Sexual Abuse
What Is the Health Professional’s Role in Prevention and Response?

Treating Complaints of Sleep Disturbance
Female Inmates Claim Discrimination
Updates Conference Preview

National Commission on Correctional Health Care
1145 W. Diversey Parkway, Chicago, IL 60614
Updates in Correctional Health Care

Partners in Public Health

Nashville, Tennessee • April 24–27, 2010

One of the largest gatherings of professionals in correctional health care, Updates 2010 will share innovative developments, practices and research findings in a broad range of topics. With an emphasis on the intertwining roles of public health and correctional health, the presentations will focus on interventions that lead to reduced illness rates, financial savings, improved public safety and better use of health care resources.

For more information visit www.ncchc.org
e-mail conference@ncchc.org
or call 773-880-1460
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.

Features

6 Updates Conference Preview
8 Spotlight on the Standards: Continuous Quality Improvement Program
9 Position Statement: Health Services Research
12 Sexual Abuse: What Is the Health Professional’s Role in Prevention and Response?
14 ‘I Can’t Sleep’: Treating Complaints of Sleep Disturbances in Corrections
16 Female Inmates in Wisconsin Advance Discrimination Claims
22 Peer Review: What Should We Assess?

Departments

2 NCCHC News
3 Guest Editorial: Kevin Fiscella on Drug Treatment Policy
4 News Watch
21 Journal Preview: New Estimate of Traumatic Brain Injury in Offenders
23 Juvenile Voice: A Chat With a Clinical Psychologist
24 CCHP Page: Certification Is a Team Effort at This Company
25 Field Notes
27 Classified Ads and Ad Index
28 Standards Q&A

Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification or employment as a consultant or surveyor, or to serve on committees or the board of directors. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased and expert. And dedicated only to recognizing and fostering improvements to the field of correctional health care.
Call for Comments on Juvenile Standards
NCCHC is preparing to revise its Standards for Health Services in Juvenile Detention and Confinement Facilities. As part of this process, the Juvenile Health Committee is seeking expert opinion from accredited facilities, practitioners and our supporting organizations about the current Juvenile Standards. This input will help ensure that the revised manual reflects the highest professional and ethical exemplars for quality health services in juvenile facilities.
The manual is scheduled to be published in 2011.
If you would like to share feedback, please send your comments by April 15 to juvenilesstandards@ncchc.org, and be sure to indicate your name and professional affiliation.

Four New Guidelines Released
As reported in the last issue of CorrectCare, NCCHC’s Policy and Standards Committee has adopted a new, streamlined format for its clinical guidelines. To be more descriptive, they are now labeled “Guidelines for Disease Management in Correctional Settings.” Four guidelines, all pertaining to adult patients, have been issued thus far, addressing asthma, diabetes, hyperlipidemia and hypertension.
The guidelines aren’t meant to be a substitute for nationally accepted clinical guidelines issued by organizations such as the National Institutes of Health; the American Diabetes Association; the National Heart, Lung, and Blood Institute; and the U.S. Department of Health and Human Services. Rather, they are supplemental, with a focus on the challenges and special considerations inherent in correctional settings. They are designed to help correctional health care providers improve patient care outcomes. Each guideline provides a list of recommended resources to support evidence-based practice and quality improvement. The guidelines are posted at the Resources section at www.ncchc.org.

NCCHC Goes Social!
NCCHC is going big time in the world of social media. Facebook, Twitter, blogs and podcasts are all being used to share information about NCCHC activities—including the Updates conference in Nashville—as well as important news about correctional health care in general. We are easy to find by searching for “NCCHC.” And remember: These media are interactive, so follow us, friend us, comment us and share us!
Not sure what all that means? Then you won’t want to miss this presentation at the Updates meeting: “Using Social Media to Create a Support Network.” In this talk, our social media consultant, Lorry Schoenly, PhD, RN, CCHP-RN, and NCCHC’s director of professional services, Paula Hancock, MEd, CCHP, will discuss not only NCCHC’s social media ventures but also how these rapidly evolving technologies can help professionals in our field to make valuable contacts and stay on top of important issues. The presentation takes place Tuesday, April 27, from 10:15 a.m. to 11:15 a.m. (See page 6 for more about the conference.)

Submit Your JCHC Manuscripts Online
Submitting a manuscript to the Journal of Correctional Health Care is easier than ever thanks to SageTrack, an online service offered by Sage Publications.
• Establish an account, enter author information and submit your article
• Submit revisions through automatic linking
• Send supporting documents such as the transfer of copyright and author disclosure forms
• Track the progress of your article
• Review proofs
The system also expedites the peer review process. Check it out at http://mc.manuscriptcentral.com/jchc.

Bound for Boston!
“The Hub” will be a correctional health hot spot this summer, with two fantastic NCCHC educational programs taking place back-to-back. Both will be held at the Westin Copley Place, the AAA Four Diamond hotel in the heart of Back Bay. Attend both programs and receive a significant discount on registration!

Medical Director Boot Camp • July 9-10
Last year’s inaugural event was a great success, attracting medical directors and physician leaders of all experience levels who came to learn not only from expert presenters but also from each other. To provide even greater benefit, this year’s program will offer two tracks targeting different levels of experience.

Correctional Mental Health Seminar • July 11-12
National leaders, innovative thinkers and inspiring speakers will gather to discuss how to optimize care for a challenging population. Learn firsthand how to improve quality and efficiency across your system. Concurrent sessions will be augmented by networking events and breakfast and luncheon programs.

For the complete list of CCHP exams, including regional exam sites, see www.ncchc.org/cchp.
Drug Treatment Policy: Time for Reform

by Kevin Fiscella, MD, MPH

Drug treatment within the criminal justice system, particularly within corrections, has failed to keep pace with scientific advances in drug abuse treatment. Current national policy has generated a revolving door whereby drug offenders are arrested, incarcerated and returned to the streets untreated, resulting in a futile, costly cycle. Reforms are needed.

Scientific research has established unequivocally that drug dependence is a brain disease. Drug disorders are similar to other chronic conditions such as adult onset diabetes that result from a combination of genetic vulnerability, peer and environmental influences and ill-advised choices. The primary distinction is that drug disorders affect long-term changes in brain reward pathways resulting in craving and compulsive use, which often lead to criminal activity in order to obtain drugs.

Treatment for drug abuse within (and outside) the criminal justice system is effective. Drug courts and incarceration-based drug treatment reduce recidivism and drug use. Nationally, re-arrest rates are only 16% in the year following successful completion of drug court, much lower than those among comparable groups. Involuntary treatment can be effective.

Treatment is cost saving, in large part due to reductions in crime-related costs. Developing models that ensure access to drug abuse and dependence assessment and treatment throughout the criminal justice system would produce more than $46 billion in benefits at a cost of $13.7 billion. Cost savings from drug courts are significant, exceeding $2 saved for every $1 spent and comparable to that of other chronic conditions.

Drug Abuse Is Largely Untreated in Corrections
Among the 1.5 million arrestees with drug disorders, only about 55,000 persons are treated. Assessment for drug abuse in correctional facilities is poor, and only 10% to 15% with such disorders receive treatment. Most persons who are arrested for drug-related offenses (whether convicted or not) are eventually released. Yet, recidivism rates are very high, resulting in further crime and economic costs to affected communities. Postrelease coordination of care is poor. Rates of death from overdose following prison release are high. Worse yet, rates of treatment in prisons have actually declined by 50% since 1991.

Drug Abuse Policy Has Overwhelmed Corrections
The United States launched a national social experiment beginning in 1980, attempting to stem drug use primarily through criminal sanctions. The number of inmates incarcerated nationally for drug-related offenses has exploded from 41,000 in 1980 to nearly a half million currently, at an annual cost of roughly $22,000 per inmate.

Moreover, 40% of drug-related offenses of incarcerated persons are related to simple possession. About half of all prisoners meet established diagnostic criteria for drug abuse or dependence. This influx of inmates has overwhelmed jails and prisons across the country, resulting in exploding tax burdens for states and overcrowding of jails and prisons, overwhelming the capacity of the facilities to adequately address treatment needs.

The Status Quo Is Untenable
Rising costs from this futile policy are driving reform efforts, including national and state policies and proposals to develop more effective means for addressing this problem. Several states are now spending more on criminal justice than higher education. California prisons have been under receivership since 2001 because of the collapse of health care in prisons as a result of an exploding prison population as a consequence of proposition 184 (“three strikes and you’re out”). This has contributed to near bankruptcy of the state. Despite increasing expenditures on drug-related offenses, careful analyses conducted by independent groups suggest little or uncertain benefit from current drug policy.

Drug Treatment Needed Throughout the System
New approaches are needed to reduce tax burdens and minimize personal and family suffering from substance disorders. The evidence base for diversion programs is growing. The National Institute of Drug Abuse has established a set of principles for substance abuse treatment for criminal justice populations. Treatment is most effective when it is tailored to the needs of the person and is carefully monitored; targets factors (including attitudes, thinking and behavior) associated with criminal behavior; addresses concurrent mental health needs and applies a combination of incentives and sanctions.

A Model for Management
Based on these principles, a model for management of substance disorders in criminal justice should achieve the following:

- Unburden the judicial and correctional system from the flood of drug-related offenses that it is ill-equipped to handle.
- Implement scientifically supported assessment and treatment for substance disorders, including use of medication-assisted treatment, and for concurrent mental health disorders at all levels of the criminal justice system.

continued on page 4
Operational efficiencies and cost savings are also expected. The ultimate goal is to decrease the rate of recidivism for youth, which typically is higher than for adult offenders, according to a DJJ announcement in January. The new structure is meant to enable long-term planning for youth and their family as soon as they enter the juvenile justice system. These reforms will help ensure that persons with substance disorders obtain needed treatment, ultimately reducing the futile cycle of addiction and arrest.

Kevin Fiscella, MD, MPH, is a professor in the Department of Family Medicine, University of Rochester (NY) School of Medicine and Dentistry. He represents the American Society of Addiction Medicine on NCCHC’s board of directors.
NCCHC Accreditation

Recognition From the Most Respected Name in Correctional Health Care

For 30 years, NCCHC has worked with administrators across the country to ensure that health care provided in their facilities is effective, efficient, and meets constitutional requirements. Our success — and the success of facilities accredited by NCCHC — is unsurpassed.

Leading the Way in Every Way

- NCCHC’s standards are widely recognized by the medical profession and the courts
- NCCHC’s standards are the benchmark for measuring a facility’s health services system
- NCCHC is unmatched in our correctional health care expertise
- NCCHC’s independence assures an unbiased evaluation of your compliance with standards
- NCCHC accreditation gives greater public confidence and professional satisfaction in the work you do

No other accreditation comes close to receiving the professional acceptance and recognition that goes with NCCHC health services accreditation. **Isn’t it time you became NCCHC accredited?**

For more information on NCCHC accreditation, contact us at:
(773) 880-1460 • accreditation@ncchc.org • www.ncchc.org
 Updates in Correctional Health Care

The importance of correctional health care is more apparent than ever. At every step, your efforts benefit not only inmates, but also staff, families and the public at large. Effective delivery systems also present a tremendous opportunity for financial savings and better use of resources.

While covering a broad range of timely correctional health topics, Updates 2010 will have a special focus on the intertwining roles of public health and correctional health and ways to maximize collaboration for best outcomes.

We invite you to join 1,000 of your colleagues in a vibrant forum where you will receive timely and valuable information on these topics from experts in correctional and public health.

Program Highlights

Partners in Public Health Series
To a great extent, the physical and mental health problems of inmates originate in the community. Although correctional health care focuses on the patient, because the vast majority of inmates are released it can also have a great impact on the public health through reduced disease rates, financial savings, improved public safety and better use of health care systems and resources. This series will explore models and practices that strive toward a comprehensive approach that includes early detection and assessment, health education, prevention, treatment and continuity of care.

Something for Everyone
With a broad range of subjects that span the continuum of correctional health care, You can count on the Updates 2010 lineup offers something for everyone. Visit the Web to download the Schedule at a Glance for a list of the 60-plus presentations. Here’s a sample:

• Streamlining Mental Health Services to Cut Costs and Save Time
• Public–Private Partnerships for Community-Based Chronic Care and Specialty Services
• Making Patients Understand and Comply: Communication That Works
• When an Inmate Death Leads to Litigation
• Traumatic Brain Injury: A Diagnostic Dilemma
• Excited Delirium and Sudden In-Custody Death
• Improving Quality in Times of Fiscal Crisis
• Disease Prevention in Jail: Calling in the Health Department
• Current Recommendations for Cardiovascular Disease Prevention
• A 10-Year Jail-Public Health Partnership That Improved Health Care and Reduced Recidivism

Make the Right Connections
One of the greatest rewards of a professional conference is networking with colleagues, and our attendees are among the best and brightest. This meeting offers countless opportunities to meet and network with colleagues to learn how they are handling the problems that you face every day. Bring business cards for those people you’d like to keep in touch with.

Edifying Exhibits
Be sure to visit the exhibit hall each day to learn about the many companies dedicated to helping you provide quality health care. Representatives from dozens of companies will be on hand to show you the products and services available to assist you in your work. The opening reception on Sunday evening is your first chance to meet up with old friends, make new connections and meet with these invaluable partners.

Off to a Good Start
Get your educational experience off to a good start by attending a seminar before the conference begins. Presented by some of the most respected experts in this field, the seminars provide in-depth training on vital topics. Registration for the conference is not required to attend these seminars.

Saturday, April 24
• An In-Depth Look at NCCHC’s 2008 Standards for Health Services in Prisons and Jails (9 am - 5 pm)
• CCHP-RN Certification Review Course (9 am - 5 pm)
• Preparing Your Facility for a Pandemic: Tips and Tools for an Effective Response (1:30 pm - 5 pm)

Sunday, April 25
• Pain Management: A Multidisciplinary Approach (8 am - 11:30 am)
• Assessment and Treatment of Suicide Risk and Self-Injurious Behaviors (8 am - 11:30 am)
• Advanced Nursing Assessment for Triage and Health Assessments (1 pm - 4:30 pm)
• Achieving Quality Care in a Tough Economy (1 pm - 4:30 pm)
• Addressing the Rising Prevalence of Dementia in Inmate Populations (1 pm - 4:30 pm)

Thanks to Our Co-Hosts!
NCCHC thanks the following organizations for their support of the Updates conference:
• Davidson County Sheriff’s Office
• Shelby County Sheriff’s Office
• Sullivan County Sheriff’s Office
• Tennessee Department of Children’s Services
• Tennessee Department of Correction
• Tennessee Sheriffs’ Association
Partners in Public Health
Nashville, Tennessee
April 24-27, 2010

Make the Most of It!
It’s more important than ever to use your skills and resources most effectively. This conference has been carefully designed to help you meet the fiscal and human resource challenges in correctional health care. Here are just a few reasons why you should attend this conference.

- Discover evidence-based tools, techniques and solutions for making health services delivery more cost-effective
- Learn how other organizations have implemented successful programs for improving the efficiency of clinical processes
- Develop strategies for meeting national standards in the midst of budget cuts and staffing shortages
- Update and refresh your clinical skills while earning continuing education credit
- Network with colleagues, from top decision makers to in-the-trenches staff, to learn how they are handling the problems you face every day
- Explore problem-solving products and services in the exhibit hall

Music City and So Much More
Downtown Nashville is a visitor’s delight! Whether you are interested in history, music, entertainment, dining or specialty shopping, you will enjoy exploring this unique city.

Some say that a trip to Nashville is not complete without a stop at the authentic honky-tonk saloons along Broadway. So when sessions are done for the day and you are ready to enjoy the nightlife, pull on your boots, let loose and two-step to the tunes of a country quartet. Other stops on Broadway include the Hatch Show Print studio, Gruhn Guitars and Ernest Tubb Records. But C&W isn’t the only game in town. Music City venues feature jazz, blues, rock & roll and just about every other genre.

Whatever your pleasure, you will find plenty to do. For more information, visit the Web at www.visitmusiccity.com.

Educational Objectives and CE Credit
List major health care issues that commonly affect incarcerated individuals, including HIV, hepatitis, hypertension, diabetes, mental illness and substance abuse
Describe current public health, legal, ethical and administrative issues and ways to prevent potential problems that arise in correctional settings
Employ new practices for the treatment of major health care issues in order to better manage common medical and nursing problems found in correctional settings
Express increased understanding of common correctional health care issues by exchanging ideas with colleagues about new developments in specialty areas

Continuing Education Credit
Attendees at Updates 2010 may earn up to 25 hours of continuing education credit in the categories listed below. (This maximum number of hours includes participation in the preconference seminars.) For details, see the conference Final Program.

- Nurses
- Physicians
- Psychologists
- Social Workers
- CCHPs
- General

Registration and Venue
Register at www.ncchc.org or mail/fax the form to NCCHC. To obtain the form, visit the Web, see the Preliminary Program or call 773-880-1460.
Regular Registration: $390
Academy Member: $315 (Members of the Academy of Correctional Health Professionals save $75 on registration. To join, sign up using the conference registration form.)
One Day: $160 (Monday or Tuesday)
Guest Registration: $55 (Guests of regular or Academy registrants may attend all exhibit hall events but not educational sessions.)
Preregistration: To register in advance, your registration and payment must be received by April 16. After that date, please register on site.

Meeting Site
All events take place at the Nashville Convention Center, connected to the Renaissance Hotel, the conference headquarters. Call reservations at 800-327-6618 and mention NCCHC to receive a special group rate.

For More Information
For the latest conference information and online registration, visit the Updates site www.ncchc.org/education/updates.
The purpose of continuous quality improvement programs is to improve health care by identifying problems, implementing and monitoring corrective action and studying its effectiveness. Standard A-06 is meant to ensure that a correctional facility uses a structured process to find areas in the health care delivery system that need improvement, and that when such areas are found, staff develop and implement strategies for improvement. An essential element of quality improvement is the monitoring of high-risk, high-volume, or problem-prone aspects of health care; not every aspect of every major service needs to be studied. General areas of study include access to care, the intake process, continuity of care, emergency care and adverse patient events, including all deaths.

While the overall goal of CQI programs is universal, there are a variety of ways to conduct CQI studies. NCCHC does not stipulate a particular method or format for these studies; there are many online resources for CQI methodologies, including the popular Plan-Do-Study-Act (PDSA) model.

NCCHC is often asked to explain the difference between a CQI process study and a CQI outcome study. According to the Standards for Health Services (jail and prison), a process study examines the effectiveness of the health care delivery process and an outcome study examines whether expected outcomes of patient care were achieved. Both types of studies should identify a facility problem, conduct a study, develop and implement a plan, monitor and track results, and demonstrate improvement or restudy the problem (Compliance Indicators 3b and 4c).

For outcome studies, a CQI committee would ask whether health services are achieving desired outcomes as far as patients’ conditions. Are patients worsening as a result of the care being provided? Are patients’ symptoms decreasing? Perhaps the CQI committee has identified that diabetes care should be examined and you wish to assess the degree of control in a sample of patients with diabetes. You could develop a form or an audit tool with key indicators to evaluate during your chart reviews of those patients.

Process studies tend to focus on procedural or policy-oriented issues. For example, the CQI committee might investigate how to complete a process or activity more efficiently, or more cost effectively. Let’s say that the committee would like to schedule patients for chronic care clinics in a timelier manner. It might implement a new scheduling log and then monitor those results to determine if the intervention was effective.

Remember, the CQI program focuses on system issues. It studies specific root causes and analyzes objective aggregate data to identify improvements in organizational structure and function. Corporate or pre-set schedules for CQI topics are a great tool to use on a regional or systemwide basis and can augment the facility’s CQI program, but the CQI committee must be involved in identifying facility-specific problems (see Compliance Indicator 1 and 3bi or 4ci), as well. If on-site health staff have no input into problem identification, actual facility issues might not be addressed.

Basic vs. Comprehensive Programs

Facilities with an average daily population of 500 or less should implement a basic CQI program, and those with an average daily population of greater than 500 should establish a comprehensive CQI program (Compliance Indicator 3 or 4). An important distinction is that basic CQI programs are required to monitor fundamental aspects of the health care system though one process and one outcome study at least annually, whereas comprehensive CQI programs need to conduct two process and two outcome studies.

Comprehensive CQI programs are to be managed by a committee comprised of health staff from various disciplines (e.g., medicine, nursing, mental health, dentistry, health records, pharmacy, laboratory). The multidisciplinary approach lends itself to enhanced staff cooperation and satisfaction, as well as opportunities to solve problems jointly across disciplines. Meetings are held as necessary but no less than quarterly to design quality improvement activities, establish objective criteria for use in monitoring, develop plans for improvement based on findings, assess the effectiveness of these plans after implementation and refine the plans as necessary (Compliance Indicator 4a).

Corrective actions identified through the mortality review process should be implemented via the CQI program and monitored for systemic issues. Patient safety system failures of policy or procedure also should be examined through CQI. However, CQI generally does not focus on individual clinical performance (see A-10 Procedure in the Event of an Inmate Death and B-02 Patient Safety).

An annual review of the effectiveness of the CQI program itself is required for both types of programs (Compliance Indicator 3a or 4b). This might consist of a review of CQI studies, minutes of administrative and/or staff meetings or other relevant materials. Physician chart review is no longer a part of this standard for jails and prisons; now part of standard E-12 Continuity of Care During Incarceration, the purpose is to assure that clinically appropriate care is ordered and implemented by attending health staff. Keep in mind that involvement of the responsible physician remains a key component of basic and comprehensive CQI programs through identifying thresholds, interpreting data and solving problems (Compliance Indicator # 2).

For more details on how to organize CQI programs, see Appendix B in the jail and prison Standards manuals.
Position Statement: Health Services Research

NCCHC’s board of directors adopted this position statement on Health Services Research in Correctional Settings in October 2009. All NCCHC position statements are available at the Resources section at www.ncchc.org.

The National Commission on Correctional Health Care (NCCHC) in its Health Status of Soon-to-Be-Released Inmates (2002) report concluded that to reduce health risks and health care costs, we need answers for many health care policy questions. To improve on health care efficacy, expenditures, and prioritization, we need evidence on what affects health outcomes. The acquisition of scientific data on inmate health care will help to solve some of the leadership, logistical, financial, and policy barriers that affect many correctional systems.

AcademyHealth (n.d.) defines health services research as “the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations.” This NCCHC position statement does not address human subject research.

Very few well-designed and well-funded studies emphasizing correctional health services research have been conducted. A review of the literature finds predominantly quasi-experimental correlational studies, qualitative case and ethnographic studies, and few randomized control trials. There have been too few large-scale system or national studies on inmate health care and delivery systems (NCCHC, 2002). Such studies are essential to developing informed public and private policy. The lack of correctional health care research has hampered policy decision making in all aspects of health care organization, provision, and financing for incarcerated populations.

Furthermore, the lack of an effective method to retrieve health information (such as electronic health records) is a major deterrent in obtaining inmate health data. As a result, the correctional health workforce lacks the capacity to present aggregate inmate health data to policy makers.

If building correctional health capacity is critical, then we must collect and use health data effectively. A greater emphasis on collaboration among corrections and community partners must emerge as a model for correctional health care research. Barriers to research need to be collectively removed so that we can gain a better understanding of health care delivery in correctional settings. We need to be innovative and inclusive in addressing the research needs of the correctional health care delivery system.

Position Statement

A coordinated national health services research agenda is needed to build correctional health care research capacity in the United States. NCCHC endorses the following national research priorities for correctional health care.

- Congress, through appropriate federal agencies and health-related national organizations, should support research in correctional health care to identify and address problems unique to correctional settings.
- Appropriate federal agencies in partnership with health-related national organizations should develop mandated surveillance guidelines to promote uniform national reporting of selected conditions to enhance epidemiologic research of these conditions and assist with accurate health care planning. Ensure that the surveillance program collect data in prisons and jails in the same manner as they are collected in the community. The results of data collection should be shared with the community. Surveillance guidelines should incorporate processes for protecting confidentiality of data.
- A national correctional health care database should be created. Standardized definitions and reporting measures to assess the prevalence of selected communicable diseases, chronic diseases, and mental illnesses should be developed. An information system should be designed for use by national, state, and local correctional authorities to measure and report the data with the ability to categorize data by age, race, and gender. National, state, and local correctional and public health agencies should be encouraged to report rates of selected communicable diseases, chronic diseases,

continued on page 10
and mental illnesses to aid in planning programs and allocating resources.

- To strengthen correctional health care capacity and provide its unique insight to research findings, NCCHC endorses the model that includes correctional health and custody staff involvement in data analysis and interpretation of research findings. Custody should be included in the uniform nationwide data collection system.

- National, state, and local correctional and public health agencies should evaluate the utility of surveillance activities and implement improvements as appropriate. Build effective health care systems by improving decision making through efficient data collection. We must improve funding and efforts to establish electronic health data retrieval in correctional systems.

- Congress, through appropriate federal agencies and health-related national organizations, should fund projects to evaluate models that emphasize creative, cost-effective options for continuity of care after release; research programs to define effective health education and risk reduction strategies for inmates; and research programs to identify correctional system barriers that prevent correctional health staff from implementing prudent health care and public health recommendations.

- Congress, through appropriate federal agencies, should support large-scale research to address unique problems to the incarcerated population. Creating a research infrastructure unique to correctional health care will link researchers and practitioners, help to identify research priorities, and have an economy of scale by sharing tools and resources and building research capacity.

- Congress, through appropriate federal agencies and health-related national organizations, should develop and maintain a national literature database for correctional health professionals, including a compendium of policies, standards, guidelines, and peer-reviewed literature.

- Relevant stakeholders should be more involved in the process of setting the research agenda. Community-based participatory research is intended to include community voices in all aspects of the research process, including data analysis and interpretation. Researchers studying correctional health care should understand the importance of collaborating with policymakers, organizations, and communities to plan, conduct, and translate health services research into policy and practice.

References

To learn how to prevent MRSA, call 1.800.843.8497 or visit www.hibiclens.com
Beyond a reasonable doubt...
Medi-Dose® and TampAlerT®

The most trusted names in tamper-evident unit dose packaging

Since 1971, correctional facilities have relied on the proven Medi-Dose systems for the quickest, safest and most economical way to package solid oral medication. They’re tamper-evident, ultraviolet inhibitant and minimize errors and pilferage. Plus Medi-Dose contains no metal or glass!

With TampAlerT, a twist of the wrist is all you need to dispense liquids in no-leak, tamper-evident unit dose. TampAlerT vials are available from 15 ml to 120 ml, in natural or ultraviolet inhibitant polyethylene, with either regular or child-resistant screw caps. Each cap contains a tamper-evident seal. And TampAlerT contains no metal or glass!

Both Medi-Dose and TampAlerT can be easily identified using our MILT software ... providing complete labeling and log reporting, even bar coding!

There’s no doubt about Medi-Dose and TampAlerT, proven in correctional facilities for over 30 years.

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.mendidose.com
E-mail: info@medidose.com

Responding to pharmacy packaging needs around the world
In a correctional facility, the health professional’s role is to provide timely access to appropriate medical and mental health care. Nothing differs for victims of alleged sexual abuse. We have high expectations for ourselves to act professionally, with sensitivity, insight and confidentiality. And we recognize the particular vulnerabilities of victims of sexual abuse behind bars: Not only do they suffer the physical and mental trauma itself, but their claims are too often dismissed, they are subject to retaliation for reporting abuse and the typical grievance process may not be the best route to a safe and effective response.

The NPREC standards outline a clear role and a set of policies and practices for correctional health professionals, including the following:

• Collaborate with the agency or facility executive team to develop and implement policies.
• Be trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond effectively and professionally to victims and know how to report allegations or suspicions of sexual abuse.
• Screen inmates during intake to assess their risk of being sexually abused by other inmates and their risk of being sexually abusive toward others. The screening should be guided by a written instrument tailored to the facility’s population (for example, by gender). The staff must obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18, where consent is not required.
• Participate in a coordinated response with first responders, investigators and facility leadership to ensure that victims receive all necessary immediate and ongoing medical, mental health and support services. This includes timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.
• Communicate and coordinate with qualified forensic medical examiners. Where there is a need to collect forensic evidence, a recommended best practice is for evaluation and treatment, including examination, by community medical examiners, even if the facility has a forensic medical examiner on staff.
• Provide ongoing medical and mental health care as correctional health professionals deem appropriate and necessary in the exercise of their professional judgment, including help for victims of sexual abuse during their transition to the community. The abuser should also be assessed for mental health needs as the abuse may be related to mental illness, and be provided treatment accordingly.
• Report any alleged in-facility sexual abuse of inmates whether by staff or other inmates, unless otherwise prohibited by law. This applies to knowledge gained in the lunchroom as much as it applies to direct information from patients. The duty to warn and protect your patient and other inmates overrides your patient’s privacy interest, in this unique circumstance. The reporting is on a need-to-know basis to preserve privacy. Mandatory reporting does not apply to reported sexual abuse prior to incarceration. Victims should be informed about the reporting at the outset of any interview or treatment so that they can know what information will be held confidential.
• Cooperate with investigations.

The NPREC standards for juveniles differ in several respects from those for adults. As an example, medical and mental health staff are required to inquire into sexual orientation and gender identity as well as prior victimization and participation in sexual abuse, tailored to the child’s age and developmental status. Reporting is mandatory for all sexual abuse, including prior abuse. Juvenile facilities must provide access to outside victim advocates for emotional support, in addition to on-site mental health support.

Be Mindful of Pitfalls
The pitfalls of effective prevention and response to alleged sexual abuse are confidentiality, continuity and coordination of care. Considering the three C’s will help correctional health professionals meet their duties.

First, confidentiality should not be used as a shroud to prevent reporting incidents of alleged sexual abuse. Reporting alleged abuse is critically important, as reflected in the NPREC standards, to protect the patient from further abuse or to protect other inmates. Hopefully, you will be able to obtain patient consent by convincing your patient that he or she will be safe and protected from unintended consequences of reporting, such as minimizing the allegation, rebuff with responses like “you didn’t fill out the proper form” or retaliation by staff or other inmates. If you believe your patients won’t be assured safety and treated with respect, you must still report—but you should also work with prison officials to change the institutional culture.

Second, emergency response and crisis intervention is not enough. Nor is a timely visit to the emergency department for a qualified forensic evaluation (e.g., when there has been penetration or there is forensic evidence to collect). Patients need continuity of care. On return to the facility, the victim may still have the emotional burden of the assault, fears for safety and wounds to heal. Follow-up laboratory testing is critical. Victims may have been tested for sexually transmitted infections, but it is important to remember the incubation periods of STIs and especially the period between contact and laboratory evidence of infection, which ranges from days to months depending on the organism. Diseases to consider are gonorrhea, chlamydia, syphilis, HIV, viral hepatitis and herpes. In cases of vaginal penetration, women should have laboratory testing for pregnancy severel weeks after the assault.

Third, just because a victim appears fine emotionally does not mean there will not be late effects, such as anxiety disorders or PTSD. It is important for medical and nursing professionals to consider the victim’s mental status for months after an assault and to coordinate care with mental health staff, as needed. After an initial evaluation, mental health staff should follow up with their patients over time and coordinate care for their somatic complaints.

Meaningful Contribution
Thoughtful implementation of NPREC standards will go a long way to minimize inmates’ risk of harm from sexual abuse. This is about safety and respect, important aspects of professionalism. Correctional health professionals can contribute to an institutional culture of zero tolerance for sexual abuse in a large and meaningful way.

Robert B. Greifinger, MD, is a physician consultant and college professor based in New York. He served as a member of the NPREC Standards Development Expert Committee.

Resources
Prison Rape Elimination Act of 2003
www.ojp.ncjrs.gov/about/PubNo108-79.txt
Bureau of Justice Statistics Reports
• Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09
• Sexual Victimization in State and Federal Prisons Reported by Inmates, 2007
• Sexual Victimization in Local Jails Reported by Inmates, 2007
NPREC Standards
• Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails
http://nprec.us/publication/standards/adult_prisons_and_jails
Medical Forensic Examination Protocol
• A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents (U.S. Department of Justice)
www.ncjrs.gov/pdfiles1/ovw/206554.pdf
‘I Can’t Sleep’: Treating Complaints of Sleep Disturbances in Corrections

by Joyce Rackauskis-Anderson, MSN, ARNP

The first patient of the day has written a sick-call slip stating, “I need something for sleep.” When asked about her major problem, she immediately responds, “I can’t sleep and need something to help me sleep.” In the past, my immediate response was, “I don’t give medications for sleep.” Eventually, I realized that the therapeutic relationship with my patients was compromised by this response, and I needed to change how I dealt with complaints about insomnia in the jail.

Practitioners often become frustrated when trying to deal with inmate complaints about sleeping problems and feel pressured to prescribe sleeping medications, which may not be the optimal treatment for insomnia in the correctional setting. However, untreated sleep disturbances may cause symptoms of depression, irritability, impaired cognitive function, fatigue, difficulty with concentration and focus, and daytime sedation.

In the correctional environment, a variety of factors may cause difficulty with sleep, including medical issues, psychological problems and poor sleep hygiene practices. Primary insomnia occurs in 25% of patients and is related to poor sleep environment, poor sleep hygiene, rebound insomnia from sleeping aids, side effects to medications and shift work. Secondary insomnia occurs in the remaining 75% of the patients and is directly related to medical and/or mental health illnesses.

To deal effectively with an inmate’s sleep disturbances, the practitioner should obtain a comprehensive medical, psychological and sleep history and then identify any factors interfering with sleep and develop treatment plans to resolve identified problems.

Medical Comorbidities

The psychiatric/medical evaluation should include an identification of the patient’s medical comorbidities as virtually any medical comorbidity can cause insomnia. These include respiratory problems such as COPD, asthma, allergic rhinitis, sleep apnea and acute respiratory infections, which can interfere with the ability to sleep by compromising adequate air exchange; rashes and infections, which cause pain and itching; gastrointestinal problems such as heartburn, diarrhea, acute gastritis and irritable bowel syndrome; cardiac problems, including angina, irregular heart rates, lower extremity pain or ulcerations from poor circulation; and uncontrolled hypertension. Additionally, any cause of chronic or acute pain may interrupt sleep patterns. Arthritis, fibromyalgia, neck and back pain from old or new trauma, and neuropathy from diabetes or chronic alcoholism will prevent the patient from falling asleep and being able to stay asleep. All of the above need to be adequately treated to minimize effects on sleep.

Mental Health Factors

Psychological factors that interfere with sleep include bipolar disorders, anxiety, depression, psychosis and PTSD, along with addiction and withdrawal from drugs and alcohol. The bipolar patient in the manic phase will report difficulty with sleep, often obtaining only 3 to 4 hours of sleep a day. Rapid speech, flight of ideas and restlessness significantly interfere with the normal sleep pattern in these patients. A psychotic patient who is actively having auditory or visual hallucinations and paranoid delusions will demonstrate inappropriate behaviors, irritability and restlessness such that sleep may be nonexistent.

Depressed patients may complain of fatigue and difficulty staying awake, as well as the desire to remain in bed all the time. Alternatively, they may complain of fatigue but with an inability to sleep, along with feeling restless and overwhelmed most of the time. PTSD causes nightmares about previous traumatic experiences and thus interrupts the patient’s sleep. Anxiety causes restlessness, irritability, feelings of being overwhelmed with life stressors and difficulty maintaining a normal sleep pattern.

Practitioners can control psychological symptoms that interfere with the patient’s sleep by identifying the mental health disorder and prescribing appropriate medications. In addition, the practitioner should make appropriate referrals to self-help programs offered by the facility. Narcotics Anonymous, Alcoholics Anonymous, church groups, therapeutic counseling, trustee work, educational courses and group therapy enable the patient to develop healthy coping skills, institute healthy lifestyle changes and identify mechanisms to reduce life stressors.

Sleep patterns may be disrupted by substance abuse, and these patients may need treatment for the symptoms of withdrawal. Amphetamines, crystal methamphetamine and cocaine will cause prolonged episodes of wakefulness with a period of sleepiness and drowsiness when the patient stops using the drug. Opiates can cause sedation with significant withdrawal symptoms when the opiates are discontinued. Alcohol addiction may cause alcoholic withdrawal seizures or life-threatening delirious tremors requiring immediate treatment with a benzodiazepine taper.

Patients should be educated regarding the deleterious
effects of drugs and alcohol on the normal sleep pattern. Furthermore, patients should be encouraged to make healthy lifestyle changes by avoiding future use of alcohol and illegal drugs.

Medication Effects
Various medications (e.g., steroids, hormone replacement medications, beta blockers, beta-agonists, antidepressants, antipsychotics, amphetamines, decongestants, antineoplastic agents, bronchodilators, diuretics, Dilantin and thyroid medications) can interfere with a patient’s ability to sleep and should be considered when determining the etiology of an individual’s sleep disturbances. Psychiatric medications associated with insomnia include Abilify, Celexa, Effexor, Lexapro, Luvox, Pristiq, Prozac, Sinequan, Wellbutrin and Zoloft. Patients admitted to the correctional facility also may experience rebound insomnia when their prescribed sleeping medications are discontinued.

The practitioner should obtain a list of current medications and evaluate each for its potential to be the cause of the sleep disturbances. Adjustments in medication dosage or administration times may be needed to alleviate insomnia or somnolence associated with prescribed medications.

Sleep Hygiene
In addition, practitioners should assess sleep hygiene practices. A comprehensive sleep history will assist in understanding the patient’s sleep behavior. It should seek to identify problems with insomnia prior to incarceration, what the patient has done in the past to get to sleep and stay asleep, factors that have caused sleep problems in the past and current causes of the patient’s insomnia in the correctional environment.

Lastly, practitioners must be vigilant in monitoring who are patients attempting to obtain sedative medications for self-gain.

Treatment of verified sleep disturbances is three pronged and includes education in appropriate sleep hygiene practices, self-help in identifying causes that preventing adequate sleep and changing behavior as outlined below.

This article was reprinted with permission from the Summer 2009 issue of CorrDocs, the newsletter of the Society for Correctional Physicians. This version has been modified for CorrectCare and adds the tables below.

Joyce Rackauskis-Anderson, MSN, ARNP, works at the Charlotte County Jail, Punta Gorda, FL. Contact her at anderson3719@comcast.net. For a list of online sleep-related resources for health professionals and for patients, please see the CorrectCare archive at www.ncchc.org/pubs.

Lifestyle Changes
1. Eat three healthy meals per day and avoid snacks high in saturated fat.
2. Get seven to eight hours of sleep each night.
3. Exercise daily in the morning.
4. Stop smoking cigarettes or using other tobacco products.
5. Develop healthy coping skills to deal with life stressors.
6. Learn how to control anger and impulsive behaviors.
7. Develop a supportive relationship with family, friends and spouse.
8. Make a commitment to stop using alcohol and/or drugs.
9. Avoid caffeinated foods and drinks, especially before bedtime.

Patient Participation
1. Have the patient maintain a sleep diary to identify what factors interfere with sleep and when.
2. Encourage the patient to be compliant with medications to treat psychiatric and medical problems.
3. Encourage the patient to discuss any side effects to prescribed medications with the practitioner.
4. Encourage the patient to discuss with the practitioner the effectiveness of prescribed medications to treat medical and psychiatric problems.
5. Encourage the patient to participate in self-help programs offered by the correctional institution.
Female Inmates in Wisconsin Advance Discrimination Claims

by Fred Cohen, LLM

“I need to see a doctor.”  
“You saw someone last week.”  
“But that was for a different problem!”  
“So?”

This is a somewhat fictionalized yet representative dialogue between a female inmate housed at Wisconsin’s Taycheedah Correctional Institution and a triage nurse, the medical delivery system’s gateway staff person.

Flynn v. Doyle (E.D. Wisc., Nov. 24, 2009) deals with female inmates’ access to medical and mental health care and Americans with Disabilities Act claims of female inmates with disabilities and their disability-related claims of denial of access to services, programs or activities. The defendants’ motion for summary judgment was denied by federal Judge Randa, who wondered aloud why it was even brought, with the defendants’ own expert characterizing sick call, for example, as awful.

Context and Complaint

TCI is the only medium/maximum security institution in Wisconsin for female inmates. There are about 700 inmates and 325 staff, of whom 167 are security. The complaints by the plaintiffs have systemic implications (which will be explored), but they are of the second-generation of such complaints. That is, these are not at the level of there are no doctors, no medical care system in any real sense of the term, needless amputations, rampant loss of life and the like.

Nonetheless, the charges are quite serious. A representative sampling includes the following:

Medical
• Triage nurse decisions are not timely and are often cynical.
• Access to physicians is flawed due to inadequate nursing assessments and then unreasonable delays.
• The medication system is flawed in multiple ways. (Distribution by correction officers is a serious flaw and is now forbidden.)
• Lack of an infirmary impairs care for acute medical needs.
• Follow-up care after off-site care (e.g., surgery) is flawed.
• Absence of an on-site medical director impairs quality of care. (How this becomes a constitutional problem is yet another matter.)
• Physicians are insufficiently involved in patient care.

Mental Health
• There are 258 women at TCI diagnosed with serious mental illness (SMI) and only 61 treatment beds. Clinical staff is inadequate in number and training.
• Initial assessments take too long, rely on inadequate records and tend to miss post-traumatic stress.
• Psychiatrists take three to four weeks for assessments regarding psychotropic medications.
• Treatment planning is in the hands of those least qualified to do so.
• The absence of inpatient mental health care at TCI leaves women suffering needlessly and raises a credible equal protection claim given a lack of parity with the men’s facility.

Disabilities
• TCI has a segregated dining hall in that inmates using wheelchairs, canes or walkers are denied access and must eat, often alone, in their cells.
• There are a number of treacherous paths rendering access to desirable programs and activities hazardous.
• Inmates with hearing disabilities receive no signing or interpreter help.
• Reasonable requests for aid with visual impairment are denied.

Legal Framework

Flynn v. Doyle raises serious issues under the Eighth Amendment, the 14th Amendment’s equal protection clause and the ADA. While the court granted the defendants’ motion as to dental care, it found sufficient credible evidence to support the plaintiffs’ other claims.

As for medical care, it is now crystal clear that prisons must provide medical care for serious medical problems and may not be deliberately indifferent in the failure to so provide or the manner in which care is extended.

In ruling against defendants, Judge Randa stated:

In response to the defendants’ motion for summary judgment, the plaintiffs come forward with a mountain of evidence which is relevant to both prongs of the “systems” inquiry. There is a great deal of evidence demonstrating that there are “systemic and gross deficiencies” in staffing, facilities and procedures at TCI. There are also plenty of examples of negligent acts which suggest a pattern of conduct by the medical staff at TCI. Moreover, the evidence tends to establish that the defendants are and have been subjectively aware of the risks that are posed by the administration of medical and mental health care at TCI.

The defendants simply cannot overcome the pres-
ence of genuine issues of material fact with respect to
the plaintiffs’ Eighth Amendment claims. Essentially,
the defendants argue that they follow their internal
procedures, which are adequate to ensure that con-
stitutional minimums are satisfied. The evidence in
the record belies this assertion. Procedures might be
followed in many instances, but the plaintiffs provided
evidence demonstrating that these procedures are
inadequate or frequently ignored to the detriment of
the TCI inmate population. It is true that errors often
occur in any system, but a system that is overwhel-
mingly error-prone can violate the Eighth Amendment.
Ultimately, the Court finds it curious that the defen-
dants would even bother moving for summary judg-
ment when their own expert describes the system as
one designed to let people “fall through the cracks.”
(Slip Opinion, p. 36)

**Equal Protection**

The court indicated that to state a prima facie claim under
the equal protection clause, plaintiffs must show (1) they
are situated similarly to members of the unprotected class,
(2) they are treated differently from members of the unpro-
tected class and (3) the defendants act with discriminatory
intent. Discriminatory intent can be shown by direct or cir-
cumstantial evidence. All that is required is that the action
(or lack of action) taken be motivated by the gender of the
plaintiff. No hatred, animus or dislike is required.

The plaintiffs cogently argued that the state’s failure
to provide an inpatient mental health facility for women
that is equal to the one provided for men (the Wisconsin
Resource Center) violates equal protection. The defendants
basically conceded that men are treated more favorably
than women in this context. They claimed that this was not
discriminatory, but rather a natural outgrowth of the his-
torically small number of female prisoners in Wisconsin.

This may explain but hardly justifies differential treatment
for similarly situated female prisoners. Indeed, the defen-
dants’ ongoing knowledge of the disparity in treatment is
strong circumstantial evidence of discriminatory animus.
It raises the inference that the defendants deemed female
prisoners less important than male prisoners. The plaintiffs
were found to have established a prima facie case on their
equal protection claim.

The defendants also argued that the court must defer to
its future plans to build a female inpatient health treatment
facility. The Wisconsin State Legislature approved funding
for such a facility for female prisoners and it is slated to
open in early 2011. If this plan actually is completed and
the facility is comparable to the men’s facility, this claim will
be mooted. For now, the plaintiffs’ equal protection claim
remains viable. And the case goes on.

**ADA (Title II) and Rehabilitation Act Claims**

The ADA was enacted to “provide a clear and comprehen-
sive national mandate for the elimination of discrimination
against individuals with disabilities.” Title II of the ADA pro-
hibits discrimination in connection with access to public
services, requiring that “no qualified individual with a dis-
ability shall, by reason of such disability, be excluded from
participation in or be denied the benefits of the services,
programs, or activities of a public entity or be subjected to
discrimination by any such entity.”

The ADA and the Rehabilitation Act both apply to pris-
oners. Title II of the ADA was modeled after Section 504 of
the Rehabilitation Act. The elements of the two claims are
nearly identical, and precedent under one statute typically
applies to the other.

The elements of an ADA claim are (1) plaintiffs are quali-
ﬁed individuals with disabilities, (2) plaintiffs were either
excluded from participating in, or denied the benefits of, a
public entity’s services, programs or activities, or were oth-
erwise discriminated against and (3) such exclusion, denial
of beneﬁts or discrimination was by reason of disability.
Intentional discrimination, or discrimination “by reason of
disability,” can be established by evidence that the defen-
dant intentionally acted on the basis of the disability, the
defendant refused to provide a reasonable modiﬁcation or
the defendant’s rule disproportionately impacts disabled
people. If needed, a plaintiff must demonstrate “the exist-
ence of a reasonable accommodation” that would enable
her to participate in the program, service or activity at issue.

When a plaintiff, as here, meets these basic require-
ments, the burden shifts to the defendants to show that

continued on page 18
the accommodation was effective or that what was sought would have resulted in a fundamental alteration of procedures or (a defendant’s favorite) an undue financial or administrative burden. Deference is accorded to facility administrators as to their legitimate (e.g., security) interests.

Without going into the full evidentiary narrative here, suffice it to say that the plaintiffs provided evidence of a variety of potential ADA violations, including the maintenance of a segregated dining hall, a lack of program access to prisoners with mobility disabilities and the failure to provide auxiliary aids to prisoners with hearing and vision disabilities. Programs like church services and medical appointments are rendered inaccessible by treacherous paths connecting the various buildings on TCI’s campus. Instead of repairing these unsafe conditions, TCI uses other prisoners as wheelchair “pushers.” One inmate declared that she would like to attend Catholic religious services. However, there is a steep path leading up to the chapel, and it is difficult for the wheelchair pushers, so she stopped going. This is not a voluntary type of nonparticipation. Simply being singled out, as here, in a negative way, is a type of discrimination.

The defendants raised other credible issues related to federal standards and exemptions for pre-1992 constructed buildings. Accessibility is the key and physical changes to a building are required only where there is no other feasible way to make the program accessible.

Author’s Comment

The court’s decision, to be clear, is on a motion for summary judgment—a request that the case be decided “on the papers” and without a trial. The defendants did prevail on dental care (not discussed here) but the case goes forward, not necessarily for trial but a likely settlement of some sort.

There is another complicating factor in the case. In September 2008, Wisconsin entered into a settlement agreement with the Department of Justice on the mental health issues. The parties agreed that Jeff Metzner, MD, would serve as “consultant” and issue a series of status reports following DOJ metrics. Dr. Metzner is quite respected in correctional mental health and is likely to shepherd Wisconsin to a higher ground.

My own limited experience with the DOJ as a monitor in the juvenile justice area was not so sanguine. I found the Special Litigation Section to be shoddy in its legal research, to consistently overreach its statutory authority on investigations and “findings” and to be compulsively petty in its review of relevant reports. I hope the estimable Dr. Metzner has a different experience.

In the aggregate, Judge Randa’s opinion is solid and Wisconsin must basically revise its delivery of medical care beginning at the front door of assessment and continuing through to the most basic aspects in the provision of medical care.

Wisconsin’s female inmates legally require and deserve much better medical care. Comparing females’ medical care with that provided to males, the equal protection approach, does not provide a constitutional benchmark for medical care but it does show unacceptable distinctions. Certainly that is the case here on inpatient mental health care.

Fred Cohen, LLM, is the coeditor of the Correctional Law Reporter. This article is in press for a future issue of CLR, ©2010 Civic Research Institute, Inc., and is reprinted here in slightly abridged form with permission of the publisher. All rights reserved.

For subscription information, contact Civic Research Institute, 4478 U.S. Route 27, P.O. Box 585, Kingston, NJ 08528; 609-683-4450; www.civicresearchinstitute.com.
TREATING HIV Confidently With TRUVADA

- Demonstrated efficacy and tolerability profile through 3 years in Study 934
- DHHS-preferred dual-NRTI backbone for more than 5 years
- Chosen partner with leading PIs

Depend on TRUVADA to be your NRTI backbone

Important Safety Information

- Please see boxed WARNING information about lactic acidosis, severe hepatomegaly with steatosis, and exacerbations of hepatitis B upon discontinuation of therapy.

- Drug interactions have been observed between tenofovir DF and atazanavir or lopinavir/ritonavir.

Atazanavir 300 mg should be boosted with ritonavir 100 mg and taken with food when administered with TRUVADA. Atazanavir without ritonavir should not be coadministered with TRUVADA. Patients on atazanavir or lopinavir/ritonavir plus TRUVADA should be monitored for tenofovir-associated adverse reactions. TRUVADA should be discontinued in patients who develop tenofovir-associated adverse reactions.

Reference:
Health care providers who work with offender populations—both behind bars and in other settings—see plenty of cases of traumatic brain injury. But what is the actual prevalence rate? This is not an idle question, say researchers at the Medical University of South Carolina, Charleston. Given the many difficulties associated with TBI, a better grasp of prevalence would help in developing correctional policies aimed at improving screening, treatment and management of inmates with TBI, as well as public policies that could improve continuity of care and the social functioning of these individuals upon release to the community.

In the April 2010 issue of the Journal of Correctional Health Care, Eric Shiroma and colleagues report on findings from their meta-analysis of 20 epidemiologic studies on TBI in adult offender populations.

In the general population, prevalence of TBI is estimated 8.5%. In contrast, the commonly reported rates in the medical literature concerning adult offenders are from 25% to 87%. Among juveniles, the reported range is even broader, from 4% to 74%. Such wide ranges reflect the fact that studies vary in factors such as how terms are defined, how screening is done and the specific population under study.

Shiroma and colleagues sought to systematically analyze the reported prevalence rates in terms of gender proportion, offender type, case definition of TBI and method of determining TBI. From this analysis of 20 studies that met specific criteria and a combined sample of 4,865 individuals, they calculated an overall estimate of TBI prevalence in adult offender populations of 60%. Using a 95% confidence interval, the estimated range is 48% to 72%. (The article describes statistical analysis methods in detail.)

Subgroup Findings

Clearly, this 60% figure comes with many conditions. The rate is overall, without adjusting for differing definitions, methods of determination, proportion of males in the sample (rates of TBI among males are about twice that of females) or other sample characteristics.

The researchers also conducted subgroup analysis based on many of these variables. One important distinction was the individual studies’ definition and severity of brain injury—for example, whether the injury was described as “moderate/severe,” or whether it produced a loss of consciousness. The estimated prevalence of TBI when the subject lost consciousness was 50% (confidence interval 40% to 61%).

TBI is inherently difficult to diagnose, especially in less severe cases, the researchers note, and thus use of extensive in-depth interviews by trained mental health professionals is the “gold standard” because it produces more complete and accurate histories compared to other methods. Studies that used such interviews found an estimated prevalence of 67%, higher than the overall prevalence.

By gender, analysis of the males-only subgroup reveals prevalence of 64%, lower than that of the females-only group, 70%. However, the females had a much larger confidence interval, 50% to 90%, compared to the men, 53% to 76%. In addition, looking only at the cases that involved loss of consciousness, prevalence was greater among men (59% +/- 12%) than women (55% +/- 14%).

The article breaks out other data, and notes study limitations, as well. It also summarizes the poor outcomes and costs associated with TBI. Ultimately, the authors argue that this study—which they believe to be the first of its kind—points to a need for more appropriate allocation of resources and formation of community partnerships to better manage a significant public health concern that afflicts incarcerated individuals at high rates.
There are plenty of reasons NOT to do peer review, but none of them hold water. That was an early message in a presentation by John DesMarais, MD, at the National Conference on Correctional Health Care last October. As medical director for the Ohio Department of Rehabilitation and Correction, DesMarais has plenty of experience in physician peer review and quality assessment, and he shared his knowledge and insights with an appreciative audience.

After dispensing with the Top 10 excuses, he explained keys to success in peer review, then described the ODRC model, which seeks to assess not only clinical quality of individual providers but overall system efficiency and quality of patient “caring.” This model focuses on four primary areas for peer review of advanced-level providers, and examines key targets in each, as outlined below.

### Top 10 Reasons For Not Doing Peer Review

1. I know these guys and they’re all good docs.
2. We’re not in a lawsuit (yet) and we don’t have to do it.
3. I like being confrontational.
4. I don’t like being confrontational.
5. Who needs quality when you’re in the state with the best-looking doctors?
6. Hey, the health care is free—you get what you pay for.
7. They’re just prisoners.
8. Medicine is gray, not black and white.
9. It’s just a paper trail.
10. I know these guys and they’re all good docs.

### Activity Data
- Number of providers and hours at the institution
- Average number of patients seen per day (productivity)
- Number of chronic care clinic patients enrolled
- Number of nursing sick call screens per day
- Nursing/doctor sick call pass-through ratio
- Average number of patient no shows per day
- Average number of off-site consults per month
- Average number of emergency transfers per month with admit ratio
- Average number of infirmary admissions per month with average length of stay
- Backlogs
- Number of patients over 50 years old
- Number of medications per inmate per month

### Citizenship (a measure of institutional ownership)
- Percent of medical leadership quarterly meetings attended in last year
- Percent of facility-specific meetings attended in last year
- On-call availability and promptness of return calls
- Educational activity participation
- E-mail responsiveness
- Documentation legibility
- Department-specific goal compliance
- Timeliness and punctuality

### Service Quality
- Number of written patient informal complaints/grievances
- Number of written peer complaints or grievances
- Number of sentinel events related to the provider
- Number of documented disruptive practitioner instances
- Rapport/manner/professionalism
- Appearance and dress

### Clinical Quality
- Audit forms for each area: chronic care clinics, doctor sick call, ED trips, consults, infirmary admissions and intake
- Chronic care clinic forms, including hypertension, diabetes mellitus, HIV, chronic pain, seizures, lipids, anticoagulation, asthma and COPD
- At least 20 charts

Visit [www.dcp Providersonline.com](http://www.dcp Providersonline.com) to purchase a recording of the presentation; select session no. 178.
In this column, Judith Robbins, LCSW, JD, CCHP-A, talks with Ohiana Torrealday, PhD, for a clinical psychologist’s perspective on youth mental health services, program evaluation and motivational interviewing.

**JR: Tell us about youth served by UTMB-CMC.**

**OT:** As the contracted health provider, we provide medical and mental health services to committed youth, ages 10 to 18, in Texas’ juvenile correctional facilities. At the time of their incarceration, many youth have exhausted all “least restrictive” rehabilitative options or have committed a serious delinquent act requiring removal from the community. After this secure placement, some older adolescents prepare for community reentry by “stepping down” to halfway houses.

Over the years, like most systems, we’ve seen increasing rates of committed youth with serious mental health problems and youth dually diagnosed with mental health and substance abuse disorders. Also concerning are the numbers of adolescent females with significant mental health, substance abuse and trauma histories.

Unfortunately, corrections can be a youth’s first mental health contact. Thus, we must triage, evaluate and treat these youth. While psychiatric services are provided in custody, continuity of care is ever more critical, enabling youth to receive necessary services upon release. Providing this continuity is a huge challenge due to many factors, such as a lack of family involvement or awareness, limited community access and lack of financial resources.

**JR: You are very interested in program evaluation and evidence-based practices. Tell us about that.**

**OT:** It’s challenging to maintain high quality care given high referral volume, complex clinical problems and systems-related issues. In our settings, mental health providers are involved from the initial intake and, during the youth’s stay, provide clinical intervention, engage guardians and plan for continuity of care upon release.

Given our critical role with youth, we need to know if our interventions are effective. Program evaluation activities enable psychologists to work on this question, making programmatic changes as indicated. While there’s evidence-based literature regarding diverse juvenile justice-involved populations, it’s important to figure out if these evidence-based practices, found effective for various youth across the country, are effective for our own patients. Juvenile justice populations vary and one evidence-based program does not “fit all.”

For example, let’s say that after a significant search you find a cognitive behavioral treatment curriculum that seems right for your adolescent male detainees. However, this curriculum has only been found effective for court-referred boys in distance residential treatment centers. In this situation, curriculum implementation, while working with trained program evaluators, could be an extremely worthwhile project.

While your “gut” said it could be a great curriculum for your patients, program evaluation will ascertain if this is true. Did the curriculum help your specific patients? Can it be revised to potentially improve outcomes? While program evaluation is not simple, it’s an excellent opportunity to measure program effectiveness and guide necessary changes, all to the patients’ benefit. It also helps us to manage precious resources.

**JR: You’re trained in motivational interviewing, a highly regarded, evidence-based intervention. Why is MI valuable?**

**OT:** We’re always challenged by patients who are not ready to make life changes, despite needing to do so. Ambivalence and resistance are common, and confronting or challenging resistant youth is usually ineffective.

MI is best known in the substance abuse treatment field. However, it’s also effective with court-involved youth. Its empathic, person-centered approach focuses on eliciting and strengthening a patient’s own verbalized motivations for change.

Here’s a brief example of how MI works. A detainee voices disinterest in altering his substance use. Hearing his statement, professionals can unwittingly reinforce resistance to change by stating, “You need to stop. It’s dangerous.” Fortunately, MI can reduce struggles by offering different ways of communicating, such as asking the youth, “Can you ever imagine—even in the future—cutting down?” Using this approach, a youth’s true motivation can be elicited. Instead, you might hear, “No way I’ll use if I have kids! My dad was alcoholic and violent.” Now, you have the start of a meaningful dialogue.

**For Further Reading**


Judith Robbins, LCSW, JD, CCHP-A, directs the Juvenile Detention Mental Health Program of Yale Behavioral Health, Department of Psychiatry, Yale Medical School, New Haven, CT. She represents the National Association of Social Workers on NCCHC’s board of directors and chairs the juvenile health committee.

Ohiana Torrealday, PhD, a clinical psychologist, is an administrator, Mental Health Services, University of Texas Medical Branch’s CorrectionalManaged Care.

We welcome your comments on this column or other juvenile correctional health topics. Please write to us at editor@ncchc.org or CorrectCare, c/o NCCHC, 1145 W. Diversey Pkwy, Chicago, IL 60614.
In the past year, a trend has emerged in NCCHC’s certification program: large groups of applicants from a single correctional system or contract services company. Among the first was Armor Correctional Health Services, Inc., which also recruited one of the largest applicant groups thus far. We talked with company officials to learn about this ambitious effort.

First, some background. A relatively young company, Armor was established in July 2004 in Florida to provide medical, dental and mental health services to jails and prisons. Today Armor employs 1,200 people and serves more than 20 facilities in Florida, Virginia and Oklahoma.

The physician-owned company prides itself on maintaining a high level of expertise among its health care staff. “Armor has been a strong advocate for staff education from the beginning,” says Kathy Harkis, RN, BS, CCHP, director of staff development. With more than 25 years of experience in correctional health care in five states, she has worked in numerous management capacities and well understands the importance of good training and the value of professional certification.

The management team shares her view. “Our CEO saw the benefit of additional training and thought of starting with management staff,” Harkis explains. “The next step was to offer certification to all employees, and the campaign began. The motivation was to achieve yet another level of training that would positively impact patient care and benefit the employee, as well.”

**All Aboard!**

“Once the idea was floated, it was eagerly endorsed by everyone,” says Don Morgan, CCHP, director of program development. “We recognize the CCHP as a sign of professional commitment for our staff and a measure of quality for our customers.” Morgan entered the correctional field in 2001 after more than 15 years of hospital and mental health administration experience in the community.

In early 2009, Harkis contacted NCCHC to arrange for a large number of CCHP applicants. She and Morgan were among the first group of Armor employees who took the exam at the Updates conference last April and officially became CCHPs in July. Ultimately, more than 100 employees applied, so NCCHC set up special testing dates in May and June. Future group exams are planned for this year.

Morgan lauds the positive feelings that the campaign generated: “I found the staff members to be enthusiastic and highly motivated to both learn and to pass the test. I also enjoyed the encouragement I received from them. The team spirit was impressive!”

**Well-Stated**

Harkis explains why becoming was certified was important to her: “I always knew it was important for professional growth as well as being a role model for staff, and now was the time. Maintaining certification assures that I will keep up with changes and trends in corrections and gives me a well-rounded perspective to share with others.”

For Morgan, the value is different, yet just as important: “I wanted to challenge myself to learn more of the basics and to secure a stronger relationship with my peers who are expert, clinical professionals. Since my background is management, not clinical, I can now bring better understanding to my work on a daily basis.”

But it’s not just the higher-ups who are pleased about their credential. Staff feedback has been highly favorable, Harkis reports. Not to be overlooked is the good will that came from the company’s generosity. Armor paid each applicant’s fees, and has committed to pay for annual recertification. The COO also sent a letter of congratulations to each CCHP, enclosing a certificate for dinner for two.

“Armor went above and beyond especially in today’s economy,” one staff member wrote. And from another, “Staff feel very proud to have the NCCHC certification and the knowledge that comes with it.”

**CCHP Exam Dates**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 25</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>July 11</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>August 21</td>
<td>Multiple regional sites</td>
</tr>
<tr>
<td>October 10</td>
<td>Las Vegas, NV</td>
</tr>
</tbody>
</table>

For more information about the application process or the exams, please visit www.ncchc.org/cchp.

We are seeking additional sites for the regional exams, as well as CCHPs to proctor the exams. If you would like to participate, contact the CCHP coordinator at 773-880-1460 or cchp@ncchc.org.
This department features news and information from NCCHC’s supporting organizations and other partners that share our goal of promoting quality health care in correctional institutions. If your organization has news to share, please contact editor@ncchc.org, 773-880-1460.

National Association of Social Workers
NASW has launched a new specialty practice section called Social Work and the Courts. It is meant for social workers who perform community safety or offender assessments; provide forensic evaluations, custody and guardianship recommendations, mediation or parent coordination, or expert testimony in civil or criminal matters; or work in the areas of corrections, law enforcement or probation/parole. Specialty practice sections offer NASW members opportunities for professional development specific to their area of practice. Learn more at www.socialworkers.org/sections.

Society of Correctional Physicians
Joseph Paris, MD, PhD, CCHP-A, is SCP’s new representative to the NCCHC board of directors. He replaces Ronald Shansky, MD, who retired from that position. Paris has a long and illustrious history in correctional health care. Today, after retiring as medical director for the Georgia Department of Corrections in 2005, he is in high demand as an independent consultant, although he continues some hands-on work at the DeKalb County (GA) Jail. Over the years he has provided expert opinion in some 130 cases of correctional litigation, both for the plaintiff and the defense. He also has a long history with NCCHC, as a physician surveyor, frequent conference speaker, writer for CorrectCare and the Journal of Correctional Health Care, CCHP trustee and other activities.

Patricia Reams, MD, CCHP
Pat Reams, MD, CCHP, received an “Outstanding Woman” award from the YWCA. The award recognizes those who positively impact the community through their commitment to eliminate racism, empower women and elevate children. Reams was honored for her many years of community service in the Greater Richmond (VA) area, including her work as a pediatrician at Cumberland Hospital, a rehabilitation hospital for patients ages 2 to 22. She also serves as medical director of the Fan Free Clinic, which provides medical treatment, health education, social services and advocacy for clients with limited access to care, and as a consultant for Access Now. She previously was chief physician for the Virginia Department of Youth and Family Services. As an NCCHC board member representing the American Academy of Pediatrics, Reams plays many important roles, among them, board secretary, surveyor, juvenile health committee member and others over the years.

Veterans Administration
The Veterans Administration has granted approval to include the exam fees for NCCHC’s new specialty certification for RNs in its licensing and certification benefit. Thus, veterans who are eligible for the GI bill or the Veterans Education Assistance Program may be reimbursed for a substantial part of the CCHP-RN exam fee. Visit the CCHP Page at www.ncchc.org for more information, or call the Department of Veterans Affairs at 888-442-4551 to speak with an education case manager.

At Wexford Health, we take our responsibilities seriously. That’s why we have been a trusted partner to more than 250 correctional facilities across the country, helping them to control costs without sacrificing quality of care, cutting corners, or inappropriately denying services. The pride we take in meeting your needs is plain to see.

412-937-8590
SALES@WEXFORDHEALTH.COM
MEDICAL
DENTAL
HEALTH
PHARMACY
STAFFING
EMR
UTILIZATION MANAGEMENT
CLAIMS PROCESSING
TELEMEDICINE

www.ncchc.org
Winter 2010 • CorrectCare
Correctional health care is a vast marketplace where $7 billion per year is spent to provide government-mandated health care to the 2.3 million individuals housed in the nation’s jails, prisons and juvenile facilities. Clearly, this sector provides a great opportunity for companies that offer products and services that can aid in the provision of quality care to inmate populations. How to reach the decision makers? NCCHC’s Updates conference.

1,000 health professionals will gather in this vibrant forum to receive timely and valuable information and instruction from experts in correctional and public health. They come seeking to augment their knowledge and skills and to improve health care in their organizations. We invite you to contribute to their experience. This multidisciplinary audience is comprised of the leaders and high-level staff who make and influence purchase decisions. When you connect with these influential professionals, you also reach the facilities, departments and staff they work with every day. Don’t miss this chance to develop valuable prospects and connect with customers during three days of exhibit hall activities.

- 77% of last year’s attendees visited the Updates exhibit hall at least three times
- 95% of attendees said they found the exhibit hall worthwhile
- 78% said they visit the exhibit hall to learn about products and services

Exhibitor Benefits

- 2 full conference registration passes per 10’ x 10’ booth
- Discounted registration for additional personnel (up to 5)
- 75-word listing in the final program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free listing in NCCHC’s online Buyers Guide
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Discounted advertising in the conference programs and CorrectCare
- Priority booth selection for the 2010 National Conference

Sponsorship Opportunities

Enhance your presence and maximize marketing dollars through these outstanding opportunities.

- Premier programming: Sponsorship of educational sessions on hot topics demonstrates support of the correctional field and gives your company high-profile exposure.
- Final proceedings: The CD-ROM provides a lasting record of concurrent sessions, with abstracts, handouts and PowerPoints. The sponsor is acknowledged on the cover.
- Internet Lounge: Enjoy a high-tech presence by sponsoring the exhibit hall computer stations, where attendees gather to check e-mail and browse the Web. Your company will be prominent on the home page.
- Exhibit Hall reception/luncheon/breaks: These events enable attendees to meet with exhibitors and network with colleagues while enjoying refreshments.
- Other opportunities: Conference bags, lanyards, water bottles, badges and banners are all good ways to boost visibility. Have an idea we haven’t mentioned? Let us know!

Registration Information

Updates is the perfect opportunity for you to define your role in this specialty field, so don’t delay. The meeting site is the Renaissance Hotel in downtown Nashville. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details or to reserve your space, please see the Exhibitor Prospectus, available online at www.ncchc.org, or contact the exhibits and sales manager at conference@ncchc.org or 773-880-1460.
MARKETPLACE

To order, or for an NCCHC catalog, visit www.ncchc.org or call 773-880-1460.

Standards Reference Sets
Our best-selling publications at substantial savings! Besides NCCHC Standards, these packages contain Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, an essential reference for every facility.

- NCCHC Reference Set—Save 25%
  Standards for Health Services manuals for jails, prisons and juvenile detention and confinement facilities, plus the Standards for Mental Health Services in Correctional Facilities and Correctional Health Care Guidelines. A $314.75 value, the discounted package is only $236.10.
- CCHP Study Package—Save 30%
  Standards for Health Services manuals for jails OR prisons (choose one) and for juvenile detention and confinement facilities, plus Correctional Health Care Guidelines. A $174.85 value, the discounted package is only $122.40.

Special Savings
10% discounts are offered for Academy members (single copies) and bulk purchases of a single title. (Excludes already-discounted items.)

New! Handbook of Correctional Mental Health, 2nd Ed.
Changing patient demographics and evolving treatment modalities make it essential that correctional health professionals have the most practical, up-to-date and comprehensive resource. This expanded edition is that resource. In 20 chapters, national experts address the most pressing issues facing clinicians, presenting the current standard of care through all phases of the criminal justice system. Topics include unique populations; legal requirements and minimizing risk; malingering; administrative aspects such as documentation, quality assurance and consent decrees; and five new chapters on clinical assessment and treatment. Useful tables and summary points appear throughout. Edited by Charles Scott, MD. American Psychiatric Association (2010). Soft cover, 646 pages, $77

New! Manual of Forms and Guidelines for Correctional Mental Health
This compendium of forms, guidelines and procedures focuses on practical applications and useful tools. Topics include principles of record keeping and informed consent, checklists for suicide prevention, screening tools for mental illness, cross-discipline communication, treatment planning, medication management, quality improvement, advances such as touch-screen computing, plus modifiable tools. Sample forms are written "incorrectly" and "correctly" to illustrate concepts. A CD-ROM has interactive versions of the forms. Edited by Amanda Ruiz, MD, CCHP, Joel Dvoskin, PhD, Charles Scott, MD, and Jeffrey Metzner, MD, CCHP-A. American Psychiatric Association (2010). Softcover, 256 pages, $115

ADVERTISER INDEX

NCCHC BUYERS GUIDE FOR CORRECTIONAL HEALTH CARE

If you source or purchase products for your department, you have a powerful tool at your fingertips. The NCCHC Buyers Guide search engine continually indexes the Web sites of all companies represented in the directory. You can easily locate products and services unique to this field using these options:
- keyword-driven search (like a traditional search engine)
- category-specific search

Both methods produce the most relevant results on the Web without the clutter of a general Internet search.

A downloadable application enables you to search from a small window on your desktop, making the process even more convenient and time-efficient. Using the Request for Proposal (RFP) tool, you can contact a group of suppliers with one click of a button.

www.ncchcbuyersguide.com

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

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

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

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

Expert Advice on NCCHC Standards

by Jennifer E. Kistler, MPH, and R. Scott Chavez, PhD, MPA, CCHP-A

Corrective Action Documentation
Q Our prison recently received its accreditation survey report, which states that we need to take corrective action. When we send documentation of that action to NCCHC, who must sign off on the document? The DOC’s chief medical director? Our facility medical director? The health services administrator? Does it matter that the latter two work for a contract services company?

A NCCHC accredits individual facilities, not systems, so the correspondence must come from the responsible health authority’s designee at the facility (standard A-02 Responsible Health Authority, Compliance Indicator 4). Usually this is the facility health services administrator. When materials are sent by contracted, system-level or regional providers, the facility-based designee must verify the documentation, usually by a cosignature. It doesn’t matter that the designee’s employer is a contractor.

Physician Staffing
Q We want to revise our health services staffing plan to improve efficiency. Our ADP is roughly 4,000. The jail standards give general guidance on how many hours our physicians must be on site, but how do we factor in time spent by physician assistants and by specialists?

A The Staffing standard (J-C-07) intends that prescribing clinician time must be sufficient to prevent unreasonable delay in patients receiving necessary care. Because of variability among inmate populations NCCHC does not mandate an exact clinician-to-patient ratio, but the general guideline is that the staffing plan includes at least one physician on site 3.5 hours per week for each 100 inmates, regardless of facility size. However, this number is not among the compliance indicators for accreditation. Where permitted by state law, midlevel providers (e.g., nurse practitioners and physician assistants) under the supervision of a physician can substitute for a portion of the physician’s time seeing patients. It is up to each facility to determine staffing based on its unique inmate needs and to provide justification if physician hours are less than we suggest, or if midlevel hours are used to cover part of the physician’s time. Finally, on-site time of specialists, including psychiatrists, does not count toward the basic primary provider time.

Paperwork From Off-Site Providers
Q When an inmate returns after a hospital visit, certain paperwork is supposed to accompany him back to the jail. According to standard J-D-05 Hospital and Specialty Care, Compliance Indicator 2, the written agreement with the hospital requires the hospital “to give the inmate a summary of the treatment given and any follow-up instructions...” Is it wise to let the inmate have these papers?

A The phrasing is not meant to imply that the inmate should literally take possession of the documents. Rather, such documents should be given to health staff. Our intent with this standard is to convey the importance of having the outside provider send this information at the same time that an inmate is returned to the facility so that it can be reviewed immediately by facility health staff (see also J-E-12 Continuity of Care, Compliance Indicator 3).

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. R. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. If you have a question about the NCCHC standards, please write to info@ncchc.org or call 773-880-1460.

For an archive of past Standards Q&A questions, visit www.ncchc.org and go to the Resources section.
At Spectra Diagnostics, we realize you deserve more than just test results from your clinical laboratory partner. That’s why we provide the focused, personalized support and flexibility you need to get the job done.

Count on Spectra Diagnostics for:

- Customer Liaison assigned to each facility for personalized, single-source support
- Reliable results and rapid turnaround times
- STAT testing services
- Extensive courier network
- Customized requisitions
- Access to results and reports via custom interfaces
- Comprehensive training tools

For more information, email us at spectra.diagnostics@fmc-na.com or call 888-726-9105
Busting Myths of Correctional Mental Health

All mental health treatment is the same

There's a big difference between simply dispensing medicine for inmates and providing specialized mental health programming.

MHM has developed more than 50 treatment modules for inmate groups of varying needs and cognitive abilities, including those restricted to their cells. Clients credit these programs for calmer segregation units. Our behavior management expertise also helps reduce problems and exorbitant off-site costs.

Our training curriculum for correctional officers and staff helps them understand and identify the signs of mental illness. Morale improves and turnover decreases as staff learn to better manage inmates.

How do we know what works? Clients tell us. Plus, we proactively audit every program and share plans for improvement.

It's a fact—for proven, powerful clinical programs, it's time to see the specialist. Contact MHM today.

MHM Services, Inc
800.416.3649
www.mhm-services.com