The Health Care Reform Law
What Does It Mean for Jails?

‘I Can’t Eat That!’
Sorting Out Food Allergy
Truth From Fiction

Position Statement:
Substance Use Disorder Treatment
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.
Welcome to Our New Director of Education!

NCCHC is pleased to welcome Angie Silberhorn, CMP, as our director of meetings and education. A Certified Meeting Professional, she joins our team with a strong background in planning events for high-profile organizations. When Angie entered this line of work 16 years ago, she started with the American Health Information Management Association (a supporting organization of NCCHC) and she later worked for the American Association of Neurological Surgeons as well as SmithBucklin, a large association management company. For the past three years she has been an independent meeting manager working with many clients, including the International Special Events Society, the World Society for Stereotactic and Functional Neurosurgery and the American Burn Association. Angie is an active member of the Professional Convention Management Association and serves as vice chair of its Greater Midwest Chapter’s program committee. She also is an adjunct faculty member teaching event management at a community college in suburban Chicago.

Since coming on board in early January, Angie has jumped right in, getting to know the education committee, working on programming for the Updates conference and becoming immersed in the accreditation process that enables NCCHC to provide professional continuing education credit.

“I’m excited to join the well-established team at NCCHC and look forward to contributing to the continued success and growth of our educational programs,” Angie says. Angie will make her conference debut May 21-24 at the Updates meeting in Phoenix. Be sure to say hello!

Save the Date for Summer Seminars in Vegas!

**Medical Director Boot Camp**
*July 8-9*

Designed by experts from the Society of Correctional Physicians, this event provides essential training that physician leaders won’t find anywhere else. The program features two tracks: one for those new to the role, one for seasoned professionals. With its collegial, intensive atmosphere, the Boot Camp will strengthen participants’ understanding of the core elements of medical direction of inmate health care and explore contemporary practices. CME is offered.

**Correctional Mental Health Seminar**
*July 10-11*

This intensive seminar brings together national leaders, innovative thinkers and inspiring speakers to help correctional health professionals and administrators address the challenges of providing adequate care to the growing population of inmates with mental illness and substance abuse problems. This sharply focused event features three tracks of concurrent sessions plus special networking events to enable participants to learn from each other. CE is offered.

Calendar of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 21-24</td>
<td>Updates in Correctional Health Care conference, Phoenix</td>
</tr>
<tr>
<td>May 22</td>
<td>CCHP exam, Phoenix</td>
</tr>
<tr>
<td>June 17</td>
<td>Accreditation committee meeting</td>
</tr>
<tr>
<td>July 8-9</td>
<td>Medical Director Boot Camp, Las Vegas</td>
</tr>
<tr>
<td>July 10</td>
<td>CCHP exam, Las Vegas</td>
</tr>
<tr>
<td>July 10-11</td>
<td>Correctional Mental Health Seminar, Las Vegas</td>
</tr>
<tr>
<td>Oct. 15-19</td>
<td>National Conference on Correctional Health Care, Baltimore</td>
</tr>
</tbody>
</table>

For the complete list of CCHP exams, including regional exam sites, see www.ncchc.org/cchp.

In Other News...

**Supporting Organization News**

The Foundation of Correctional Health Professionals’ partner organization National Specialty Underwriters will host another in a series of free, two-hour Webinars on May 4. The topic is Reducing Malpractice Risk Through Strong Communication Systems in Correctional Health Care. Through an Academy sponsorship, NSU Healthcare offers special medical malpractice insurance coverage with risk management resources for employers of correctional health professionals. The Webinar offers 1.0 contact hour of credit. Learn more about the insurance program and the Webinar by visiting the Foundation at www.correctionalhealth.org.

**Juvenile Statistics on the Way.** A new edition of the Standards for Health Services in Juvenile Detention and Confinement Facilities is now in production. Two years in the making and informed by input from the field, the revised manual is modeled after the 2008 Standards for adult facilities but takes into account the issues unique to juvenile settings and populations. The manual will make its debut at the Updates conference in May. Order online at www.ncchc.org. Also see the Standards Q&A column, page 28, for information about compliance deadlines for accredited facilities.
New STD Screening Guidelines for Corrections

by Jamie L. Miller, MPH

Screening and treating incarcerated young adults and adolescents in short-term facilities is an important intervention for reducing rates of sexually transmitted diseases, and their complications, in the community due to the sheer number of individuals with risk factors for STDs who pass through correctional facilities, often repeatedly.

Chlamydia and gonorrhea are the most common STDs, especially among adolescents and young adults. Adolescents and young adults entering short-term correctional facilities have high rates of these diseases. According to the Centers for Disease Control and Prevention’s 2009 STD surveillance report, among young women ages 12-18, 14.8% of those entering 83 juvenile facilities were positive for C. trachomatis and 3.9% of those entering 71 juvenile facilities were positive for N. gonorrhoeae. Among young men ages 12-18, 6.6% of those entering 123 juvenile facilities were positive for C. trachomatis and 1.0% of those entering 118 juvenile facilities were positive for N. gonorrhoeae. Prevalence data for adult women yielded 7.2% positivity for C. trachomatis (31 reporting facilities) and 1.6% positivity for N. gonorrhoeae (29 facilities). Positivity rates for adult males were lower: 6.6% for C. trachomatis (59 facilities) and 1.2% for N. gonorrhoeae (57 facilities).

While correctional health care guidelines and standards from NCCHC include diagnostic testing for STDs at medical assessment, they do not provide disease- or gender-specific screening and treatment recommendations. Instead, they require correctional providers to seek guidance from the local public health authority regarding the need for screening for specific STDs as the appropriateness of screening may depend on local community prevalence. Again, chlamydia is the most common STD and screening should be considered for specific age groups and genders. For gonorrhea and syphilis, seeking guidance from the local public health authority is appropriate.

Heightened Attention to Corrections

The CDC’s recently released 2010 Sexually Transmitted Diseases (STD) Treatment Guidelines has brought greater attention to the importance of screening in this high-risk population with the addition of recommendations for correctional facilities in the Special Populations section. These new guidelines call for routine STD screening of adolescent females in juvenile detention facilities and of young women in adult correctional facilities, enhancing previous recommendations for routine annual chlamydia screening and treatment of sexually active women up to 25 years of age in the general population. They also provide general guidance for syphilis screening.

Screening at intake ensures reaching the highest number of individuals, resulting in early identification of new cases. The rapid return of positive test results to the facility ensures the greatest success of treatment as high proportions of persons can be treated before their release into the community. For those who cannot be treated before release, ensuring effective referrals for treatment is essential.

Expanding STD screening and prevention programs to correctional settings provides opportunities to intervene with high-risk and hard-to-reach populations. Routine STD screening in short-term facilities with high turnover will have the greatest potential to reduce transmission of infections to the community through identification and treatment of previously undiagnosed cases. In addition, since a large proportion of those entering long-term facilities pass through jails, early identification of STDs through screening in short-term jail and juvenile detention facilities may reduce not only the long-term consequences of untreated STDs but also the prevalence within the long-term correctional populations.

There is ample evidence to support recommendations to screen all adolescent females for C. trachomatis and N. gonorrhoeae and to test adolescent males where rates are sufficiently high to support this intervention. Evidence also supports universal screening in young women in adult facilities and in young men where rates are sufficiently high. Testing young adults for syphilis in communities experiencing significant increases in reported early infectious syphilis, especially among women and heterosexual men, has also been shown to be effective.

Enhanced collaboration between correctional entities and their public health counterparts will maximize this public health opportunity. Both are encouraged to reach out to their partners at the local level to determine if the following activities may help to ensure STD testing and prevention services: educational programs, other prevention programs, testing/screening, case reporting, information/records, counseling, partner services/notification, outbreak investigations, treatment/prophylaxis and discharge planning.

It is unlikely that the United States will achieve the 2020 public health goals of lower rates of C. trachomatis, N. gonorrhoeae and early infectious syphilis without short-term correctional facilities’ implementation of these newly recommended screening guidelines. Racial and ethnic disparities in STD rates may also be affected.

Jamie L. Miller, MPH, is the Corrections, STD Specialty Clinics, and Substance Abuse Unit Manager, California Department of Public Health, STD Control Branch, Richmond, CA.

She is presenting on this topic at the Updates in Correctional Health Care conference, May 21-24 in Phoenix.
Preparing in Advance of Outbreaks

I want to thank the Bexar County Jail for sharing its mumps outbreak experience in the Fall 2010 issue of CorrectCare. Having been through several H1N1 outbreaks in 2009 and a few varicella outbreaks here in Maryland's juvenile detention centers, I can sympathize with the amount of work and resources that an outbreak demands.

Over a year ago, we implemented screening of every new admission for immunity to measles, mumps, rubella and varicella (MMRV) in order to know in advance who may be vulnerable or protected in case of an outbreak and to immunize those who were lacking immunity or vaccination records. The screening occurs as part of our admission blood work and is sent to our state department of health laboratory, with which we have an interagency agreement for laboratory services for HIV, syphilis, viral hepatitis, MMRV and urine gonorrhea and chlamydia testing. We are charged only the cost of the reagents for the MMRV testing. I feel much more confident and secure knowing that we have these immunity levels in advance of a potential outbreak, and the results have aided our immunization efforts to bring all of our juvenile detainees, who often lack vaccination records, up to date on their immunizations.

Fortunately, we are able to order vaccines, including the influenza vaccine, from the Vaccines for Children Program, which allows our agency to devote efforts to our immunization program without worrying about cost. Due to frequent readmissions for our population, our efforts to screen for MMRV immunity and to immunize for all recommended vaccinations pays off over time in helping to prevent the spread of infectious disease through our facilities and throughout the state. I highly recommend screening for MMRV upon admission and vaccinating for recommended immunizations whenever possible.

Jennifer Maehr, MD
Medical Director
Maryland Department of Juvenile Services, Baltimore

We welcome your comments. Send an e-mail to editor@ncchc.org, or write to Editor, c/o NCCHC, 1145 W. Diversey Pkwy., Chicago, IL 60614. Please include your full name and a phone number. Letters may be edited for clarity or length.

NCCHC Standards on Juvenile Immunization
A new edition of the Standards for Health Services in Juvenile Detention and Confinement Facilities is on the way. The recommendations regarding immunization have not changed from the current edition.

Y-B-01 Infection Control Program: The responsible health authority ensures that immunizations to prevent disease are provided when appropriate. [Compliance Indicator 2d]

Y-E-04 Health Assessment: The initial health assessment includes review of immunization history and update of schedules as needed. [Compliance Indicator 2c]

Y-E-11 Nursing Assessment Protocols: Standing orders are not used, with the exception of preventive medicine practices (e.g., immunizations) that are in keeping with current community practice. [Discussion section]
Correctional Medical Services will help you achieve significant savings by privatizing your statewide correctional healthcare system without compromising quality of care or medical outcomes. With a 32-year history of delivering healthcare programs tailored to the correctional environment, CMS is the leader in privatized correctional healthcare.

Discover an organization that:

- Takes full financial risk
- Manages your risks proactively
- Provides integrated service and single-source accountability
- Offers pharmacy services through PharmaCorr, our wholly-owned subsidiary pharmacy
- Recruits, trains and manages top medical professionals
- Delivers better health outcomes through aggressive care management
- Executes a seamless transition

“We are leading a new era in the delivery of correctional healthcare. CMS is a partner you can count on to deliver lower costs and better patient outcomes.”

Richard H. Miles, Chairman, CMS
Position Statement: Substance Use Disorder Treatment for Adults and Adolescents

Scientific advances in understanding the pathophysiology of substance use disorders and in developing effective treatments have progressed dramatically in the past several years. The justice system has not kept pace. Current policy has generated for drug and alcohol offenders a revolving door of arrest, incarceration, release to the streets untreated or undertreated, and then rearrest and return to incarceration, resulting in a costly, futile cycle.

The incarceration of substance use offenders has overwhelmed many correctional facilities and hampered efforts to provide adequate treatment. This mismatch between high treatment need and constrained resources to meet this need undermines efforts to address what is often the underlying cause of incarceration and one of the reasons why resources are strained in the first place.

This position statement addresses the need for treatment of substance use disorder in corrections facilities. It does not address the broader issue related to national drug policy.

**Position Statement**

NCCHC advocates the following principles for care of adults and adolescents with substance use disorders in correctional facilities; these principles reinforce and expand on principles articulated in NCCHC’s standards for health services.

1. Screening of detainees/inmates upon entry using valid instruments that are available from a variety of sources (e.g., National Institute on Drug Abuse; see also NCCHC standard E-02 Receiving Screening).

2. Assuring that correctional and health staff receive appropriate training in receiving screening.

3. Formal evaluation for substance use disorder and comorbidity, including concurrent mental health disorders, by qualified health professionals trained and experienced in managing comorbid disorders.

4. If ordered by a correctional physician, continuation of prescribed medications for substance use disorders.

5. Assessment of opioid and alcohol/sedative withdrawal using valid scales such as the Alcohol Withdrawal Assessment Scoring Guidelines and the Clinical Opiate Withdrawal Scale.

6. Evidence-based treatment such as cognitive-behavioral treatment and medication-assisted treatment of substance withdrawal.

7. Evidence-based behavioral and pharmacological treatment for substance use and mental health disorders.

8. Prerelease referral for, and coordination of, treatment for substance use and mental health disorders.

NCCHC recommends adopting the principles of drug abuse treatment for criminal justice populations promulgated by the National Institute on Drug Abuse (2007) and endorsed by the American Society of Addiction Medicine, including support for comprehensive reentry services designed to minimize relapse and recidivism.

NCCHC supports high-quality research regarding best practices related to treatment of substance use disorders in corrections. Although a substantial evidence base exists for such treatment, there is a high need for research to determine the best practices for provision of treatment in different types of correctional facilities. Such research is needed to inform optimal treatment type, intensity, timing, and post-release coordination for different populations (e.g., adolescents, those with chronic persistent mental illness, and those with different types of substance use disorders). Research should also address issues related to risk stratification and composition and training of substance use disorder teams.

*Adopted by the NCCHC board of directors October 2010.*
A receiving screening should take place for all inmates as soon as possible by qualified health care professionals or health-trained correctional officers. As we know from the E-02 standard, this is a two-step process.

The first step is medical clearance. This should happen as soon as the individual is admitted into the facility (it is often done in the sally port). A correctional officer can quickly inspect individuals to determine who may be too ill to wait for routine screening or be admitted, those identified to get immediate medical clearance are pulled from the group before admission. The medical clearance may come from on-site health staff or may require sending the individual to the hospital emergency room.

Medical clearance is conducted to ensure that emergent health needs are met. Particular attention should be paid to signs of trauma. Those arriving with signs of recent trauma should be referred immediately for observation and treatment. In addition, staff have a responsibility to report suspected abuse to the appropriate authorities. Remember, the medical clearance should be documented in writing.

**Structured Screening ASAP**

The second step is the actual screening. The receiving screening is a process of structured inquiry and observation designed to prevent newly arrived inmates who pose a threat to their own or others’ health or safety from being admitted to the facility’s general population. It is intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and currently on medications are identified for further assessment and continued treatment. It is conducted using a form and language fully understood by the inmate, who may not speak English or may have a physical (e.g., speech, hearing, sight) or mental disability.

What does “as soon as possible” mean? If a group of 80 detainees comes in, obviously they cannot all be screened simultaneously. Standard E-02 does not define a concrete time frame. However, the screening should be conducted promptly without delay. This means that it is not acceptable to wait to start the screening until correctional staff complete the admission process.

Ideally, the receiving screening is conducted within minutes of an inmate’s arrival; however, a good rule of thumb is that it should take place no more than two to four hours after admission. An individual may be medically cleared, but health staff still need to get an idea of inmates’ urgent health needs, identify and meet any known or easily identifiable needs that require medical intervention prior to the health assessment (see E-04 Initial Health Assessment), and identify and isolate inmates who may be contagious. For example, we do not want a person in need of insulin sitting in a holding cell for hours on end.

Prescribed medications are also reviewed and appropriately maintained according to the medication schedule that the inmate was following before admission (see Compliance Indicator 9 of standard E-02 and also see D-02 Medication Services).

An important concept here is that all inmates are to be screened. This means that all inmates are to receive all elements of the screening as described in the standard. This includes every inquiry and observation as outlined in Compliance Indicators 5a-k and 6a-f. It is not acceptable to conduct an abridged version as soon as possible with the remaining questions being asked several hours later or the next day. Another process that would not meet the intent of the standard is where inmates are asked some of the questions and only a “yes” to certain questions triggers a complete receiving screening. It is certainly acceptable to conduct more in-depth screening later, as long as the screen as described in the standard is being completed promptly.

The receiving screening inquiries include current and past illnesses, health conditions or special health requirements (e.g., dietary needs); history of or current suicidal ideation; past or current mental illness, including hospitalizations; allergies; legal and illegal drug use (including type, amount and time of last use); dental problems; drug withdrawal symptoms; current or recent pregnancy; past serious infectious disease; and recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats). Other health problems on the screening form should be designated by the responsible physician.

Observations include that of appearance (e.g., sweating, tremors, anxious, disheveled), behavior (e.g., disorderly, inappropriate, insensitive), state of consciousness (e.g., alert, responsive, lethargic), ease of movement (e.g., body deformities, gait), breathing (e.g., persistent cough, hyperventilation) and skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos and needle marks or other indications of drug abuse). It is good practice to train screeners not only to observe but also to ask additional questions. An example is when an individual does not have a rash visible to the screener. Asking questions will elicit the best possible screening.

Screeners should make adequate efforts to explore the potential for suicide. This includes both reviewing with an inmate any history of suicidal behavior and visually observing the inmate’s behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression or evidence of self-mutilation). Screeners should also investigate the potential for individuals to be exhibiting symptoms of withdrawal from alcohol and other drugs. These approaches, coupled with training in aspects of mental health and chemical dependency, enable staff to

*continued on page 8*
Intervene early to treat withdrawal and to prevent most suicides (see G-05 Suicide Prevention Program and G-06 Intoxication and Withdrawal).

**Training Tips**

The training given to correctional officers who conduct the receiving screening depends on the role they are expected to play in the process. At a minimum, they should receive instruction on how to take a medical history, how to make the required observations, how to determine the appropriate disposition of an inmate based on responses to questions and observations and how to document their findings on the receiving screening form. When health-trained correctional personnel perform the receiving screening, they are to call health staff for disposition of the inmate if problems are identified (Compliance Indicator 4). Because newly arrived inmates may need urgent medical assistance, correctional officers in the reception area should have current training in first aid and CPR.

Finally, it is important to train all of your screeners to record the disposition of the inmate (e.g., immediate referral to an appropriate health care service, place in general population) and the date and time of the screening with their signature and title (Compliance Indicators 7 and 8) on the receiving screening form. Timeliness of the receiving screening makes a great CQI process study.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation; Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee. Contact them at info@ncchc.org or 773-880-1460.

---

**Spotlight on the Standards**

The articles in this series shed light on the nuances of NCCHC’s Standards for Health Services, exploring the rationale behind various standards, the intended outcomes, compliance concerns, the impact on the accreditation process and more.

The complete series is available in the Resources section of the NCCHC website, along with an archive of Standards Q&A columns.

For more in-depth information about the standards, attend one of the preconference seminars at NCCHC’s annual spring and fall conferences. Learn more at the Education section of our website.

www.ncchc.org
The Patient Protection and Affordable Care Act, commonly known as “health care reform,” is now law in the United States. Although it faces legislative challenges and possible revision of its components, we have analyzed the law as it stands now to understand what implications it may have for correctional health care.

As it turns out, the impact could be fairly significant for jails and for the populations that pass through their doors.

Interpreting the Language

The general purpose of the ACA (the shorthand term for the law) is to improve access to health care. Some of its provisions have been widely reported—for example, access to insurance coverage for those with preexisting conditions, the creation of state health insurance exchanges and the expansion of Medicaid eligibility based on income. But, as with Medicaid in its current form, the new law excludes incarcerated people from receiving certain benefits.

Specifically, individuals are not eligible (“qualified”) to enroll in a health plan through a health benefit exchange “if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.”

Careful analysis suggests that pretrial detainees may be eligible to take part in state health plans, including Medicaid.

“Incarcerated” is not defined in the act, and unless federal guidance or regulations are issued to resolve this matter, there may be ambiguity when determining how a person’s incarcerated status affects eligibility to enroll in a health plan. At present, however, this language leaves open some promising possibilities for pretrial detainees.

Pretrial detention generally refers to being held before trial on criminal charges due to inability to post bail or denial of release—in other words, before “disposition of charges.” This suggests that hundreds of thousands of individuals held in jail each year as pretrial detainees may indeed be qualified to enroll in a health plan.

Also open to question—and favorable interpretation—is the eligibility status of individuals detained on probation or parole violations for whom disposition of charges is pending, and of those adjudicated guilty but released, including those released with a sentence of time served.

Finally, the restriction “at the time of enrollment” can be read to mean that if individuals are otherwise eligible to enroll in a health insurance exchange plan, they may do so as long as they are not incarcerated (however that is defined). But what happens if they later become incarcerated? Will they continue to be covered under the plan? Currently, in many states such coverage is generally terminated or suspended as soon as an enrollee becomes incarcerated pending conviction. This typically happens a few days or longer after the person has been detained. The Centers for Medicare and Medicaid Services encourages
suspension (rather than termination) of benefits for persons who are incarcerated pending disposition of charges.

As to how the ACA will affect Medicaid with regard to detainees, one element should prove beneficial to those with mental illness and/or substance abuse disorders. Such detainees are eligible for Medicaid under the law, which also requires states to streamline enrollment procedures in coordination with health benefit exchanges.

States also have the option under the ACA to offer presumptive eligibility to individuals based on income. Without going into detail here, eligibility and enrollment processes would differ depending on (a) whether or not the detainee is already enrolled in a plan, (b) income level and (c) incarceration status—pretrial, convicted and jailed, or convicted and released. (For hypothetical scenarios based on these variables, see the Resources list, COCHS health reform issue papers.)

Assessing the Impact
Assuming our interpretation of the ACA language is correct, the law will require expanded roles for jails or other agencies responsible for health care for individuals who are detained or incarcerated. These roles are outlined below, along with other important factors to note.

Expanded Access Through Enrollment
Pretrial detainees are unlikely to have enrolled for health care coverage through the means used by most people in the community (such as their employers). To expand access to care, the ACA directs the U.S. Department of Health and Human Services to develop enrollment standards and protocols to facilitate enrollment in federal and state programs. Such methods include notifying individuals and authorized third parties of eligibility and verifying eligibility within 180 days of passage of the bill.

The first expanded role of jail authorities will be to establish linkages with Medicaid, Medicare, health plans and other entities, such as insurance exchanges. The HHS protocols should provide correctional agencies with a conduit for streamlined exchange of data between state and community partners.

For those not currently enrolled with Medicaid or another health plan, the enrollment process must be timely and reliable. Agencies responsible for health care for pretrial detainees have a strong financial incentive to develop a seamless process (see Resources for incentive information). Once detainees are enrolled, these agencies will be eligible to recoup money spent for their health care. This income can be substantial to agencies burdened with high health care costs and tight budgets.

Communication of Health Information
The second expanded role for jails is to provide continuity and coordination of care into and out of custody through an electronic health record system. Again, the ACA provides incentives for this. An EHR can facilitate health care transitions, saving countless hours of staff time and contributing to patient safety. It also can offset the costs of some of the expanded roles for jails by reducing medical record staffing requirements. As in any health care encounter, it is critical that health information be kept private and confidential, as required by law. Consent must be obtained to share such information.

Claims
If the jail bills on a fee-for-service basis, its third expanded role will be to develop and implement a billing and accounting system. Claims and health care staff will have to be familiar with the utilization management programs of the entitlement or insuring entity providing coverage. Collaboration with Federally Qualified Health Centers would facilitate this process.

Standards of Care
As payment for inmate health care gets redesigned, it is important for policy makers and public authorities to meet the constitutional standard of care. As care behind bars becomes better integrated with care in the community, health status can be expected to improve. Correctional systems should get guidance from standards such as those published by the National Commission on Correctional Health Care, the American Public Health Association, the American Bar Association and the United Nations.

Oversight
To achieve optimum health status and cost containment, a successful correctional health care program will have independent oversight and self-critical quality management programs. For example, a jail would arrange for periodic assessment of timely access to appropriate medical care by an independent reviewer, who would validate the self-critical quality management program and advise on improvements.

Throughcare
It is as important to have access to the individual’s health care information at booking as it is to provide treatment planning and continuity of care on release.

Adequate staffing and training are essential for program success. The discharge planning program should be written out for staff and incorporated into any contracts for care with third-party providers. Discharge planning begins during the initial risk assessment process. (See Resources for information about the discharge planning process.)

Once the basic elements of the discharge planning process have been implemented, correctional agencies can expand their programs with options such as case management, groups to provide life skills and reentry education for patients with special needs, liaison with probation and parole agencies, staff training on building community linkages, and evaluation using valid and reliable performance measures.

Provider Networks and Payment
Physicians and other licensed independent health care practitioners who work behind bars are often isolated from their community peers. This isolation is a barrier to

continued on page 12
strong collegial relationships, although it is less of a problem in small facilities where the physician is only part-time. Physicians who affiliate with a network will have greater access to diagnostics and specialty care, as well as billing services. The ACA provides an option for affiliation through "accountable care organizations." There is a potential financial advantage to affiliation with an ACO. Although they do not take risk and billing can be fee-for-service, ACOs that spend less than the anticipated amount for their patients will receive 80% of the savings. These savings can be shared by the practitioners or invested in enhanced patient care. The high morbidity of jail populations is not necessarily a barrier to achieving savings as the anticipated spending will be risk-adjusted.

**Conclusion**

While at first impression the ACA appears to unduly restrict access to health services for millions of individuals who are incarcerated, a more careful analysis suggests that many who are detained pending the disposition of criminal charges and not yet sentenced may still benefit by being eligible to participate in state health plans, including state Medicaid plans for which eligibility generally is expanded under the new law.

Moreover, state agencies and other organizations that provide eligibility and enrollment services to prospective and current beneficiary populations are now given the opportunity to pursue grant support and other resources with which to improve their outreach to beneficiary populations. Such support may be tapped by correctional and other agencies to mainstream pre-trial detainees and released prisoners into community health networks so that needed health services, particularly mental health and substance abuse services, can be arranged.

Importantly, given the past record of Medicaid restrictions, we must remain vigilant about implementation of ACA provisions by federal and state regulatory agencies to ensure that pretrial detainees retain their eligibility to participate in the health-related benefits provided under the new law. Assuring that pretrial detainees, as well as inmates, will have access to needed health services requires that all who are interested in promoting public health among incarcerated populations be prepared to assume an active role in the administrative and regulatory process of ACA implementation.

There are serious barriers to improving health services in prisons and jails, even after effective health care coverage is established for pretrial detainees (and perhaps sentenced prisoners) through health care reform. These include insufficient executive-level champions, data resources, continuity of care, public health programs, communication of cost-effectiveness and community receptivity, as well as internal barriers (attitudes, policies and practices) and myriad political barriers. Even so, these barriers can be addressed through capable leadership, community involvement and innovative planning and implementation.

Patricia Blair, PhD, LLM, MSN, is a health law attorney based in Texas and an adjunct associate professor in the College of Nursing and Health Sciences, University of Texas at Tyler. She represents the American Bar Association on NCCHC's board of directors. Contact her at pblair@pblairlawfirm.com.

Robert B. Greifinger, MD, is an independent correctional health care consultant as well as an adjunct professor of health and criminal justice and a distinguished research fellow at John Jay College of Criminal Justice, City University of New York.

This article is based on an issue paper written by the two authors and T. Howard Stone, JD, LLM, on behalf of the ABAs Criminal Justice Section. It was developed for a health reform conference hosted by Community Oriented Correctional Health Services (COCHS), a nonprofit organization established to build partnerships between jails and community health care providers.

---

**Resources**

- COCHS health reform conference webcast and issue papers: See www.cochs.org/health_reform_conference
- Electronic health records incentive programs: See www.cms.gov/EHRIncentivePrograms

---

**crimspace**

the criminology and criminal justice network

**www.crimspace.com**

**Read • Comment • Post • Listen • Share**

- Read journal articles and book chapters
- Post a reading list, podcast or video
- Create or join a group
- Trade teaching resources
- Search jobs and events
- Start a discussion
- Connect with colleagues

brought to you by SAGE
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.**

---

**Medi-Dose, Inc.**

**EPS, Inc.**

**Responding to pharmacy packaging needs around the world**

---

Milton Building, 70 Industrial Drive
Ivyland, PA 18974
800-523-8966, Fax: 800-323-8966
215-396-8600, Fax: 215-396-6662
www.medidose.com
E-mail: info@medidose.com
‘I Can’t Eat That!’ Sorting Out Food Allergy Truth From Fiction

by Jeffrey E. Keller, MD, FACEP

In my previous incarnation as an emergency physician (before I discovered "The Way" of correctional medicine), I saw a lot of cases of acute allergic reactions. It is a very common emergency complaint; I have probably seen hundreds in my career. But when I began my jail medicine career, I was still unprepared for the sheer volume of food allergies claimed by inmates. Who knew so many inmates had so many food allergies?

Of course, most of them don’t. Most just don’t want to eat something on the jail menu. Inmates believe that if they claim an allergy to a food they dislike, you cannot serve it to them. They will claim allergies to tomatoes, onions, mayo, etc., when really, they just don’t like these foods. Tuna casserole doesn’t seem very popular, for some reason.

However, some inmates truly are allergic to some foods and we can potentially harm them by ignoring their complaint. How do we correctional medical staff sort out the truly allergic from the “I don’t like it” crowd? It is an important question because we certainly don’t want anyone in our care to have a sudden anaphylactic reaction!

To answer this question, we need to understand the mechanism of food allergies, the overall incidence of food allergies as well as the incidence of death, how to accurately diagnose a true food allergy and what steps to take once we find one. All of this is important to make accurate risk assessments.

Understanding Food Allergies

The incidence and causes of food allergies vary markedly with age. For the most part, food allergies are a problem of childhood. In children, the most common food allergies are milk, eggs, wheat and nuts. However, most of these allergies abate with time. So a child who is allergic to eggs most likely will be able to eat eggs as an adult. One important exception to this rule is peanuts and tree nuts (like almonds, cashews, etc.). Those allergies tend to persist into adulthood. The most common adult food allergies are peanuts, tree nuts, shellfish and fish.

True food allergies come in two types. The first is called IgE-mediated allergic reactions because the IgE antibody is essential to the reaction. The second type of allergic reactions does not involve IgE and so, of course, is called non-IgE mediated food allergies. The best example of this is celiac disease, in which patients are allergic to gluten found in grains. Non-IgE-mediated allergic reactions are typically indolent and chronic and may not be discovered for several years.

IgE is an antibody that is created by the body to react to a specific antigen substance. This substance can be ragweed pollen, of course, but it also can be food proteins. Later on, if the person eats the same food that triggered the creation of IgE, the protein locks onto the IgE, causing the release of inflammatory chemicals such as histamine, cytokinins, prostaglandins and leukotrienes.

The most common symptom caused by these inflammatory chemicals is hives, the itchy splotchy rash we have all seen. The second most common symptom is angioedema, which is swelling of the face. Angioedema most commonly occurs around the eyes but also rarely can cause the tongue to swell. Third and less frequently, the allergic reaction can cause bronchospasm in the lungs, so the patient wheezes as if having an asthma attack. Finally, the patient can suffer anaphylaxis, which consists of acute vasodilation leading to hypotension, shock and possibly death.

All of these allergic symptoms occur within minutes of eating. Allergic hives that occur several hours after eating are probably not due to the food.

Of these four allergic symptoms, by far the most common are hives and angioedema. However, most of the time hives and angioedema are nuisances rather than life-threatening emergencies. On the other hand, anaphylaxis is an acute medical emergency. Anaphylaxis is the allergic reaction we should fear the most and work to prevent.

The Centers for Disease Control and Prevention estimates that approximately 100 deaths from food allergies occur in the United States each year. Almost all of the reported deaths occurred in teenagers or young adults who knew that they were allergic to the food they ate. By far, the most common culprit foods are peanuts and tree nuts (85%), with shellfish coming in second. In contrast, 400 deaths due to allergic reactions to penicillin occur every year, and most of those occur in people who have no idea that they are allergic.

Risk Assessment Tips

You can use these principles to do a risk assessment for individual patients. Patients at higher risk of an anaphylactic allergic reaction are those who are younger (late teens, early 20s) who state an allergy to peanuts, tree nuts or shellfish and who have had a previous documented allergic reaction. Patients with a lower risk are older patients who state an allergy to a low-risk food (say, onions or peppers) and cannot document a previous severe allergic reaction. Someone who has had a severe allergic reaction to a food in the past should be able to tell you about an emergency room visit, allergy testing, EpiPen prescriptions and how they avoid the food in restaurants and while shopping.
However, there are other tests that can help you sort out the confusing cases. The first is a CAP RAST test. This is a blood test that measures the levels of IgE to a certain specific allergen, say peanuts. We then draw blood for a CAP RAST for peanuts. A positive result is peanut-specific IgE of greater than 2.0 Ku/L. If the test comes back at, say, 0.35 Ku/L, then the patient is not allergic. The test is quite sensitive but not specific. That means that you can believe a negative result, but patients with positive results might still not be allergic. The main problem with a CAP RAST test is that it is expensive—around $45. However, that is probably less expensive than the cost in time and energy to put out a special diet.

A second test is the skin prick test. The patient’s skin is pricked with a small instrument and a drop of allergen extract is placed on the site. If a patient is truly allergic, she will form an itchy wheal at the site within 5 to 15 minutes. The advantage of this test is that it is cheap and easy to do and the results are immediate. The disadvantage is that you have to order and store the extracts and be trained in the procedure, usually by an allergist.

“Food challenge” tests probably should not be done in a correctional setting. This is where you simply feed the food to the patient and wait to see what happens. If this is done in a double-blinded fashion it is the most accurate test of all. Sometimes patients will have done their own food challenge without knowing it. For example, a patient might say he is allergic to eggs but admits to eating pasta and mayonnaise, both of which are made with eggs. He is likely not truly allergic.

Setting Policies

Of course, the easiest way to deal with the foods most likely to cause severe allergic reactions is not to serve them at all. Most jails do not serve shellfish to inmates. (If your jail does, write to me; I would like to know about it!) If your facility uses tree nuts in cookies, consider eliminating them from the menu. Then you won’t have to worry about it. That just leaves peanuts as the food served in most prisons and jails that has the greatest potential to cause allergic reactions.

Once you have discovered that a patient has a positive CAP RAST test to peanuts, what should you do? It may not be enough to simply order a peanut-free diet. Since allergic reactions can be triggered by even a small amount of allergen contact, you should consider these other factors:

1. You probably have peanut-containing items on your commissary. Should this inmate have a commissary restriction?
2. Should this inmate be allowed to work in the kitchen, preparing peanut butter sandwiches?
3. Should this inmate be housed with other inmates who may be eating peanut butter sandwiches right next to him?
4. What about an Epi-Pen? Where should it be kept?

I hope this information will make you a little more confident the next time an inmate says she is allergic to, say, “all vegetables” (as one patient told me once). You can also use these principles of risk assessment, history and testing to write a policy and procedure for the clinical assessment of food allergies. If you need help, e-mail me and I will send you mine.

Jeffrey Keller, MD, FACEP, is the president of Badger Correctional Medicine, Idaho Falls, ID. Contact him at jkeller@badgermedicine.com.

Food Allergy Essentials

1. Allergies tend to occur in childhood and abate with time.
2. If you were allergic to something as a child, most likely you will not be allergic as an adult.
3. The important exceptions to this is peanuts, tree nuts and shellfish. These allergies commonly do persist into adulthood.
4. The older you are, the less likely you are to have a severe anaphylactic reaction.
5. The food allergens most likely to produce anaphylaxis are peanuts, tree nuts and shellfish.
6. In most deaths due to an acute allergic reaction to food, the person had a previous severe allergic reaction.
Correctional Nursing Practice: What You Need to Know (Part 5)

NCCHC’s Certified Correctional Health Professional program offers specialty certification for RNs. The CCHP-RN certification is the formal recognition of the specialized knowledge, skills and experience deemed specific to the practice of nursing in a correctional setting. Whereas nursing licensure establishes legal authority for an individual to practice nursing, specialty certification reflects achievement of the special knowledge and skills needed for a particular practice area.

This column, written by members of the CCHP-RN task force, discusses various areas of correctional nursing practice covered in the CCHP-RN exam outline. This will assist nurses preparing to take the exam as well as explain the key concepts of the specialty for the novice correctional nurse. Learn more about the CCHP-RN program at www.ncchc.org/cchprn, where you can also view the entire test outline (see downloads).

Ethical and Legal Issues

In the correctional setting, the patient is at the core of professional nursing practice. The fact that the patient is incarcerated is only a circumstance of his or her situation and does not, and should not, change how the nurse practices or how the nurse views the patient. Correctional nursing allows the nurse to practice the essence of nursing while recognizing that all patients have intrinsic value. Achieving and staying true to professional nursing values while practicing in the correctional setting can create a unique set of ethical, legal and professional issues for the nurse. This article will examine some of the ethical and legal issues correctional nurses must address in their practice.

Ethical Concerns

For the nurse in a traditional medical setting, ethical decisions occur occasionally and at times the nurse may face ethical dilemmas. In contrast, the correctional nurse may face ethical situations daily. The correctional nurse makes ethical decisions about care delivery, caring and patient advocacy in planning and providing safe patient care.

There are six ethical principles that arise frequently for the nurse who works in the correctional setting.

1. Respect for persons (autonomy and self-determination)
2. Beneficence (doing good)
3. Nonmaleficence (avoiding harm)
4. Justice (fairness, equitability, truthfulness)
5. Veracity (telling the truth)
6. Fidelity (remaining faithful to one’s commitment)

These principles serve as a guide to the nurse in making ethical decisions. The correctional nurse can find support for ethical decisions by referring to the American Nurses Association’s code of ethics. The code delineates the ethical standards for nurses across all settings, levels and roles, setting expectations as well as providing guidance.

One of the common ethical concerns that arises for the correctional nurse relates to demonstrating caring in a custody environment. Correctional nurses must find balance in displaying an attitude of care and compassion while recognizing and maintaining safe boundaries.

Another area of ethical concern is the nurse’s responsibility for ensuring that patients have access to care. The values associated with nursing practice include nurse advocacy, respect for humans and eliminating barriers to care. The correctional nurse is in a unique position to evaluate the quality and effectiveness of patient care. He or she works with custody to ensure that the health needs of inmates are respected and responded to in a timely manner.

End-of-life care is another ethical concern for the correctional nurse. Patients die while incarcerated and the nurse has a role in helping the patient to die with dignity and comfort. In some prisons, nurse participation in execution may arise as an ethical issue. The correctional nurse should not participate in executions. This position is supported by the ANA’s code of ethics and NCCHC’s Standards for Health Services in Prisons (standard P-I-07). Participation in execution is inconsistent with nursing values.

Finally, professional practice is an area that can create ethical concerns for correctional nurses. Nurses are encouraged to refer to the ANA’s scope and standards of practice for correction nursing and to their state’s nurse practice act in addressing practice issues.

[Editor’s note: Both ANA books are available in the Publications catalog at www.ncchc.org.]

Legal Issues

The legal implications of nursing practice are tied to licensure, state and federal laws, scope of practice and a public expectation that nurses practice at a high professional standard. The nurse’s education, license and nursing standards provide the framework by which nurses are expected to practice. When a nurse’s practice falls below acceptable standards of care and competence, this exposes the nurse to litigation.

The basis for litigation can relate to negligence, failing to exercise the level of care that a reasonable, prudent nurse would under similar circumstances; malpractice; and professional negligence, which means an act of neglect committed in the nurse’s professional role. Acts of omission and commission will also subject the nurse to litigation and professional license review. Both litigation and professional license review can result in reprimand of a nurse’s license or loss of a license.
Correctional nurses can be especially vulnerable to litigation because the correctional patient population has a constitutional right to health care. Compounding this, inmate-patients encounter nurses more than any other type of health care provider. Failure to provide inmates with access to health care to meet their serious medical needs can be litigated under the Eighth Amendment as deliberate indifference or under the 14th Amendment as a civil rights violation.

Inmates have several ways to access health care, such as by submitting a request slip or form. Another way is through oral communication, for example, by telling a correctional officer of a need to be seen by medical, or mentioning a health concern to the nurse during medication administration.

Regardless of the method, the nurse has a legal and ethical obligation to respond to the request for care. In general, the nurse should see the patient to evaluate health needs and determine the level of care required. If the communication is from the officer to the nurse, the nurse has a responsibility to speak to the inmate. A face-to-face discussion would be best, but the nurse could also first speak with the inmate by phone, making sure to ask the right questions, and then determining if the inmate should be moved to the medical unit or if the nurse should go to the inmate’s housing area.

Based on the information provided, the nurse must determine the type and level of nursing intervention required, and then implement an action. The nurse may determine that the patients’ health needs can be managed within his or her scope of practice, or determine that a higher level of care is needed and refer the patient to a mid-level provider or physician, or refer for transfer to a health facility that can provide the care that is needed. It is always appropriate for the nurse to follow up to evaluate the inmate’s response to the intervention.

However the nurse is apprised of an inmate’s health needs, the nurse must document the health needs, how notification of the health need occurred, actions taken and the patient outcome.

Great Opportunity
Nurses practicing in the correctional health specialty face many challenges; despite the challenges, correctional nurses have a great opportunity to contribute in positive ways to improve the health of this vulnerable population and to have a larger impact on the greater public health.

Mary V. Muse, MS, RN, CCHP-A, CCHP-RN

Mary V. Muse, MS, RN, CCHP-A, CCHP-RN, is the chief nursing officer for the Wisconsin Department of Corrections, Madison. This column is coordinated by Lorry Schoenly, PhD, RN, CCHP-RN, an independent consultant specializing in correctional health care and social media; she is based in Pennsylvania. Both are members of the CCHP-RN task force. For correspondence about this column, write to editor@ncchc.org.
New treatment modalities, updated practice recommendations, evolving standards of care, shifts in patient presentation trends, ever-changing laws and regulations, innovative cost containment — there’s a lot going on in the complex work of correctional health care and it can be a challenge to keep up. Updates 2011 is designed to shed light on many of the emerging issues that affect our work and to propose strategies for managing them. A broad array of well-crafted presentations will share information, insights and solutions for these and other timely topics.

Phoenix Fun

Things are different in the desert. The sky is bigger. The stars are brighter. The sunsets stop you in your tracks. Projected against this rich backdrop is a panorama of urban sophistication that is Phoenix, America’s fifth largest city and its sunniest metropolis.

What to do? Sports fans can see the Phoenix Suns, Mercury or Diamondbacks, or visit one of the many golf courses. Downtown, art lovers will enjoy the Herberger Theatre (from off-Broadway to Ballet Arizona), Orpheum Theatre and Symphony Hall. Take the Metro Light Rail a few stops north to the Phoenix Art Museum and Heard Museum. Or splurge at stylish and eclectic shopping centers.

Conference Site

The all-new Sheraton at Phoenix Civic Plaza downtown is surrounded by great dining, shopping and nightlife. The 31-story hotel redefines the skyline with its cloudlike rooftop that turns translucent at night. This chic style is also reflected within the hotel, with restaurants that boast stunning city views, a large outdoor pool and a fitness center. The spacious guest rooms offer the latest in creature comforts.

Early-Bird Discount

Register by April 8 to save on the full conference registration fee. You’ll also be entered into a drawing to win a two night stay at the Sheraton. For more details about the conference or to register, visit www.ncchc.org.

Continuing Education Credit

Up to 25 hours of CE credit is available in five categories (includes attendance at weekend seminars). See the conference program or website for details.

- Certified Correctional Health Professionals: Category 1 credit for CCHP recertification
- Nurses: Contact hours provided by NCCHC, as approved by the Illinois Nurses Association
- Physicians: AMA PRA Category 1 Credits™ provided by NCCHC
- Psychologists: CE provided by NCCHC, as approved by the American Psychological Association
- Social Workers: Contact hours provided by the National Association of Social Workers

Phoenix Fun

Things are different in the desert. The sky is bigger. The stars are brighter. The sunsets stop you in your tracks. Projected against this rich backdrop is a panorama of urban sophistication that is Phoenix, America’s fifth largest city and its sunniest metropolis.

What to do? Sports fans can see the Phoenix Suns, Mercury or Diamondbacks, or visit one of the many golf courses. Downtown, art lovers will enjoy the Herberger Theatre (from off-Broadway to Ballet Arizona), Orpheum Theatre and Symphony Hall. Take the Metro Light Rail a few stops north to the Phoenix Art Museum and Heard Museum. Or splurge at stylish and eclectic shopping centers.

Conference Site

The all-new Sheraton at Phoenix Civic Plaza downtown is surrounded by great dining, shopping and nightlife. The 31-story hotel redefines the skyline with its cloudlike rooftop that turns translucent at night. This chic style is also reflected within the hotel, with restaurants that boast stunning city views, a large outdoor pool and a fitness center. The spacious guest rooms offer the latest in creature comforts.

EMPOWER YOUR NURSES
Nurses know more and do more with powerful online reference tools from a trusted source of point-of-care, evidence-based resources.

LIPPINCOTT’S NURSING PROCEDURES AND SKILLS
Improve and standardize care with over 1,050 evidence-based procedures.

LIPPINCOTT’S NURSING ADVISOR
Online clinical support for nurses.

Convenient & Authoritative
• Online
• Evidence-Based
• Up-to-Date

Effective & Valuable
• Improve patient care quality and safety
• Build staff competency and confidence
• Reduce errors
• Optimize time management
• Evaluate and train staff

tel. 800.326.1685
e-mail LWWSolutions@wolterskluwer.com
www.LWWNursingSolutions.com
CDCR Study Yields ‘Starter Set’ of Prison Health Care Quality Measures

The California prison health care system has received a lot of attention in the past several years and produced shock waves when it was put into federal receivership in 2005. But as the receiver’s turnaround plan has progressed, the reports are increasingly positive, showing steadfast commitment to improvement and measurable goals for achieving it. For instance, the five-year strategic plan issued last summer sets a goal of bringing 90% of the prison system’s health care programs into compliance with NCCHC standards for health services.

Another significant initiative is described in the April 2011 issue of the Journal of Correctional Health Care. In a special three-part section, a team of researchers from the RAND Corporation highlight a project conducted at the request of the California Department of Corrections and Rehabilitation to help it establish a sustainable quality measurement program that will aid with ongoing accountability and quality improvement efforts.

In this project, which took place during 2008 and 2009, RAND was charged with three tasks:
1. Assess the current clinical quality measurement approaches in CDCR
2. Survey the clinical quality measurement approaches being used by leading state prison systems and the Federal Bureau of Prisons
3. Recommend access and clinical quality measures to form the basis of a “starter set” of performance measures

The first article examines the current state of access to care and quality measurement in the CDCR, as well as assessing strengths and weaknesses of current activities. This entailed conducting interviews and site visits in the CDCR and related offices, along with document reviews. Key findings were that although the CDCR’s quality efforts do focus on pertinent issues—defined in this study as clinical effectiveness, timeliness (access) and patient centeredness—few explicit, evidence-based quality of care measures are being used. Instead, many of the current measures represent policies and procedures with vague specifications that are hard to apply uniformly and are not evidence-based.

The second task was to identify existing indicators of quality performance and to recommend a set of indicators applicable to the California prison population. The study took an environmental scan of quality measures used by the BOP and five state correctional systems, and examined what dimensions (such as clinical quality, patient experience, access to care and patient safety) and clinical areas are the focus. Barriers and facilitators to quality measurement are also explored in this article. Findings revealed substantial variation in the number and type of measures being used and in the data systems used to construct measures. The various systems all included explicit quality measures but also measures of disease prevalence and standards.

Finally, the researchers identified tested indicators of clinical quality and access that prisons could use to identify performance gaps and guide improvement. A modified Delphi method was used to select the best indicators, which an expert panel then rated on validity and feasibility. The final 79 indicators (listed in an appendix) pertain to areas such as access, cardiac conditions, geriatrics, infectious diseases, medication monitoring, metabolic diseases, obstetrics/gynecology, screening/prevention, psychiatric disorders/substance abuse, pulmonary conditions and urgent conditions. With their explicit, well-defined denominators and numerators, this list provides a basic library of quality measures.
Opportunities available:

HEALTH SERVICES ADMINISTRATORS (RNs)
REGISTERED NURSES
PHYSICIANS (Full-Time and Part-Time)
MEDICAL SERVICES DIRECTORS
NURSE PRACTITIONERS

GEO expanded operations following a recent merger with Cornell Companies and now owns and manages 119 correctional, detention and residential treatment facilities with 81,000 offender and residential treatment beds worldwide, including North America, Australia, South Africa, and the United Kingdom. Learn more about where we are growing since our recent merger with Cornell Companies!

For A World of Opportunities, Visit:

JOBS.GEOGROUP.COM

For more information, contact:
Nichole Adamson, Manager, National Recruitment, Toll Free: 866-301-4436, Ext. 7537
Fax: 561-443-3839 • Email: nadamson@geogroup.com

Equal Opportunity Employer • All candidates must be able to pass background investigation, drug screen, and medical evaluation.
CMS and PHS Announce Plans to Merge

CorrectCare doesn’t usually cover the business side of the correctional health field, but this news is likely to have far-reaching impact on more than 400 correctional facilities and the thousands of health professionals who provide care in them. On March 3, the parent companies of Correctional Medical Services and PHS Correctional Healthcare announced the signing of an agreement and plan of merger under which the two companies would be combined. According to a press release, CMS’ parent company, Valitás Health Services, Inc., will acquire PHS’ parent company, America Service Group, Inc., for approximately $250 million ($26 per share). Although the transaction has to clear the usual hurdles before it is finalized, the merger agreement was unanimously approved by the boards of directors of both companies and is expected to close in the second quarter of 2011.

Composed of two of the oldest and largest correctional health care contractors, the combined company will have some 11,000 employees and independent contractors and will serve more than 400 facilities. Annual revenues are expected to total approximately $1.4 billion for 2011.

The companies’ chief executives proclaimed the benefits of the merger. Rich Hallworth, America Service Group’s president and CEO, said it will “...bring together the best people in our industry to serve our clients and patients and provides the best value to states and counties seeking to wisely use taxpayer dollars by privatizing their correctional health care facilities. The new company will have enhanced scale, broad service offerings, industry leading clinical approaches and growth opportunities for our employees.” He added an assurance to clients that the merger will cause no disruption in services and that “We do not anticipate making changes to these personnel or direct support staff members as we ensure continuity of services and care.”

The operational headquarters for the new company will be in St. Louis, MO, and the corporate headquarters will be in Brentwood, TN.

Source: eon.businesswire.com/news/eon/20110303005963/en/correctional-m

Reduced Need for Drug Abuse Treatment Behind Bars?

A trend noted in a recent Wall Street Journal article could reduce the need for substance abuse treatment services in correctional facilities. In short, a growing number of states are concluding that it’s more effective and less expensive to reduce penalties for drug offenders and to increase treatment programs. On March 3, Kentucky joined the ranks of states with such laws, and similar bills are pending in Delaware, Florida, Indiana, Massachusetts and Pennsylvania. Drug arrests nationwide rose from about 580,000 in 1980 to about 1.6 million in 2009, according to the FBI.

Source: online.wsj.com/article/SB10001424052748704728004576176514208186374.html?mod=googlenews-wsj

Florida Prisons to Go Smoke-Free

The new head of Florida’s Department of Corrections has announced that the state’s prisons will ban tobacco in six months. Edwin Buss said the move should cut health care costs, noting that inmate hospitalizations for tobacco-related illnesses cost nearly $9 million in the past year. The prisons will offer smoking cessation assistance to inmates, and will provide outdoors smoking areas for employees.

Source: www.wtvrc.com/home/headlines/New_Florida_prison_chief_bans_tobacco_in_6_months_117938689.html
Special Housing Unit Smooths Reentry

by Michele Maynard and Vickie Alston, MSW, LCSW, QICSW

Part of Connecticut’s Department of Correction, Manson Youth Institution is a programmatically rich, 719-bed correctional facility housing males aged 14 through 20 who are being tried as adults. Many of these youth meet the qualifications for a period of supervised community placement before the end of their sentence, which strongly supports their successful reentry and reintegration into the community.

However, an obstacle deeply imbedded in the correctional culture was disrupting, and in some cases eliminating, these early release options. As administrators, we were faced with many youth approved for early release who subsequently had serious disciplinary infractions that forced the rescission of their early release program decisions.

Upon researching this issue and speaking with these youth, we found a collective mindset and practice among the incarcerated population in which youth approved for early release were being engaged in fights, assaults and other serious infractions with the aim of threatening or preventing their participation in early release programs.

As this only compounded the negativity of incarceration as well as the youth’s sense of loss, disappointment and failure, a new initiative was needed.

Reentry Housing Aids Transitions

Manson Youth Institution’s reentry housing unit was created in January 2010 as an immediate intervention for those youth approved for early release. The unit can house up to 72 youth who, on average, reside there for four to six weeks. After moving this group into the same housing unit, the incidents that threatened these release decisions dropped significantly and to date are almost nonexistent.

Program and service needs for the unit began to arise immediately. No additional staff were needed, although we did reallocate some current staff and resources to the unit. Some existing program components were adopted; a mental health process group that addressed the anxiety and stressors associated with discharging was expanded; a community daily meeting that worked so effectively in our inpatient substance abuse program was adopted; and enhanced discharge planning systems and other supportive programs were established.

But we found ourselves asking what else is needed to assist the successful reentry of a youthful population. We, as adults and correctional professionals, thought we knew what these youth needed by researching best practices and reviewing evidence-based programs. Ultimately, however, we formed focus groups with willing participants and asked them about their experiences, their needs and their goals after incarceration.

The information gathered from these surprisingly candid youth was unexpected and so basic. When asked about their most positive experience at Manson Youth Institution, the majority pointed to their healthy relationships with facility staff.

In hindsight, knowing that most of the youth were entering the system from families that had current or recent involvements with the Department of Children and Families, it should not have been surprising that the stable and positive relationships provided by Manson’s staff were a welcomed support. Parlaying this information into the foundations of the reentry unit’s programs, we concentrated on the availability of a variety of staff to mentor, counsel and provide one-on-one services to the youth in conjunction with formal preemployment and discharge readiness programs and services.

Community Partners Support Success

We added our community partners to our on-unit seminar presenters to help establish and cultivate relationships with these community agency providers prior to discharge. Also, for each discharging youth we create customized “kid-friendly” wallet-sized resource cards that list contact names, addresses and phone numbers of those community providers set to deliver preestablished and prescheduled services.

Another positive development that arose from this initiative is the reentry working group. Composed of facility staff and community partners, this group meets monthly to report successes, present issues, recruit support and seek resolution to discharge obstacles for reentry unit residents.

We continue to explore possible additions to our programs and to establish evidence-based practices. This meeting grows in scope and membership every time we meet.

Outreach to established reentry councils in the larger catchment areas is ongoing and we are continually being contacted by new providers and others with resources who want to be involved. This grassroots enthusiasm can be attributed to the uniqueness of this program and the creativity of its approach. Staff and providers can help to craft individual reentry plans for these youth and in the process become personally vested in their success. For all of us in the “people business,” this is the essence from which we draw our job satisfaction and our unwavering drive to engage youth in a system that may otherwise breed negativity and staff burnout.

Michele Maynard is deputy warden of programs, Manson Youth Institution, Cheshire, CT; e-mail Michele.Maynard@po.state.ct.us. Vickie Alston, MSW, LCSW, QICSW, is health services administrator and manager of the transitional services program, Correctional Managed Health Care, University of Connecticut Health Center, Farmington, CT; e-mail: valston@uchc.edu.
Three-Time Trustee Demonstrates Devotion to Professional Development

When the CCHP board of trustees election concluded in February, Margaret Collatt, BSN, RN, CCHP-A, CCHP-RN, emerged the winner of a three-year term on this essential governing body. The board of trustees is charged with, among other things, developing policy, writing examination questions and analyzing exam results.

This isn’t the first time Collatt has been in the ranks of this important group; in fact, this is her third term serving as a trustee since 2000. And her involvement with the program goes back much further. She was first CCHP certified in 1993 and achieved Advanced certification in 2003 and CCHP-RN certification in 2009.

A veteran of 27 years with the Oregon Department of Corrections, she has held several positions in the health services section, but primarily training and development specialist, which is her current position. After nearly three decades, Collatt says, she still loves her work.

Deep Commitment

That is evident in her deep commitment to correctional health care as a discipline. Collatt is highly active in field through numerous roles at educational conferences, including presenting and moderating sessions, volunteering for booth assignments and helping out in myriad other ways. She has helped to advance the nursing specialty by contributing to the American Nurses Association’s development of practice standards for correctional nurses. She also is a member of the task force that developed the CCHP program’s specialty certification for RNs, and participated in test writing for the exams for all three certifications.

In addition, Collatt is a longtime member of the NCCHC education committee, helping to develop programming that provides continuing education credit. She also has served on the Academy of Correctional Health Professionals’ board of directors as a member, chair, recorder and treasurer.

Positive Outlook

The growing numbers of CCHPs and now the rapid growth in CCHP-RN certification are impressive, she says. “With today’s economy and budget constraints, the rising CCHP numbers are a tribute to the increased professionalism in the correctional field today.” She believes that with the newly designated specialties of CCHP-RN and upcoming certification of physicians and mental health workers, the program will continue to become larger and stronger.

“The investment made in employees today will result in increased professionalism, knowledge of the standards and an understanding of the correctional health care field, and may reduce lawsuits tomorrow,” Collatt adds. All around, it’s a win-win for the field—and one that has benefitted greatly from her efforts.

---

**20 Years of Professional Certification!**

As the Certified Correctional Health Professional program reaches its 20th anniversary, we are sharing tidbits about the program, its history and its supporters. Have something to share? Get in touch at cchp@ncchc.org.

**History:** In April 1989 the first meeting of the ad hoc certification committee was held in Chicago. Committee members were Robert Hilton, RPh (chair), James Owens, MD, Edwin Megargee, PhD, Charles Meyer, Jr., MD, Curtis Prout, MD, Bernard Harrison, JD, Edward Harrison, MBA, and Scott Chavez, MPA, PA-C. The purpose was to research and develop a certification program for specialists in the correctional health care field.

---

**Thanks, Proctors! We Couldn’t Do It Without You**

Because certification exams are offered several times per year at dozens of sites across the country, we rely on a network of dedicated CCHPs to administer the exams under a strict set of procedures. We thank them profusely for their help. Listed below are the proctors for the February exams:

<table>
<thead>
<tr>
<th>Yvonne Barton, LPN, CCHP</th>
<th>Frank Komykoski, MBA, CCHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcie Burr, RN, CCHP</td>
<td>Susan LaFan, RN, CCHP-A, CCHP-RN</td>
</tr>
<tr>
<td>Deborah Embree, BSN, RN, CCHP</td>
<td>Linda Lawrence, ASN, CCHP-RN</td>
</tr>
<tr>
<td>Tara Brown Flynn, RN, CCHP</td>
<td>Gene Lincoln, MS, RN, CCHP</td>
</tr>
<tr>
<td>Deborah Franzoso, LPN, CCHP</td>
<td>Peggy Minward, MSHCA, BSN, CCHP-RN</td>
</tr>
<tr>
<td>Veda Hodge, RN, CCHP</td>
<td>Tanya Munger, MSN, FNP-BC, CCHP</td>
</tr>
<tr>
<td>D. G. Hughes, CCHP</td>
<td>Mary Muse, MS, RN, CCHP-A, CCHP-RN</td>
</tr>
<tr>
<td>Martha Ingram, CCHP</td>
<td>Diane Purks, RN, CJM, CCHP</td>
</tr>
<tr>
<td>Sobeda Jerez, BSN, RN, CCHP</td>
<td>Mary Silva, MBA, BSN, CCHP</td>
</tr>
<tr>
<td>Christopher Kent, CCHP-A</td>
<td>Theresa Stenmark, RN, CCHP</td>
</tr>
</tbody>
</table>

---

**CCHP Exam Dates**

| May 12        | Wisconsin Dells, WI |
| May 22        | Phoenix, AZ        |
| July 10       | Las Vegas, NV      |
| August 20     | Multiple regional sites |
| October 16    | Baltimore, MD      |

We are seeking additional sites for 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. Learn more at www.ncchc.org/cchp.
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.

**Ryung Suh, MD**
NCCHC board member Ryung Suh, MD, was named the William Kane Rising Star Award winner at Preventive Medicine 2011, the annual meeting of the American College of Preventive Medicine. The award honors a member of ACPM who is certified by the American Board of Preventive Medicine and has demonstrated a commitment to preventive medicine and the potential to make significant contributions to the field of preventive medicine and its organizations. Suh, a graduate of the U.S. Military Academy, completed his medical, public policy and management studies at Georgetown University and Trinity College, Oxford University. He is the founder and CEO of Atlas Research, a health care consulting and research firm based in Washington, DC. He also teaches at Georgetown University Medical Center and other institutions. Suh joined the NCCHC board in October as representative of ACPM. Learn more: www.acpm.org/awards.htm

**Marc Stern, MD, MPH, CCHP**
The 2010 Armond Start Award, the highest honor bestowed by the Society of Correctional Physicians, was presented to Marc Stern, MD, MPH, CCHP, at the SCP awards luncheon last October. The award, which was established in honor of an SCP co-founder, has four criteria:
- Adherence to the highest of professional standards
- Unceasing advocacy for better patient care and professional correctional medical environments
- Adherence to the highest of ethical standards
- Dedication to research, publication and training

Stern is a physician surveyor for NCCHC’s accreditation program and serves on the editorial board of the Journal of Correctional Health Care. Learn more: SCP newsletter, Fall 2010, www.corrdocs.org

**National Institute of Corrections**
The NIC is hosting a live satellite/internet broadcast on how effective formulary management can reduce costs, lower risks and enhance services. NCCHC board members Joseph Penn, MD, CCHP (American Academy of Child and Adolescent Psychiatry) and Peter Perroncello, MS, CCHP (American Jail Association) are helping develop the program. Learn more: www.nicic.gov/training/SIB11S9001

---

**Prevention can cost less than you think; treatment may cost more.**

The average cost of treating a MRSA infection in the hospital has risen to over $60,000\(^1\), and that cost does not include the staff time required to supervise a hospitalized inmate.

Correctional facilities are at high risk for the spread of skin infections due to the close quarters and crowding that is unavoidable in these environments.

Hibiclens\(^®\) and Hibistat\(^®\) wipes can help prevent bacterial infections and viral illnesses by providing an extra benefit on the skin. Both products contain Chlorhexidine Gluconate (CHG), which bonds to the skin and provides continuous killing action for up to 6 hours after use\(^2\). It is simply not possible to wash and bathe after every potential contact with contaminants, but Hibiclens and Hibistat wipes can help provide lasting protection against contamination that may lead to illness or infection. Hibiclens has also been proven in a dermatological test to be non-irritating to the skin\(^3\).

We can assist you with a plan to both reduce infection rates and to also fit within your budget. You can find your local representative by going to www.Hibiclens.com or by calling 800.849.0034.

Hibiclens and Hibistat wipes are available through your correctional distributor. They may also be purchased at CVS, Walgreens, Rite Aid, Target, Walmart, Stop & Shop, Giant, and SuperValu stores in the first aid section.
Big Numbers, Big Opportunity
With 2.3 million individuals incarcerated in the United States, serving their wide-ranging health care needs is a big business. In fact, the nation’s correctional facilities spend roughly $7 billion each year to provide this government-mandated care. Just as in the community, services span the spectrum, from acute care to chronic disease management to routine care, including dental and mental health, along with substance abuse treatment, prevention and health education. That’s a big challenge—and a big opportunity for companies that serve this market.

Build Relationships With the Industry’s Best
Our multidisciplinary audience is a microcosm of the health care field at large. They are the leaders—and emerging leaders—in this field. Connecting with these influential professionals extends your reach to the departments, facilities and staff they work with every day.

Effective Outreach
- Exhibitions are the #1 source for attendees who make purchasing decisions.
- Exhibition leads cost 56% less to close than field sales calls.
- Exhibitions allow you to reach an average of 88% of unknown prospects.
Source: The Center for Exhibition Industry Research (CEIR)

Exhibitor Benefits
- 2 full conference registrations per 10’ x 10’ booth
- Discounted full registration for up to 5 additional personnel
- 75-word listing in the Final Program (deadline applies)
- Electronic attendee lists for pre- and post-show marketing
- Free basic listing in NCCHC’s online Buyers Guide
- Discounted advertising in meeting programs & CorrectCare
- Lead retrieval technology available for rental on site
- Opportunity to participate in raffle drawings
- Priority booth selection for the 2012 Updates conference

Sponsorship Opportunities
Enhance your presence and maximize marketing dollars through these outstanding opportunities.
- Premier programming: Educational sessions and breakfast/luncheon programs give attendees a fresh experience while giving your company exclusive exposure.
- Final proceedings: With your company’s name on the cover, the CD-ROM enables attendees to continue their learning with these PowerPoint presentations.
- Exhibit Hall reception/luncheon/breaks: Attendees will appreciate your contribution as they gather in this high-energy center to mingle and network throughout the day.
- Smaller opportunities with big impact: Promote your company name while enhancing the attendee experience by sponsoring the conference bags, lanyards, water bottles, badges, banners and more.
- Customize your contribution. NCCHC will work with you to develop a personalized package tailored to your needs and your budget.

Registration Information
The National Conference is the premier event where you can meet with important contacts and raise your profile in this specialty field, so reserve your space now. Standard booth sizes are 10’ x 10’; double-size and premium spaces are available. For details and a reservation form, please see the Exhibitor Prospectus, available online at www.ncchc.org, or contact Kim Simoni, exhibits and sales manager, at conference@ncchc.org or 773-880-1460.
EDUCATION

FREE LIVE WEBCAST
Antiretroviral Therapy Update 2011
April 6, 2011 (12:00 – 2:00 p.m. ET)
Continuing Education Credits
www.amc.edu/hivconference

CME & DENTAL-ACCREDITED
SELF-STUDY MODULE (1hour)
www.amc.edu/hiv (go to correctional education)

ALBANY MEDICAL COLLEGE
518.262.4674 - hiv@mail.amc.edu

EMLOYMENT

Looking for a new job? This benefit is free to job seekers. Post your resume online and showcase your skills and experience to prospective employers to find the best job opportunities.

Hiring? Receive member discounts on job postings and access the most qualified talent pool to fulfill your staffing needs.

For more information Please visit the career services section of our Web site at www.correctionalhealth.org or contact us at 877.549.2247.

MARKETPLACE

Special Savings! 10% discounts are offered for Academy members (single copies) and bulk purchases of a single title. (Excludes already-discounted items.) To order or for a catalog, visit www.ncchc.org or call 773-880-1460.

Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice, 2nd Ed

Thoroughly updated and in full color, this best-seller is a user-friendly guide to implementing evidence-based practice in nursing and health care. Real-life examples assist readers in actualizing important concepts and overcoming barriers to implementation of evidence-based care. This edition contains a new chapter on implementing evidence in clinical settings and emphasizes all the steps needed to make evidence-based practice part of a sustainable health care culture. Web alerts direct readers to Internet resources to further develop evidence-based practice knowledge and skills. A CD-ROM has checklists and other guides to aid formulating clinical questions and appraising various types of quantitative and qualitative evidence. By Bernadette Melnyk, PhD, RN, and Ellen Fineout-Overholt, PhD, RN. Lippincott Williams & Wilkins (2010). Softbound, 7x10, 624 pages, 49 illustrations. $65.95

Nurses’ Handbook of Health Assessment, 7th Ed.

Renowned for its holistic perspective and see-and-do approach, this full-color, pocket-sized handbook offers step-by-step guidance on every phase of the nursing assessment—for adults, children and special populations. The focus is on what nurses need to know to assess clients: the health history, physical examination, normal and abnormal findings, nursing interventions and nursing diagnoses. This edition completely updates all content and references, with new chapters on mental status and assessing frail elderly clients. By Janet Weber, RN, EdD. Lippincott Williams & Wilkins (2009). Spiralbound, 4.25 x 7.125, 800 pages, 230 illustrations. $49.95

ADVERTISER INDEX

Academy of Correctional Health Professionals........15
Bristol-Myers Squibb – Sustiva.................................9
CCHP Study Package.............................................17
CorrecTek..............................................................8
Correctional Health Partners.................................6
Correctional Medical Services...............................5
Correctional Mental Health Seminar.........................IFC
CrimSpace............................................................12
GEO Group.........................................................21
Hibiclens & Hibistat................................................25
InFocus Lists.........................................................26
Journal of Correctional Health Care.......................28
Lippincott’s Nursing Solutions............................19
Medi-Dose...........................................................13
MHM Services ..................................................BC
PHS Correctional Healthcare...............................22
Spectra Diagnostics..............................................IBC
Wexford Health Sources.......................................4

www.ncchc.org Winter 2011 • CorrectCare
Mental Health Screening by COs

Q Our facility is trying to make better use of staff time by reassigning job duties. One idea was to have correctional officers perform the mental health screening for new inmates. Is this OK under the standards?

A No. To be clear, let’s distinguish between receiving screening and mental health screening. Standard E-02 Receiving Screening states that the screening done at intake includes questions related to mental health and these may be asked by a health-trained correctional officer. However, these questions alone do not constitute the mental health screening. Within 14 days of admission, an initial mental health screening needs to be conducted by qualified mental health professionals or mental health staff (see E-05 Mental Health Screening and Evaluation). “Mental health staff” includes qualified health care professionals who have been trained and are supervised in identifying and interacting with people in need of mental health services.

Provision of Reading Glasses

Q Under the standard regarding Aids to Impairment (G-10), are we required to provide reading glasses to inmates?

A No. The standard requires that when determined by the responsible physician or dentist, an aid to impairment should be supplied in a timely manner when the health of the inmate would otherwise be adversely affected [emphasis added]. Such aids include eyeglasses when, for example, the inmate’s health and adaptation to the correctional facility could be affected. The visually impaired individual could be at a distinct disadvantage trying to assimilate into the jail or prison. This category would include elderly inmates and patients with diabetic retinopathy who are visually impaired to the extent that they require assistance in activities of daily living. (Also see G-02 Patients With Special Health Needs.)

Juvenile Standards Timeline

Q We hear that a new edition of NCCHC’s standards for juvenile detention facilities is being published. We are accredited and due for our next survey this fall. Will we be held accountable for following the new standards?

A Indeed, the new edition of the Standards for Health Services in Juvenile Detention and Confinement Facilities is now being prepared for publication. The following timeline assumes it will be published this spring.

- May 1: All juvenile facilities seeking initial accreditation will be surveyed under the 2011 edition of the Standards.
- May 1 through September 30: All currently accredited juvenile facilities will be surveyed under the 2004 edition.
- October 1: All juvenile facilities will be surveyed under the 2011 edition.

Jennifer E. Kistler, MPH, is NCCHC’s director of accreditation. Scott Chavez, PhD, MPA, CCHP-A, is NCCHC’s vice president and liaison to the policy and standards committee.
58 million tests a year have taught us one thing: you deserve more from your lab than just test results.

Visit us at www.spectradiagnostics.com to learn how we’re personalizing lab services for the correctional healthcare community.

© 2010 Fresenius Medical Care Holdings, Inc. All rights reserved. Spectra, Spectra Diagnostics, and © are trademarks of Fresenius Medical Care Holdings, Inc.
“LAST YEAR, I HELPED OUR CLIENTS SAVE $15+ MILLION IN DRUG COSTS.”

“My team and I monitor medication usage trends and track best practices to give our clinicians better medication choices. We not only find ways to lower costs, we give savings back to you.”

Gregg Puffenberger, PharmD, MBA
MHM Director of Pharmacy Management

MHM is the leading national provider of correctional mental health. We provide value-added pharmacy management services to all of our clients to contain costs and improve outcomes.

Delivering correctional healthcare the right way costs less. Find out how by contacting Dr. Puffenberger at 800.416.3649 or gpuffenberger@mhm-services.com

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

The Public-Private Partner for Healthcare®