUE!

“This was my first time attending an NCCHC conference, and it far exceeded my expectations. The pertinent information provided about delivery of medical care in corrections greatly enhanced my knowledge, and I believe what I learned will help me to practice in a more enlightened, compassionate and caring manner.”

— 2018 Spring Conference Attendee
NCCHC Recommends Safeguards to Care for Juveniles in Adult Facilities

The National Commission has long been concerned about the health and mental health implications of adolescents housed in adult correctional facilities, and issued its first position statement on the matter in 1998. The latest review of this statement led to significant updates to reflect the shifting trends in juvenile offending, criminal justice policy and resulting outcomes.

Adopted by the board of directors in October 2018, the revised position statement highlights the complex developmental aspects of adolescence and the negative effects of housing juveniles in facilities designed for adults, such as exacerbation of mental health disorders. It also describes the limited capacity of most adult facilities to adequately care for juveniles, including the lack of staff with appropriate education and training to work with youth and a heightened risk of physical and sexual assault.

Fundamentally, NCCHC’s position is that adolescents should not be incarcerated in adult facilities. If they are, however, it is imperative that correctional programs caring for adolescents be designed specifically to meet their needs. The position statement outlines four primary principles to guide such programs; these principles are listed on the following page.

Below is the position statement in its entirety. It is available at the NCCHC website along with all of NCCHC’s position statements; go to www.ncchc.org/position-statements.

Health Services to Adolescents in Adult Correctional Facilities

Background

Judicial and correctional authorities have always been challenged with the problem of adolescents committing offenses. In response to rising rates of serious violent juvenile crime (aggravated assault, rape, robbery, murder) in the 1980s and 1990s, state legislatures expanded laws facilitating transfer of juvenile offenders to the adult criminal justice system, including lowering the age that adolescents could be tried in adult criminal court and increasing the housing of youth in adult correctional facilities (Sickmund & Puzzanchera, 2014). In recent years, progress has been made in raising the mandatory age for charging youth in the adult criminal system solely based on their age (Justice Policy Institute, 2017), but all states have provisions for transferring cases to the adult criminal court (National Conference of State Legislatures [NCSL], 2011a; Statistical Briefing Book, n.d.; Teigen, 2017).

Although rates of juvenile offenses and serious violent crime have steadily declined since the mid-1990s (Sickmund & Puzzanchera, 2014, Statistical Briefing Book, n.d.) and most youth in criminal courts are not charged with serious violent offenses, youth adjudicated in the adult criminal system are more likely to be detained for longer periods of time (Kurlychek & Johnson, 2006), to be rearrested, and to commit more serious future offenses than youth who remain in the juvenile justice system (Justice Policy Institute, 2017; NCSL, 2011a).

Furthermore, incarcerating adolescents in adult correctional facilities jeopardizes the long-standing paradigm of protecting the innocence of youth by incarcerating them separately from adults, maintaining their confidentiality, providing them with specialized community-based services, and ensuring that they participate in an individualized justice system. Finally, incarcerating adolescents in adult correctional facilities ignores the fact that the growth and developmental changes that occur in adolescence are substantially different from those that occur in adults.

Adolescence is a period of rapid physical, nutritional, cognitive, and social growth and development. These changes are influenced by a variety of factors including genetic, nutritional, environmental, family, and social experiences. This developmental period is also a time frame when youth are at risk for developing mental health disorders, including depressive and anxiety symptoms, and adolescents may have more than one disorder, including co-occurrence of substance abuse and mental illness (NCSL, 2011b). Approximately two thirds of adolescents who are arrested have a mental health disorder; a rate much higher than among their peers who are not involved in the juvenile justice system (NCSL, 2011a, 2011b). Confinement in any correctional facility may have a major impact on the ultimate outcome of this developmental process.

Adult facilities are not well equipped to deal with the mental or physical health needs of adolescents nor to address education and job training (NCSL, 2011a). Furthermore, staff in adult facilities commonly are not trained or prepared to work with the problems unique to adolescents, thereby impairing the ability of these youth to develop the skills needed to overcome crime and delinquency behaviors (Justice Policy Institute, 2017; NCSL, 2011a). Safety is another major concern, as juveniles housed in adult facilities are at greater risk of physical and sexual assault (NCSL, 2011a). The National Prison Rape Elimination Commission Report (2009) concluded, “Juveniles in confinement are much more likely than incarcerated adults to be sexually abused, and they are particularly at risk when confined with adults.”

Given these facts, it is imperative that correctional programs caring for adolescents be designed specifically to meet their needs. It is unlikely that adult correctional facilities can provide these complex services in a developmentally appropriate and competent manner, thus reinforcing the NCCHC’s position that juveniles should not be incarcerated in adult facilities.

Position Statement

The National Commission on Correctional Health Care believes that the incarceration of adolescents in adult correctional facilities is detrimental to the health and developmental well-being of youth. The Commission realizes,
nevertheless, that jurisdictions may continue to adjudicate youths as adults and incarcerate them in institutions for adults. Therefore, due to the unique health service needs presented by adolescents in adult correctional facilities, the Commission recommends the following:

1. Adolescent health specialists, including medical and mental health professionals, familiar with correctional health care should be consulted in the development of correctional policies and procedures dealing with adolescent inmates.

2. Correctional and health staff who are responsible for the supervision and treatment of adolescents should receive orientation and ongoing training regarding the unique health, developmental, and educational needs of youth.

3. Facilities that house adolescents should recognize their vulnerability in an adult setting. Adolescents should be separated from adults and be given opportunities for appropriate peer interaction and developmentally appropriate and specialized programming. These services should include the following:

   **Mental health**
   - Individual assessment/screening to identify presenting signs and symptoms, and ongoing care to prevent worsening of symptoms, treat underlying behavioral health disorders, and address areas of concern and distress
   - Individual and/or group interventions addressing substance use as well as social, coping, and anger management skills

   **Physical health** (including medical care, dental care, nutrition, and physical activity needs)
   - Health care and health education in accordance with nationally accepted guidelines as outlined by major medical associations that specifically address adolescent health
   - Incorporation of the NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities
   - A process for referral to pediatric/adolescent medical and mental health specialists

   **Social needs**
   - Separate and safe space
   - Opportunities to interact and socialize with peers
   - Access to age-appropriate coping and self-occupying activities

   **Life skills and skills specific to transition-age youth**
   - Educational needs
   - Job training
   - Training in attaining employment

4. NCCHC advises that the specific developmental and growth needs of an adolescent population be addressed in a special needs treatment plan as described in NCCHC standard F-01 Patients With Chronic Disease and Other Special Needs (see Standards for Health Services manuals for jails and prisons).
CONTRAINDICATIONS

VIVITROL is contraindicated in patients:

• 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.

• Prevention of relapse to opioid dependence, following opioid detoxification.

• VIVITROL should be part of a comprehensive management program that includes psychosocial support.

IMPORTANT SAFETY INFORMATION:

INDICATIONS
VIVITROL is indicated for:

• 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.

• 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

• 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

For additional Important Safety Information, please see the Brief Summary of Prescribing Information on adjacent pages.

CONTRAINDICATIONS

VIVITROL is contraindicated in patients:

- 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.

- Prevention of relapse to opioid dependence, following opioid detoxification.

- VIVITROL should be part of a comprehensive management program that includes psychosocial support.

- 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

IMPORTANT SAFETY INFORMATION 2:

INDICATIONS

VIVITROL is indicated for:

For additional Important Safety Information, please see the Brief Summary of Prescribing Information on adjacent pages.

References:


2. VIVITROL [prescribing information]. Waltham, MA: Alkermes, Inc; 2015.
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, polylactide-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 the emergence of symptoms of depression or suicidality, and to report such symptoms

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) were infrequent overall, but were more common in patients treated with VIVITROL than in patients treated with placebo. Patients treated with placebo or with VIVITROL should be given 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.

ADVERSE REACTIONS:

OVERDOSAGE:

There is limited experience with overdose of VIVITROL. Single doses of 280 mg and 380 mg were not lethal in animals. There is no known specific treatment for VIVITROL overdosage. In the event of an overdose, appropriate supportive measures should be undertaken. Patients with suspected VIVITROL overdosage should be hospitalized, monitored, and managed according to the severity of symptoms.

Clinicians should consider the possibility of eosinophilic pneumonia in patients treated with VIVITROL. Eosinophilic pneumonia has been reported in patients treated with naltrexone extended-release for alcohol dependence, with peak incidence in the first year of treatment. Patients should be advised to report symptoms of pneumonia to their provider. VIVITROL should not be administered to patients with known or suspected eosinophilic pneumonia.

ADVERSE REACTIONS:

In controlled trials of alcohol dependence, the most common adverse events seen in patients treated with VIVITROL were injection site reactions, accidental opioid overdose and depression and suicidality. The adverse events were more common in patients treated with VIVITROL than in patients treated with placebo.

VIVITROL is indicated for the treatment of alcohol dependence and may also be used for the treatment of opioid dependence. It is important to monitor patients receiving VIVITROL for the development of depression or suicidality. Patients should be advised to report any symptoms of depression or suicidality to their provider.

Pregnancy Category C: Reproduction and developmental studies have been 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

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 consistent potentiation method for determining whether a patient has had an adequate opioid-free period. A naloxone challenge test may be helpful; however, a few case reports have indicated that patients may experience precipitated withdrawal despite having a negative urine toxicology screen or tolerating a naloxone challenge test (usually in the setting of transitioning from buprenorphine treatment). Patients should be made aware of the risks associated with precipitated withdrawal and encouraged to give an accurate account of last opioid use. Patients treated for alcohol dependence with VIVITROL should also be assessed for underlying opioid dependence and for any recent use of opioids prior to initiation of treatment with VIVITROL. Precipitated opioid withdrawal has been observed in alcohol-dependent patients in circumstances where the prescriber had been unaware of the additional use of opioids or co-dependence on opioids.

Hepatotoxicity: Cases of hepatitis and clinically significant liver dysfunction were observed in association with VIVITROL exposure during the clinical development program and in the postmarketing period. Transient, asymptomatic hepatic transaminase elevations were also observed in the clinical trials and postmarketing period. Although patients with clinically significant liver disease were not systematically studied, clinical trials did include patients with asymptomatic viral hepatitis infections. When patients presented with elevated transaminases, there were often other potential causative or contributory etiologies identified, including pre-existing alcoholic liver disease, hepatitis B and/or C infection, and concomitant usage of other potentially hepatotoxic drugs. Although clinically significant liver dysfunction is not typically recognized as a manifestation of opioid withdrawal, opioid withdrawal that is precipitated abruptly may lead to the reappearance of a pre-existing condition. Clinicians should consider the possibility of hepatic injury and advised patients 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.
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 anesthesiology care setting by persons not involved in the conduct of the surgical or diagnostic procedure. The opioid therapy must be provided by individuals specifically trained in the use of anesthetic drugs and the management of the respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation. Irrespective of the drug chosen to reverse VIVITROL blockade, the patient should be monitored closely by appropriately trained personnel in a setting equipped and staffed for cardiopulmonary resuscitation.

Eosinophilic Pneumonia: In clinical trials with VIVITROL, there was one diagnosed case and one suspected case of eosinophilic pneumonia. Both cases required hospitalization, and resolved after treatment with antibiotics and corticosteroids. Similar cases have been reported in postmarketing use. Should a person receiving VIVITROL develop progressive dyspnea and hypoxemia, the diagnosis of eosinophilic pneumonia should be considered. Patients should be warned of the risk of eosinophilic pneumonia, and advised to seek medical attention should they develop symptoms of pneumonia. Clinicians should consider the possibility of eosinophilic pneumonia in patients who do not respond to antibiotics.

Hypersensitivity Reactions Including Anaphylaxis: Cases of urticaria, angioedema, and anaphylaxis have been observed with use of VIVITROL in the clinical trial setting and in postmarketing use. Patients should be warned of the risk of hypersensitivity reactions, including anaphylaxis. In the event of a hypersensitivity reaction, patients should be advised to seek immediate medical attention in a healthcare setting prepared to treat anaphylaxis. The patient should not receive any further treatment with VIVITROL. Intramuscular Injections: As with any intramuscular injection, VIVITROL should be administered with caution to patients with thrombocytopenia or any coagulation disorder (eg, hemophilia and severe hepatic failure). Alcohol Withdrawal: Use of VIVITROL does not eliminate nor diminish alcohol withdrawal symptoms. Interference with Laboratory Tests: VIVITROL may be cross-reactive with certain immunoassay methods for the detection of drugs of abuse (specifically opioids) in urine. For further information, reference to the specific immunoassay instructions is recommended.

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

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

USE IN SPECIFIC POPULATIONS: Pregnancy: There are no adequate and well-controlled studies of either naltrexone or VIVITROL in pregnant women. VIVITROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Category C: Reproduction and developmental studies have not been conducted for VIVITROL. Studies with naltrexone administered via the oral route have been conducted in pregnant rats and rabbits. Teratogenic Effects: Naltrexone has been shown to increase the incidence of early fetal loss when given to rats at doses ≥30 mg/kg/day (11 times the human exposure based on an AUC(0-28d) comparison) and to rabbits at oral doses ≥60 mg/kg/day (2 times the human exposure based on an AUC(0-28d) comparison). There was no evidence of teratogenicity when naltrexone was administered orally to rats and rabbits during the period of major organogenesis at doses up to 200 mg/kg/day (175- and 14-times the human exposure based on an AUC(0-28d) comparison, respectively). Labor and Delivery: The potential effect of VIVITROL on duration of labor and delivery in humans is unknown. Nursing Mothers: Transfer of naltrexone and 6-naltrexol into human milk has been reported with oral naltrexone. Because of the potential for tumorigenicity shown for naltrexone in animal studies, and because of the potential for serious adverse reactions in nursing infants from VIVITROL, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Pediatric Use: The safety and efficacy of VIVITROL have not been established in the pediatric population. The pharmacokinetics of VIVITROL have not been evaluated in a pediatric population. Geriatric Use: In trials of alcohol-dependent subjects, 2.6% (n=26) of subjects were >65 years of age, and one patient was >75 years of age. Clinical studies of VIVITROL did not include sufficient numbers of subjects age 65 and over to determine whether they respond differently from younger subjects. No subjects over age 65 were included in studies of opioid-dependent subjects. The pharmacokinetics of VIVITROL have not been evaluated in the geriatric population. Renal Impairment: Pharmacokinetics of VIVITROL are not altered in subjects with mild renal insufficiency (creatinine clearance of 50-80 mL/min). Dose adjustment is not required in patients with mild renal impairment. VIVITROL pharmacokinetics have not been evaluated in subjects with moderate and severe renal insufficiency. Because naltrexone and its primary metabolite are excreted primarily in the urine, caution is recommended in administering VIVITROL to patients with moderate to severe renal impairment. Hepatic Impairment: The pharmacokinetics of VIVITROL are not altered in subjects with mild to moderate hepatic impairment (Groups A and B of the Child-Pugh classification). Dose adjustment is not required in subjects with mild or moderate hepatic impairment. VIVITROL pharmacokinetics were not evaluated in subjects with severe hepatic impairment.

OVERDOSE: 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.

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www.vivitrol.com
Public health officials, correctional systems and our communities continue to grapple with the quandary of reducing communicable diseases. Finite health care dollars contrast with the myriad questions, opinions and ethical dilemmas presented by communicable diseases in incarcerated populations. This article describes the extent of common communicable diseases in U.S. jails and prisons, current programs and important questions as each ethical dilemma is considered.

The United States incarcerates more people per capita than any other nation. Approximately 2.3 million individuals are held in state, federal and military prisons; local jails; juvenile correctional facilities; state psychiatric institutions and more. The differences among the various incarceration facilities create structural challenges for health care programs as rules and funding vary across institutional types, with funds to jails being much more limited. These challenges create the potential for treatment disruptions and variation in type of programs offered.

In 2015, corrections health care spending in the United States reached $8.1 billion. Health care costs are expected to continue to rise, driven in part by the growing number of inmates aged 55 and older who have a higher burden of chronic health conditions and disabilities. Among those conditions, communicable diseases have a much higher prevalence rate in correctional populations than in the public at large.

HCV, HIV and TB Prevalence in Corrections

Nearly all states track active tuberculosis, hepatitis C virus and HIV/AIDS in correctional facilities.

Hepatitis C is the most common bloodborne infection in the country, with an estimated 4 million people infected. It accounts for 8,000 to 10,000 deaths annually. In a 2015 investigation it was estimated that 18% of the prison population was positive for HCV. In contrast, the general population HCV rate is 1%. Equally concerning is the fact that 30% (over 1 million) of all people with HCV in the United States spend at least part of the year in a correctional institution.
• HIV prevalence is roughly three times higher in incarcerated individuals than in the general U.S. population. In fact HIV prevalence in the state prisons of Florida, Maryland, and New York exceeds 3%, which is higher than the national prevalence of any country outside of sub-Saharan Africa.

• Tuberculosis is reported to be 100 times higher in prison populations, accounting for 25% of our nation’s cases. Overcrowding, poor ventilation and poor nutrition contribute to risk for prison inmates to be infected.

Minority populations are at an even higher risk since Hispanics and blacks are 30 to 40 times more likely to be incarcerated, respectively. Unfortunately, individuals who are most likely to be incarcerated are also at greatest risk of HIV and HCV infections due to a variety of behaviors.

To make matters worse, the cycle of communicable disease is perpetuated as 68% of prisoners are reincarcerated for a new crime within three years of their release. Many of these individuals continue the behaviors that placed them at risk in the first place.

Testing and Treatment Strategies
Clearly, there is a strong argument for testing and treatment of communicable diseases in corrections as they contribute to, and in many instances drive, our public epidemic. Every state has an interest in care that is aligned to constitutional requirements and improves public health and safety. However, there is significant variation in how states address communicable diseases in correctional facilities.

Various screening policies exist in jail and prison environments, and screening methods also vary. However, a number of organizations have made clear recommendations on policies that are more effective (see table below).

Treatment in correctional institutions can range from education to counseling and antiviral therapy. The Eighth Amendment bars correctional facilities from demonstrating deliberate indifference to the serious medical needs of inmates. However, there is significant room for interpretation, with general guidelines for treatment often differing between jails and prisons due to differing rules and policies, their populations and the longevity of sentences.

Testing and treatment present numerous challenges in corrections. Standards of care may vary. Coordination of care can be difficult due to institutional rules and structures. Individuals who approve a course of care may not be the same person who approves a provider’s access to the inmate. Private providers who treat inmates may not understand the rules of the correctional system. Inmate transfers may result in the patient starting over with new diagnostics and treatments, including medications—dangerously, a disruption in medication can lead to viral resistance. This also creates duplication and waste in the system.

Other challenges to effective testing and treatment include assurance of informed consent, comprehension, confidentiality and privacy. For example, patients who opt in for testing must understand the ramifications if the test result is positive. Inmates often struggle with stigma, lack of privacy about the treatment they receive, reporting mandates and even changes in living conditions.

Ethical Dilemmas
Nevertheless, correctional facilities can be an ideal environment for medical care, including treatment of other harmful conditions, such as substance use disorder. Treating communicable diseases in the correctional environment is not, however, without significant debate and differences.

Clinical and Financial Dilemmas
As noted, the Eighth Amendment protects inmate rights to medical care. Do those rights extend to the expensive new drugs that have emerged to cure HCV? One can argue that if there is an effective treatment that can eliminate suffering and eradicate a disease, we should pursue that treatment. However, this debate must also consider the significant funds required. HCV treatment costs can run as high as $100,000 per person, placing significant stress on correctional budgets. Thus officials, legislatures and the public must discuss and determine answers to questions such as...

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>State Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon request</td>
<td>Testing offered to those individuals who ask for testing to be performed</td>
<td>The least favored screening policy, according to the Bureau of Justice Statistics, not one state reported using this method.</td>
</tr>
<tr>
<td>Risk-based</td>
<td>Screening is offered only to those individuals who self-identify as belonging to a group considered at risk for acquiring a communicable disease</td>
<td>Risk-based testing is not a favored method among correctional facilities since it relies on individuals self-identifying their risk behaviors.</td>
</tr>
<tr>
<td>Opt-in</td>
<td>All individuals are offered testing, but it is performed only if the person agrees</td>
<td>In one study, an opt-in testing policy resulted in 72% of incoming inmates receiving testing.</td>
</tr>
<tr>
<td>Opt-out</td>
<td>Individuals are offered testing and it is routinely performed unless the person declines</td>
<td>Many experts recommend universal opt-out testing in jails and prisons, including 2018 Federal Bureau of Prisons guidance and the American Association for the Study of Liver Diseases and Infectious Diseases Society of America.</td>
</tr>
</tbody>
</table>
| Mandatory     | The test is performed regardless of whether the individual provides consent | • U.S. Preventive Services Task Force and World Health Organization recommend HCV testing for all individuals  
• 42% of states indicated that HIV testing is mandatory for inmates upon entering state correctional facilities  
• STD and HCV testing are mandatory in 22 states |

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the following:
  • Is not using these medications in effect rationing treatment?
  • Should these treatments be given only to the sickest?
  • Is there any hope of eradicating HCV if incarcerated individuals aren’t treated?
  • With a 100% cure rate, does uses of these medications become cost-effective in the bigger picture (re-infection, transplants, etc.)?
  • If medications were approved, who would pay for it?
  • If taxpayers pay for it, should they also be entitled to the treatment?
  • How do we ensure the investment sticks? It’s no secret that substance use and risky sexual behavior are complicating factors and that there is a risk of recidivism.

Legal Dilemmas

The Eighth Amendment prohibits “cruel and unusual punishment” of incarcerated individuals, and the Supreme Court ruled in 1976 that “deliberate indifference to serious medical needs” of inmates violates the amendment. In 2015 an inmate filed a lawsuit against the Pennsylvania prison system alleging that the state failed to provide HCV care. This has turned into a class-action lawsuit and is only one of many legal issues states and government face.

• How do we reconcile the cost of treatment with the balances set by the Supreme Court?

• What specifically is meant by the Supreme Court’s ruling? To what extent are we to carry this out?

• All of these are important questions, ones that must be discussed based on your state and federal government norms and standards.

Some Best Practices

Despite the lack of consensus regarding ethical dilemmas, some best practices in treatment do stand out. Integrating prevention into existing education programs, conducting opt-out testing and providing treatment to all who are incarcerated are among leading recommendations for programs. Below are some examples of successful programs.

The HIV/AIDS Intervention, Prevention, and Continuity of Care Demonstration Project for Incarcerated Individuals Within Correctional Settings and the Community (known as the Corrections Demonstration Project) proved the effectiveness of multiagency collaboration to develop solutions for testing and treatment of HIV, HCV, tuberculosis, substance abuse and sexually transmitted infections. Between 1999 and 2004, prevention, education, testing and discharge planning were administered to a significant number of inmates in jails, prisons and juvenile facilities in seven states. The CDP was a joint project of the Health Resources and Services Association and the Centers for Disease Control and Prevention.

Inmate transitions often create interruptions in care. Project Bridge, another promising best practice, was a demonstration project that proved successful in navigating transitions to the community. The program provided intensive case management to HIV patients being released from a Rhode Island state prison. Through effective collaboration between medical and social work, these individuals received access to medical and rehabilitative care, including substance abuse. The program demonstrated that inmates will access care following release, given adequate support.

As with any public health dilemma, the response requires a multifaceted approach that includes strategies to educate inmates and correctional staff, identify and treat those who are infected and prevent new infections. Success rates of actual programs vary. Clearly, correctional facilities have room to improve; however, all struggle with the ethical dilemmas associated with care and cost—and answers to ethical dilemmas are elusive.

Peg Tinker and Stephanie DeKemper are associate directors and Catherine Sreckovich is managing director for Navigant Consulting, Inc. They are based in the health practice office in Chicago.
The Centurion Difference

Correctional healthcare is an important component of public healthcare. 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.

Our programs encourage inmates to take a more active role in their overall health and better prepares them for managing their health in the community after release.

Centurion's H.E.R. Journal was awarded the 2018 Hermes Gold Award for Print Media/Publications/Book and 2018 DecisionHealth's Platinum Award for Outstanding Achievement in Care Coordination and Specialty Programs: Women’s/Children Case Management. The H.E.R. (Health, Empowerment, and Resources) program promotes physical and behavioral health well-being for female patients and encourages habits that nourish their bodies and promote general well-being.

Centurion's Focus on Wellness program targets patients with poorly controlled chronic diseases through lifestyle coaching and health education. This program was awarded two DecisionHealth Platinum awards in 2017 for Outstanding Achievement in Patient Engagement and Education and for Outstanding Achievement in Care Coordination Specialty Programs: Case Management.
Anatomy of a Health Care Lawsuit: Issues and Strategies in Your Defense

Beth Boone, JD, MBA

If you have never had the unique experience of being named in a lawsuit, you may wonder what happens when you are sued. My firm and I represent health care providers in many arenas, and some of these providers are exposed to greater risk of lawsuits by the nature of what they do. Unfortunately, correctional health care providers are not immune from litigation and are increasingly being named individually in lawsuits that historically were reserved for sheriffs, jail officers, and correctional officers.

While you cannot prevent lawsuits from being filed, you can be aware of the overall process in the defense of litigation, including how to provide effective assistance in your defense, and learn of the strategies we pursue to successfully defend correctional health professionals.

State or Federal Court

Lawsuits are typically filed in state courts or federal courts, assuming there is not an administrative-type venue for such suits in your jurisdiction. Lawsuits filed in state courts generally “sound” in tort-based claims, such as professional negligence or medical malpractice, but could include federal causes of action. A federal-based lawsuit could include the tort claims and an allegation of federal civil rights violations.

These court systems are very different, with rules that are very specific. Where your case is pending may result in significantly different potential monetary awards, including limits or caps on damages and the potential for awards of attorney fees. You should be aware of these differences and ask your counsel about the significance attached to the court system in which litigation against you was filed.

The U.S. Constitution, the Eighth Amendment, prior federal case law and congressional acts such as the Prison Litigation Reform Act have served as the basis and evolution of many lawsuits. The cases that are decided are used as precedent in future litigation, so in addition to actual statutes, “case law” continues to be an expanding basis for future decisions. While this is a very simplistic explanation, the point is that claims and allegations against correctional health care providers have grown, changed and advanced as the law continually does the same.

Parties to Correctional Health Care Lawsuits

Most providers in a correctional setting are familiar with the pro se inmate claims, by jailhouse lawyers who represent themselves. Your patients could also be represented by attorneys with a background in constitutional law or criminal defense, possibly by the usual proximity to clients in their criminal representation. However, attorneys who focus on medical malpractice have shown an increased interest in some of the correctional health care cases that they deem “sexy”—cases usually involving what they deem egregious facts and/or inmate deaths.

Depending on your employer, you could be individually named, an employee of a private provider that is named or just involved peripherally as a fact witness due to the care and treatment that you provided. If the allegations in the case are centered or focused on the provision of medical care, you and/or your employer may be the only defendants. However, pro se plaintiffs often include many additional parties, and the different and varied claims will increase accordingly. In fact, health care providers in a correctional setting are often named as defendants in lawsuits even when the cause of action is in no way related to the provision of care and treatment.

Allegations

So, the burning question … why are we being sued? National studies and statistics regarding the most common types of claims made in medical malpractice are surprisingly similar (with a few marked exceptions) to those made in a correctional health care setting. These include failure to …

- Test/further assess
- Diagnose
- Send for a higher level of care (i.e., consult with a specialized provider, hospital or emergency department)
- Institute appropriate suicide prevention mechanisms
- Treat the patient, citing alleged malingering or frequent complaints

How is this fair, you ask? After all, the challenges of providing care to this population are many, as you generally have some of the most noncompliant patients who may be poor historians and often struggle with other issues, such as mental health and substance abuse. The level of care you provide may be constrained—you often are not involved until there are actual complaints, and although inmates are a captive audience, the traditional standard of care in a medical setting may be applied to your correctional setting. In other words, the unique circumstances of providing care during custody, and the balance of the two, may not necessarily be understood by a judge or jury.

The lack of understanding of your constraints by your patients, plaintiff attorneys and jurors alike is real. Custodial issues are primary in the provision of reasonable health care, but the allegations may make it appear that the inmate had checked into a hospital or treatment facility.

Experts

Before you become too concerned about the many challenges faced, know that your counsel will use experts in your industry, industry standards and professional organizations, and the accreditation process in your defense. This defense can include chart reviews by those with knowledge and experience in your discipline, as well as deposition or trial testimony.
These “expert witnesses” are providers just like you, with relevant experience in the correctional health care setting. Attorneys obtain names of individuals to serve as expert witnesses from professional organizations and industry contacts and involvement, networking, academia, social media and even attorney and expert databases or repositories. In other words, we want someone who works in the same setting as you to testify on your behalf—not the nurse working for a local primary health care provider. While the actual care and treatment may be similar, the setting is very different, and the differences are key in your defense.

Resolution
A defendant’s next question usually is, “How does my lawsuit get resolved?” Strategies for resolution by your defense counsel usually first involve dispositive motions—we attack the very pleadings and allegations against you and challenge their sufficiency. This could include an attack on the credentials and qualifications of the plaintiff’s expert, if an expert opinion is a requisite to filing the lawsuit. For example, in some states you cannot even file a complaint to initiate a lawsuit against a medical professional unless the plaintiff also attaches an affidavit from a “like” expert. It could also be an attack on the venue or jurisdiction, or on the timeliness or statute of limitations.

We often focus on the damages involved in the accusations and could potentially resolve very early for a “nuisance value.” This option weighs the value of settling cheaply versus paying the cost of defense, and a low dollar amount may be offered to resolve early. Depending on your employer, you may have a degree of immunity. Importantly, there are a variety of ways to engage and defend, and, most importantly, resolve as quickly as possible.

If the case cannot be resolved early, how do you defend? Obviously, most health care providers understand that attorneys, insurance companies and risk managers all try to manage risk, including the documentation of care, training, policies and procedures, and forms. But can you prevent lawsuits? Or is it just the cost of doing business? While arguable, I often tell people that anyone can allege anything. In many jurisdictions, however, there are some basic statutory requirements that assist in your defense.

Of course you should assist your counsel in your defense. Be organized and prepared from the beginning. I have had many health care providers admit to me at our first meeting that they have not bothered to read “the legal stuff” they were served with by a process server. Thoroughly read the complaint several times—this is the allegation against you and you need to know the specifics.

As an attorney providing your defense, I look at the complaint in detail, while my clients immediately ask for the patient’s chart. This is natural, as your charting and the chart entries are a documentation of your work, your care and treatment of your patient. The tendency of sued providers is to assure themselves the charting was adequate and then the case can suddenly be explained, and the attorney can make it go away.

Providing an explanation to your defense counsel does not “make the case go away” necessarily. We must educate the folks on the other side, as well, and ultimately the judge and/or jury. But sometimes a careful review of the allegations in the legal document—the complaint—along with your careful review of the chart provides valuable information that you need to share with your attorney.

For example, perhaps the allegation is that you, as an LPN providing care in a local county jail, failed to provide any care and treatment to a patient who suffered a sudden cardiac event that resulted in his death. You pull the chart and see that at 5 p.m. you documented an intake assessment in which the patient evidenced no complaints and provided a detailed history with no mention of cardiac problems, and that was the extent of the interaction. Your employer’s contract with that county provides for 8 hours of health care per day, and the cardiac event occurred at 9:30 p.m., beyond the hours of in-person, on-site contracted care.

If you as the health care provider read that complaint in detail, you can agree that you failed to provide care and treatment during the cardiac event as you were not even in the jail. It was an impossibility. But the lawyer representing the inmate’s family may or may not know the hours of contractual care and may be trying to name as many people or entities as possible in the litigation, as each additional party is a potential insurance policy. Additionally, most attorneys may not know the details of how that care is provided. Your attorney, representing you in the defense, may not yet have a copy of the contract to know the stated hours of services, and must file a timely answer on your behalf. Your input and attention to details in formulating a response assist greatly in establishing a defense.

Be honest and remain communicative throughout what sometimes can be a lengthy process. If you have concerns about the care provided, the documentation or interactions with coworkers or other named defendants in the custodial setting, let your attorney know. Surprises generally cost money, but even information that is detrimental to the defense of the case can be handled efficiently and effectively with advance knowledge. Give us the good, the bad and the ugly initially so that information will empower your counsel to make the best overall decisions.

Ultimately, an informed client who cares and communicates about their case makes the defense so much better. We want the best possible resolution for your lawsuit and rely on you to assist us in your own unique knowledge and skills sets. Help us help you!

Beth Boone, JD, is a partner at Hall Booth Smith, PC, in the Brunswick, GA, office, where she leads the firm’s Correctional Health Care Practice Group. Write to her at bboone@hallboothsmith.com. See her blog at www.hallboothsmith.com/blog/category/hbs-correctional-health-care-law-blog.
The medical intake process is a critical moment to initiate the necessary treatment plan for the patient’s incarceration stay. This is the primary opportunity for the medical staff to assess each entrant to the facility and begin any needed medical care.

At our facility, a large urban jail, we conduct both the receiving screening and the initial health assessment upon intake. The individual’s vital signs are taken upon entry, the nurse conducts the receiving screening and the person gets booked in, if appropriate. If there is a medical concern at this screen, the entrant may need to be cleared at the hospital before returning.

After the entrant is booked in, the nurse then conducts a more in-depth initial health assessment to evaluate any medical, dental or mental health conditions; this takes about 20 minutes. Our initial health assessments use a hybrid approach of the “Full population” and “When clinically indicated” models from NCCHC standard J-E-04 so every entrant undergoes a health assessment within four hours of being booked in to the facility. The nurse then contacts the facility’s medical providers, who are on-call 24 hours a day, seven days a week, for medication and treatment orders.

Scheduling the patient’s clinic visit with the medical provider becomes the next logistical challenge. Our jail has implemented a system of priority levels to schedule patients to see a medical provider. Through this triage system, we determine how urgently the patient needs to be seen by a medical provider, similar to the Emergency Severity Index system at an emergency department.

At the end of the nurse’s initial health assessment form is a “Conclusion and Follow-up” section in which the nurse determines the patient’s acuity level based on findings, risk factors and indicators. The acuity level indicates when the patient will see the medical provider. The nurse may verify the acuity level with the on-call medical provider while discussing the patient’s medical conditions and medications.

Four Acuity Levels

Our triage system allows for the delineation of higher medical acuity patients to be seen by a medical provider quicker than lower acuity patients. It has four acuity levels:

- **Level 1** patients have the most severe or urgent needs; they are scheduled to see a provider within 24 hours of being screened by the intake screening nurse. This category encompasses those who are acutely intoxicated or withdrawing from drugs and/or alcohol, those at high risk of withdrawing and those with a serious health care need for medical provider evaluation (e.g., patient recently discharged from hospital with trauma or postsurgery).

- **Level 2** are medium severity patients; they are scheduled to see a provider within three days. This category includes those with an uncontrolled but noncritical chronic care condition (e.g., patient with history of hypertension, current blood pressure 156/96, who may or may not be on medications at home).

- **Level 3** are the least severe patients; they are scheduled to be seen by a provider within seven days. These individuals include those with a controlled chronic care condition and/or those who have a routine health care need for medical provider evaluation (e.g., patient with history of hypertension, current blood pressure 114/74 and taking blood pressure medication).

- **No Level** patients have no significant medical condition, and therefore are instructed how to access health services as needed (via sick call).

Similarly, the mental health intake form completed by the intake nurse determines the priority level by which a patient is seen by a psychiatric social worker and/or mental health provider. Together, the nurse and the psychiatric social worker determine the patient’s housing assignment based on suicidality, history of mental health issues or active mental health concerns. From there, the patient is housed appropriately per security.

Prioritizing the Patient List

Every morning at the jail, the early shift medical provider creates the daily patient list to include new intake patients, chronic care patients, acute care visits and referral appointments to be seen by the medical provider staff. The list is prioritized based on the category and the date the task was created. The provider works with security staff to further prioritize who needs to be seen in the clinic by selecting specific housing unit(s) or persons to be brought down to the clinic first. We adjust the list based on how many patients need to be seen and how many are typically seen on a daily basis per provider staffing levels.

Since implementing the acuity level system, we have dramatically improved the way patients see health care providers by prioritizing those who need it the most—i.e., the most acute. If a patient is originally assigned a lower medical acuity (Level 3) and then their condition worsens later, we can change the acuity status to a higher level to be seen sooner by a medical provider.

Previously, our provider scheduling did not differentiate between patients with acute issues and those who are stable, which meant a potential delay of care for those who need medical attention the most. By focusing on acuity levels, this scheduling system enables us to maximize our flow of medical visits, ensuring that patients are seen in an appropriate and timely manner.

Brandon Decker, APNP, CCHP, is a nurse practitioner at a large urban jail.
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. Here, 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!

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To apply online, please visit [www.cchcs.ca.gov](http://www.cchcs.ca.gov)
Meet the Recipients of NCCHC’s 2018 Annual Awards

Bernard P. Harrison Award of Merit
NCCHC’s highest honor, this award is presented to an individual or group that has demonstrated excellence and service that has advanced the correctional health care field, either through an individual project or a history of service. The award is named after NCCHC’s cofounder and first president.

Carl C. Bell, MD, CCHP
A trailblazer, a visionary, an activist … determined, outspoken, unconventional … a colleague once said about Carl Bell, “He excels at changing the way people think.”

Dr. Bell is a distinguished psychiatrist, violence-prevention crusader and one of the nation’s preeminent experts on the impact of violence on children in disadvantaged communities.

His involvement with NCCHC dates back to the organization’s beginnings. He was a founding board member and served for 33 years as the National Medical Association liaison, providing unique expertise on the relationship between poverty, violence, mental health, race and incarceration. He calls his work with NCCHC “the best real public health work I have ever done.”

During his tenure, Dr. Bell served as board chairman twice; chaired the accreditation committee for more than a decade; and worked on the jail, prison and mental health standards. He also advocated for the Centers for Disease Control and Prevention to broaden its mission to include correctional health – a significant turning point for the field.

In a career spanning nearly 50 years, he has authored more than 500 articles, chapters and books, including textbook chapters on correctional psychology. He has consulted for numerous departments of corrections, universities, and local, state and federal government agencies, including the U.S. Department of Justice, the National Institute of Mental Health and the U.S. Surgeon General. He has lectured all over the world and been interviewed by news outlets too numerous to list.

In 1987, Dr. Bell founded the Community Mental Health Council on Chicago’s South Side, one of the largest community mental health clinics in the country. For 25 years it provided comprehensive services to thousands of mostly low-income patients.

He is now a staff psychiatrist at Jackson Park Hospital Family Medical Center and Clinical Professor Emeritus at the University of Illinois at Chicago College of Medicine. His recent research focuses on prevalence of fetal alcohol spectrum disorder in low-income communities.

NCCHC conference attendees have enjoyed the tai-chi classes Dr. Bell taught for many years, as well as his collection of hats.

B. Jaye Anno Award of Excellence in Communication
This award pays tribute to innovative, well-executed communications that have had a positive impact on the field of correctional health care, or to individuals for bodies of work. It is named after NCCHC’s cofounder and first vice president.

Sharen Barboza, PhD, CCHP-MH
Sharen Barboza is a licensed clinical psychologist, a fierce advocate for incarcerated individuals with mental illness, a champion for improved systems and a self-proclaimed “believer in the standards.” Throughout her career, she has worked with the most marginalized populations and tackled the toughest issues head-on.

As vice president of mental health for MHM/Centurion, Dr. Barboza monitors the care and treatment provided to mentally ill inmates in several state correctional systems and large county jails. She supervises the clinical operations team; develops training curricula for mental health, medical and corrections professionals; and creates therapeutic programs for special populations.

She is sought after as a speaker on topics including personality disorders, trauma-informed care, self-injury, continuous quality improvement and the NCCHC Mental Health Standards, which she helped to draft as a member of the Mental Health Task Force. She is consistently rated as one of the most popular speakers at NCCHC conferences. Her research has appeared in several peer-reviewed journals, and she serves on the editorial board for the International Journal of Prisoner Health.

Dr. Barboza is a strong supporter of the Certified Correctional Health Professional program and has served on its board of trustees. She sits on the CCHP-MH task force, helped develop the CCHP-MH specialty exam, taught content review courses for CCHP-MH and spearheaded an MHM policy to cover exam fees for their employees.

She is an integral part of NCCHC’s national response plan for suicide prevention, contributing her deep knowledge of the topic and her experience using outcomes measurements to create evidence-based mental health practices.

Before joining MHM/Centurion in 2007, Dr. Barboza served as psychologist at a maximum security women’s prison and chief psychologist at a maximum security psychiatric hospital. She earned her PhD in clinical psychology from Fairleigh Dickinson University.

Unlike many people who fall into correctional health care, Dr. Barboza always knew that it was the profession for her. “It’s all I’ve ever wanted to do,” she says.
**NCCHC Young Professional Award**

This award was created in 2018 to recognize new and upcoming leaders in the correctional health care field. It is presented to an outstanding correctional health professional, 45 years of age or under, who leads by example, takes initiative, demonstrates a strong work ethic and inspires others through his or her commitment to quality health care.

Pamela San Miguel, RN, PHN, CCHP-RN

Pamela San Miguel is "a strong advocate for both her patients and for the staff she supervises … never takes the easy road … and is an exemplary leader who will continue to rise through the ranks," according to one of the several colleagues who nominated her.

As the nurse manager for Ramsey County Correctional Facility in Minnesota, Ms. San Miguel works with both adult and juvenile patients. She has more than 20 years of clinical experience including emergency services, poison control, sexual assault nurse examination, community care and, for the past six years, correctional care. She works tirelessly to institute NCCHC standards and best practices at the facilities she manages to ensure the highest level of care for the populations she serves.

Ms. San Miguel earned her BSN degree from Saint Catherine's College in St. Paul, MN. She is a certified public health nurse, licensed school nurse and holistic nurse. She became a CCHP in 2016 and achieved CCHP-RN only months later. She is on the board of the Minnesota Sheriff's Association – Correctional Health Division and the Ramsey County School Patrol and serves on several committees.

Ms. San Miguel "has been a constant steadying force and has provided leadership during difficult times," said another of her nominating colleagues. "Her skill set, depth of knowledge and genuine care for both her nurses and patients makes her extremely valuable to Ramsey County."

**R. Scott Chavez Facility of the Year**

This award is presented to one facility selected from among nearly 500 jails, prisons and juvenile facilities accredited by NCCHC. It is named after NCCHC's longtime vice president.

**Central Arizona Florence Correctional Complex**

Operating health services in a large jail is difficult enough when the client is the local community, but having to answer to four masters really creates challenges. Yet Central Arizona Florence Correctional Complex takes a proactive approach that meets the differing requirements of the community as well as its federal clients: Immigration and Customs Enforcement, the U.S. Air Force and the U.S. Marshals Service.

The product of a 2017 merger between two adjacent facilities, the complex now houses some 5,000 individuals in a multilevel-security setting. Provision of quality health care is an important facet of the system, and this is evident in the extensive orientation and training requirements for health services staff. Beyond the initial, 56-hour off-site orientation, staff also receive 40 hours of on-site education, 40 days with a preceptor and orientation follow-up that extends for 90 days. Nurses also participate in an ongoing online training program that adds up to far more than the 12 hours required by the NCCHC standards.

Receiving screenings are reviewed daily to triage those who need follow-up for medical, dental or mental health care. Upon intake, inmates are given handbooks that not only explain how to access care, but also describe the health programs available and present education on common chronic diseases and wellness.

Communication is crucial in maintaining smooth operations, and to that end, the health services department produces a monthly staff newsletter that provides educational material and news about team members. Staff also participate in community enrichment activities, such as fundraising for at-risk women.

The NCCHC surveyor who nominated CAFCC says, "This facility and the employees truly believe that they can be change agents for the population they serve, and they demonstrate this belief through the positive attitude we observed."

**NCCHC Program of the Year Award**

This award recognizes programs of excellence among thousands provided by accredited jails, prisons and juvenile facilities.

**New Jersey Department of Corrections**

**Continuous Quality Improvement Program**

For health staff in the New Jersey prison system, continuous quality improvement isn’t viewed simply as an accreditation requirement, a task with eight compliance indicators to tick off. It’s part of their daily approach to their work, and something they celebrate.

To underscore this, the CQI program has a motto—“QI: It’s Everyone’s Business”— and new staff members learn about the program during orientation. Each year, CQI projects from various facilities are featured in a performance improvement fair, where teams share their work with their colleagues and a panel of judges scores the projects based on explicit criteria.

The CQI program emphasizes the partnership between the NJ DOC and its health and mental health services provider, Rutgers University Correctional Health Care. The goals are to foster a desire in staff to seek opportunities to improve services; to train them on QI concepts and practices that assist in meeting NCCHC standard P-A-06; to undertake data-driven improvement efforts; and to disseminate accurate and timely information to management and staff. The first performance improvement fair was held in 2006 and it’s been going strong ever since.

At the fair, a handout lists each facility and the names of the projects and team members. Prizes are given for first, second and third place in two categories—medical and mental health—and a “People’s Choice” award goes to one project. In 2017, 42 projects were submitted from 13 sites.
For all professionals working in correctional health, including administrative and support staff

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Federal Judge Orders Jail to Continue Methadone Treatment for New Inmate

by William J. Rold, JD, CCHP-A

In what may be the first decision of its kind in the nation, a federal judge in Massachusetts has entered a preliminary injunction directing a jail to continue methadone treatment for an inmate about to be incarcerated for violation of his probation and driving with a suspended license. The decision in Pesce v. Coppinger was reported in the New York Times on Nov. 29, 2018, and the complete legal record can be found in the federal courts’ PACER database at 18-cv-11972 (D. Mass.). What follows is taken from the Times reporting and the legal documents filed in the case, including the Nov. 26 opinion of U.S. District Judge Denise Casper.

Geoffrey Pesce has a long history of opioid addiction, including several unsuccessful attempts at treatment with buprenorphine and naltrexone. He has been revived from overdoses with Narcan at least six times. In 2016, after a conviction for driving under the influence of drugs, he was given a sentence of 60 days incarceration, suspended if he complied with terms of his probation, including drug treatment. His driver’s license was also suspended. He entered a methadone program.

For the first time, treatment with methadone, accompanied by intensive support and counseling, seemed to work. Pesce stayed clean for two years, he found employment as a machinist and he reunited with his son. His arranged for his family to drive him to work, but this plan failed one day and he drove himself. He was stopped for speeding (six miles/hour over limit) and was arrested when it was discovered that his license was suspended.

Judge Casper noted that Pesce faced jail for violation of his probation by speeding, but, even if the state judge had discretion on that point, Pesce faced a mandatory additional 60 days of incarceration under Massachusetts law for driving while his license was suspended for DUI. This made his case sufficiently “ripe” for adjudication of his medical care rights, even though he was not yet back in jail.

Forced Withdrawal Contraindicated

Judge Casper noted that the Essex County jail had several modalities for opioid treatment, but none included methadone—the only treatment shown effective for Pesce by history. Pesce tried to prepare for jail without methadone by reducing his dosage from 120 mg/day to 20 mg/day, but he became very sick.

Evidence was presented by Dr. Shorta Yuasa that Pesce was “not ready to be tapered off his medication” and that his remission depended on continuing methadone. Dr. Yuasa also described other patients previously under his care who “have relapsed, overdosed and died after being denied access to [methadone] during incarceration,” because interruption in methadone both increases likelihood of relapse and decreases tolerance to opioids after release if relapse occurs.

As part of a maintaining a “drug-free environment” and for security reasons, the jail’s substance abuse program provided for “forced withdrawal” from methadone under medical supervision—with non-opioid medication for pain, stomach cramps, diarrhea, nausea, indigestion, anxiety and high blood pressure. It also offered Vivitrol, a “non-opioid medication aimed at preventing substance abuse relapse.” Judge Casper noted that Essex County had recently been awarded a federal grant to continue this program.

Individualized Care

Nevertheless, Judge Casper found a sufficient likelihood that Pesce would prevail in his challenge to denial of methadone as applied to him and his history to justify the issuance of a preliminary injunction ordering continuation of the methadone. Both the Americans with Disabilities Act and the Eighth Amendment require an individualized assessment, not a “blanket” policy. Pesce’s history and circumstances required consideration of an exception.

Judge Casper noted that the women’s state prison in Framingham allowed methadone for pregnant inmates to prevent withdrawal, and it was apparently conceded here that methadone could be administered in liquid form with medical supervision, to satisfy security concerns.

While the provision of methadone in jails and prisons remains relatively rare, it has been offered in Rhode Island since 2016 and in the New York City Rikers Island jail complex since the 1980s. This decision indicates that the courts will become involved when correctional providers refuse to consider the individual circumstances of their patients. After access to care and the right to care that is ordered, the third basic right to health care under the Eighth Amendment is the right to an individualized medical judgment. Sheriff Coppinger’s office issued a statement that it is “carefully considering the decision.”

William J. Rold, JD, CCHP-A, is a civil rights attorney in New York City and a retired judge. He previously served as the American Bar Association’s liaison on NCCHC’s board of directors.

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A Solution to Help Prisons Pay for HCV Drugs: Nominal Pricing

Researchers from Emory, Harvard and Brown universities and the Alaska Department of Corrections have proposed a solution to help correctional facilities pay for hepatitis C virus treatment while also saving money for society. An article describing the proposal appears in the January issue of the Journal of Correctional Health Care. Development of the strategy was aided by 340B expert William von Oehsen, JD, who was a coauthor on the article.

The Department of Health and Human Services’ strategy to eliminate hepatitis C in the United States relies on engaging the criminal justice system in the diagnosis and treatment of HCV. It recommends that treatment with the newest direct-acting antiviral agents, which clear HCV infection nearly 100% of the time, be made accessible to incarcerated people. However, the current cost of providing HCV treatment to all inmates can exceed the overall health care budget of a prison. Therefore, only a fraction of HCV patients in prisons get treatment.

The researchers propose use of the little-known federal law on nominal pricing. Nominal pricing permits manufacturers to sell drugs to correctional systems at a low price without disrupting the Medicaid market. “This approach could cut the cost to cure HCV in prisons drastically,” says lead author Anne Spaulding, MD, MPH, CCHP-P, associate professor of epidemiology and medicine at Emory.

When the strategy was first drafted in 2017, HCV treatment cost about $70,000 per patient course. At this price point, nominal pricing would cut spending from $3.3 billion to $337.5 million, saving U.S. taxpayers approximately $3 billion.

HCV drug manufacturers have since reduced the cost of a full course of treatment to as low as $25,000. However, the budget needed to treat all inmates still remains unaffordable without making deep cuts elsewhere, such as in drug treatment programs, a counterproductive move.

“By providing treatment to everyone in prison who needs it using nominal pricing, society will gain in terms of reduced costs, lower disease transmission and more deaths averted,” says coauthor Jagpreet Chhatwal, PhD, assistant professor at Harvard.

A Win-Win for Prisons and Manufacturers

The authors suggest that using a nominal pricing mechanism even at a price point of $25,000 will still allow drug companies to sell the drug above production price and make a profit. According to federal laws, the nominal price of a drug must be less than 10% of the average market price. Since many prisons still cannot provide enough HCV treatment even at $25,000 per patient, they remain an untapped market for drug company sales. Nominal pricing is a strategy that will help close the gap between drug demand and the affordability of treatment.

No new laws would need to be enacted to implement this strategy. The nominal pricing mechanism could also be used for other drugs, such as injectable penicillin, which is currently sold to correctional systems at a price greater than 300 times the price for public health clinics.

The article by Spaulding and colleagues is available at http://journals.sagepub.com/doi/full/10.1177/1078345818805770.

Pharmaceutical companies and correctional systems interested in partnering with Spaulding’s group to explore nominal pricing for drugs should contact her at Aspauld@emory.edu.
Quality and Patient Safety Culture Are Top Goals of New Board Trustee

by Katie Przychodzen, MA

When Leonora Muhammad, DNP, APRN, CCHP, first heard about NCCHC’s Certified Correctional Health Professional program in 2010, she was thrilled to learn that correctional health care was being recognized as a specialty, similar to emergency care and critical care nursing. "The fact that you could be designated as an expert in the field of corrections was exciting," she says.

At that time, she was the director of nursing for Corizon Health, St. Louis City Justice Center. When her regional directors of nursing began to encourage all clinical leaders to obtain certification, Dr. Muhammad eagerly sat for—and passed—the exam, along with many of her peers.

Having worked for Corizon Health in various correctional facilities since 2006, Dr. Muhammad looks back on her time in these settings as a huge learning opportunity. "You have the opportunity to work with patients who need the most care, as access to appropriate health care in the community is limited based on a patient’s ability to pay for services." She sees great value in being able to start educating patients immediately after they arrive at a facility. This education, she says, is the best way to improve patients’ self-care management and ultimately their life expectancy.

Since earning her CCHP, Dr. Muhammad has risen through the ranks at Corizon. Today she serves as senior director of quality improvement and patient safety, working to ensure that the facilities she oversees have best practices in place to protect both patients and employees. When problems or concerns arise, she and her team seek to identify root causes and develop quality improvement plans to alleviate any issues. "Decreasing and eliminating risk for our clients and customers is the number one priority," she says.

Leading by Example

In her senior director role, Dr. Muhammad knows it is her duty to lead by example to help staffers provide the best possible patient care. To this end, she sees her involvement with the CCHP program as essential. "Your career should be filled with continuous learning opportunities, and the CCHP credential helps with this by requiring individuals to earn continuing educational credit on topics related to correctional health." By keeping up with the latest research and standards of care, she says, staff members show their dedication to quality and patient safety and earn recognition from peers and management alike.

Recently elected to the CCHP board of trustees, Dr. Muhammad is committed to creating a confident and highly skilled correctional health workforce. An important means to this end is making sure that CCHP exams measure real knowledge and skills. As a trustee, she is now responsible for, among other things, helping craft high-quality CCHP exam questions.

For Dr. Muhammad, passing the exam means much more than knowing the answers to the questions. Rather, it is about "understanding how to apply a given question to real-life scenarios that we are faced with in our everyday lives."

Dr. Muhammad has a piece of advice for those considering a career in corrections and for current staffers who are undecided about taking the CCHP exam: "Go ahead and take the leap! You never know where that one decision will take you in the next five years."

Katie Przychodzen, MA, is marketing and communications manager for NCCHC. For more information on the CCHP program and to apply, please visit www.ncchc.org/cchp.

2015 Standards for Mental Health Services in Correctional Facilities

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

This second edition represents the culmination of hundreds of hours of careful review by a large group of experts, including specialists in psychiatry, psychology, social work and professional counseling, to ensure that NCCHC standards remain the most authoritative resource for correctional mental health care services. Notable updated topics include continuous quality improvement, patient safety, clinical performance enhancement, medication services, inpatient psychiatric care, mental health assessment and evaluation, continuity and coordination of care, emergency psychotropic medication and women’s health. This edition supports facilities in achieving and maintaining compliance with NCCHC accreditation and constitutionally required care.

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- Administrator: 14%

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- Prison facility: 21%
- State DOC/agency: 13%
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- Federal agency: 6%
- Juvenile detention or confinement facility: 4%

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- Dental care and supplies
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- Health care staffing
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- Mental health services
- Pharmaceuticals
- Safety equipment
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**Expert Advice on NCCHC Standards**

**by Tracey Titus, RN, CCHP-RN**

**Hepatitis Screening on Admission**

**Q** Our state performs hepatitis testing on admission into our prison system. We are finding that approximately 30% of our inmates are positive. Subsequently, our physicians have been ordering tests and treatment for these patients. Do the standards discuss hepatitis screening on admission?

**A** In the 2018 standard P-B-03 Clinical Preventive Services, compliance indicator #4 requires that the responsible physician determine the medical necessity and/or timing of screening for communicable diseases, to include laboratory confirmation, treatment and follow-up as clinically indicated. Similar language appeared in previous editions of the standards under the requirements for initial health assessments. The responsible physician also makes the decision as to which diseases to test for on admission.

Also note that Standard F-06 Response to Sexual Abuse does require that prophylactic treatment and follow-up care for sexually transmitted infections or other communicable diseases (e.g., HIV, hepatitis B) be offered to all victims of sexual abuse as appropriate.

The 2018 standards mention hepatitis in a few other areas, as well. A-04 suggests that infectious disease monitoring (e.g., hepatitis, HIV, tuberculosis) be included in monthly statistical reporting; B-01 recommends that hepatitis A, B and C be included in educational programming; and E-05 recommends further questioning regarding history of hepatitis and other health problems as a follow-up to the mental health screening.

**Infirmary-Level Care Coverage**

**Q** Does the infirmary standard require RN coverage of the facility’s infirmary 24 hours per day, seven days per week?

**A** It is important to note that standard F-02 Infirmary-Level Care was updated in the 2018 jail and prison manuals to focus on the level of care provided in a facility, not a physical location. Staffing levels for qualified health care professionals should be based on the number of infirmary-level patients, the severity of their illnesses and the level of care required for each. However, the standard does require that, on a daily basis, a supervising RN ensures that care is being provided as ordered.

One of the most important aspects in determining compliance with this standard is the facility’s definition of the scope of services it provides. The general rule is, the sicker the patients, the higher the skill level and hours of coverage for staff required to attend to them.

**Discipline-Specific Health Records**

**Q** In our facility, each of the major disciplines (medical, dental, mental health) keeps its own records separately. Is a unified health record required for accreditation?

**A** In the 2018 manuals, standard A-08 Health Records does not require a unified health record for accreditation, but it is certainly recommended to facilitate continuity of care. Allowing each major discipline to maintain its own records is not only less efficient, but also less effective in that it allows more room for error.

While we recommend a unified health record, if the facility chooses to maintain records separately by discipline, this is acceptable for accreditation purposes, provided that the following criteria are met:

- Pertinent basic information must exist in all three charts. For example, all three charts would have to list current problems, allergies and medications. We recommend establishing a mechanism to ensure that basic information with respect to treatment in progress is provided by each discipline to the other disciplines.

- Other aspects of the management of the health record would apply to all three charts. For example, all three charts would have to observe the standard with respect to confidentiality of health records, transfer of the health records or summaries, reactivation of records and retention of the health records.

Tracey Titus, RN, CCHP-RN, is NCCHC’s vice president of accreditation. If you have a question about the standards, write to accreditation@ncchc.org or call 773-880-1460. For an archive of Q&A topics as well as the Spotlight on the Standards column, visit www.ncchc.org.

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